STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax (608) 267-4549
http://etf.wi.gov

Date: November 14, 2017

To: All Potential Proposers to RFP ETH0020

RE: **ADDENDUM No. 1**
Request for Proposal (RFP) ETH0020
Medicare Advantage Plans for Medicare-Enrolled Participants in the State of Wisconsin Group Health Insurance and Wisconsin Public Employer Programs

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Acknowledgement of receipt of this Addendum No. 1:

Proposers must acknowledge receipt of this Addendum No. 1 by providing the required information in the box below and including this Page 1 in Tab 1 of their Proposal.

Proposer's Company Name:
Authorized Person (Printed Name and Title):
Authorized Person's Signature:
Date

Please note the following updates to RFP ETH0020:

1. **ADD** the following bullet to Page 20 of the RFP, Section 2.4, to the right of TAB 1, General Information and Forms, directly proceeding "Provide the following in the following order:"
   - Page 1 of ADDENDUM No. 1: Completed and signed Page 1 of Addendum No. 1.

2. **ADD** the following language in red to Page 20 of the RFP, Section 2.4, to the right of TAB 1, General Information and Forms, under TRANSMITTAL LETTER:
   - TRANSMITTAL LETTER: A signed transmittal letter must accompany the Proposal. The transmittal letter must be written on the Proposer's official business stationery and signed by an official that is authorized to legally bind the Proposer. Include in the letter:
     1) Name, title, and signature and of Proposer's authorized representative;
     2) Name and address of firm;
     3) Telephone number and e-mail address of representatives who will be responsible for providing Services under this RFP;

4) RFP number and title: ETH0020 Medicare Advantage Plans;
5) Type of Proposal being submitted: "National PPO with Pharmacy," "Regional Plan with Pharmacy," or "Regional Plan without Pharmacy;" and,
6) Executive Summary.

3. **REVISE** RFP Section 2.4, Assumptions and Exceptions, Table 7. *No Assumptions or Exceptions Allowed* as follows:

Table 7. No Assumptions or Exceptions Allowed

No.	Document	Item/Section
1	Exhibit 1	155B and 315 Performance Standards and Penalties
2	Exhibit 1	155D Audit and Other Services
3	Exhibit 1	155F Privacy Breach Notification
4	Exhibit 1	155H Contract Termination
5	Exhibit 1	220 Benefits
6	Exhibit 1	250 Grievances
7	Exhibit 1	400 Uniform Benefits
8	Exhibit ~~2~~ 3	15.0 Applicable Law and Compliance
9	Exhibit ~~2~~ 3	17.0 Assignment
10	Exhibit ~~2~~ 3	32.0 Hold Harmless
11	Exhibit ~~4~~ 5	6.0 Audit Provision
12	Exhibit ~~4~~ 5	13.0 Contract Dispute Resolution
13	Exhibit ~~4~~ 5	14.0 Controlling Law
14	Exhibit ~~4~~ 5	16.0 Termination of this Contract
15	Exhibit ~~4~~ 5	17.0 Termination for Cause
16	Exhibit ~~4~~ 5	18.0 Remedies of the State
17	Exhibit ~~4~~ 5	22.0 Confidential Information and HIPAA Business Associate Agreement
18	Exhibit ~~4~~ 5	23.0 Indemnification
19	Exhibit ~~4~~ 5	28.0 Data Security and Privacy Agreement
20	Form J	Non-Disclosure Agreement with Truven Health Analytics (entire document~~s~~)

4. **REVISE** RFP subsection 6.6.7 as follows:

Please describe in detail your plan to address and manage the elimination of Health Insurance Claim Numbers (HICN) and replacement with Medicare ~~billing~~ beneficiary identifiers ~~(MIB)~~ (MBI) through the transition period and effective date.

5. **REVISE** RFP subsection 7.2.4 3) as follows:

3) For urgent and emergent out-of-network claims, how do you ensure that Participants are not responsible for balance billing from out-of-network providers.

6. **ADD** the following language in red to the beginning of Section 8, on page 47 of the RFP:

8 Network Submission Requirements, alternative benefit design, and cost proposal

Only the Uniform Benefit Cost Proposal in this section is scored. (200 total points)

This section contains the submission requirements required to be submitted by the Proposer.

Attachments A, D and E, and all answers, confirmations, attachments, reports, documentation, summaries, etc. requested within Section 8 must be submitted to Segal via Segal's Secure File Transfer (SFT) system.

7. **REVISE** Exhibit 1 subsection 135B(3) as follows:

3) Pilot Programs. At the request of the DEPARTMENT, the CONTRACTOR shall enter into a pilot or limited-term trial. See Section 225(6)~~Section 215C~~.

8. **DELETE** Exhibit 1 subsection 155E 3):

~~**3) Appeal Process Support**.~~

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

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

9. **Note to vendors:** the appeal process language above (Exhibit 1 subsection 155E 3) appears in Exhibit 1 Section 250E.

10. **REVISE** Exhibit 1 subsection 155H 1) a) as follows:

The ~~CONTRACT~~ BENEFIT maximum is reached.

11. **RENUMBER** Exhibit 1 Section 225, the second item numbered 5 as follows:

~~5)~~ 6) The CONTRACTOR shall collaborate with providers on quality initiatives to address current population health issues. The CONTRACTOR shall report to the DEPARTMENT semi-annually any initiatives and pilot programs offered by the CONTRACTOR or the CONTRACTOR'S IN-NETWORK providers, including information on patient engagement and outcomes.

12. **REVISE** the fourth paragraph of Exhibit 1, subsection 250E as follows:

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. Participation means providing evidence and testimony necessary to explain the claim decisions made by the CONTRACTOR. The CONTRACTOR shall be responsible for any cost required for

participation in the administrative hearings by the CONTRACTOR'S staff and any approved subcontractors, including but not limited to time spent at the hearing and travel time to and from the hearing. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

13. **REVISE** Exhibit 1 subsection 305(6) as follows:

6)	*Intentionally left blank.*	

14. **DELETE** Exhibit 1 subsection 310A(26):

~~**26)**~~		

15. **ADD** the following questions regarding RFP ETH0020 from Proposers and answers from ETF to the RFP:

Medicare Advantage RFP - Vendor Q&A

No.	RFP Section	Page	Question/Rationale
Q1	**RFP 1.2.1, Health Insurance Program**	**4 & 5**	**Is the general intent to allow eligible retirees (those with Part A and B) to only select from available Medicare Advantage Plans, and not allow continuation on the IYC Health Plan in 2019?**
A1			The Group Insurance Board (Board) will consider what Medicare options will be available in the future once it has an opportunity to review the responses to the RFP. Any changes to the options available will be made consistent with the goals of this RFP.
Q2	**RFP 1.2.1, Health Insurance Program.**	**5**	**Does the Medicare plan options enrollment of 33,502 include Medicare enrollees that permanently live outside of the state of Wisconsin? How many people reside outside of Wisconsin and in what states are they located?**
A2			Yes. The enrollment numbers provided to vendors include members who live outside of Wisconsin. ETF has attached a document that lists the number and location of members living outside of Wisconsin.
Q3	**RFP 1.2.1, Health Insurance Program.**	**5**	**What proportion of the Medicare-eligible enrollees leave the employer medical plan for other coverage once they retire? One they leave do they lose their eligibility or are they allowed to return to the plan?**
A3			ETF analyzed the change in enrollment from 2016 to 2017 and found that 10% of Medicare eligible retirees terminated their coverage. This number does not include those changes in enrollment due to death. Whether or not a Medicare eligible retiree can return to the program following cancellation depends on the status of the retiree. State annuitants can re-enroll. This is typically done during It's Your Choice (IYC). Retirees from Wisconsin Public Employers (locals) cannot re-enroll once they cancel coverage.

Q4	RFP 1.2 Current State and Background	5	**Table 1: 2017 Enrollment in Medicare Plan Options shows 33,502 as the total number of Medicare-Enrolled Members, while the Census (Attachment F) and claims data (Attachments G & H) show around 30,000 members. Please explain the difference. Please provide either an updated census or claims data.**
A4			Table 1 includes some members that are not Medicare Primary. Use attachments F, G and H for pricing.
Q5	**RFP 1.2.1, Health Insurance Program & Exhibit 1, Section 400**	**6-8 Ex.1 89-97**	**The RFP advises in Section 1 that the plans meet Uniform Benefits. The (vendor name redacted) plan indicated a single set of benefits, however the Uniform Benefits indicates differences between the State and WPE. Is the intent that the RFP include offerings for two Part C MA benefits matching each of the categories of Uniform benefits?**
A5			The plans must be able to administer the current Uniform Benefits for both the State and local populations, as described in Tables 2 and 3 and Section 400 of Exhibit 1 Medicare Advantage Program Agreement.
Q6	**RFP 1.2, Current State and Background**	**8**	**Pharmacy Benefits - Table 3. 2017 Plan Year Pharmacy Benefit Plan Design: Are the Family Out-of-Pocket Limits (OOPL) just comprised of EGWP members or could the Family OOPL include EGWP plus Commercial/Active members?**
A6			Currently the family OOPL is inclusive of all members on the policy. Under a Medicare Advantage contract, it is anticipated only members eligible under the contract would be covered.
Q7	**RFP 1.2, Current State and Background**	**8**	**Pharmacy Benefits - Table 3. 2017 Plan Year Pharmacy Benefit Plan Design: On the footnote to Table 3, does the federal Affordable Care Act (ACA) annual combined medical and prescription drug maximum out-of-pocket (MOOP) limits; $7,150 for an individual and $14,300 for a family in 2017, apply to the EGWP plan?**
A7			Currently, any member cost share associated with the claim adjudicating through the PDP benefit (EGWP/ MedicareRx plan/etc.) **does not** accumulate to the Federal MOOP. However, any member cost share associated with the claim adjudicating through the Wrap benefit **does** accumulate to the Federal MOOP. Prescription drugs will not apply to the federal MOOP under the program described in the RFP
Q8	**RFP 1.2, Current State and Background**	**8**	**Pharmacy Benefits - Table 3. 2017 Plan Year Pharmacy Benefit Plan Design: The Level 4 Non-Preferred Copay of 40% co-insurance ($200 max) exceeds the CMS cost-share guidelines for the specialty-tier. There could be situations where the member pays more than the 33% allowed. Can we adjudicate at 33% with a $200 max?**

A8			Proposers must administer Uniform Benefits, which is both a Prescription Drug Plan and a Wrap plan. Any amount above the 33% allowed by CMS would fall under the Wrap plan. Proposers may also offer alternative benefit designs.
Q9	**RFP 1.2.1, Health Insurance Program** **Table 3. 2017 Plan Year Pharmacy Benefit Plan Design**	**8**	**Please provide a comprehensive list of Preferred Specialty Drugs by NDC.**
A9			Proposers should bid their drug list.
Q10	**RFP 1.2.1, Health Insurance Program** **Table 3. 2017 Plan Year Pharmacy Benefit Plan Design**	**8**	**Please request a list of preventive drugs at $0.**
A10			For reference, ETF is attaching the following two documents from Navitus Health Solutions that give broad categories: • Health Care Reform Preventive Drug Coverage Guidelines – Updated September 2015 • High Deductible Health Plan Preventive Drug List – Updated July 2015
Q11	**RFP 1.2.1, Health Insurance Program** **Table 3. 2017 Plan Year Pharmacy Benefit Plan Design**	**8**	**Does the current PBM, for Level 4, have a preferred specialty network of pharmacies?** **If so, please provide a comprehensive list of Preferred Specialty Pharmacies by Pharmacy NPI.**
A11			The current Level 4 specialty pharmacy benefit utilizes a network of pharmacies with preferred specialty pharmacies identified. Proposers should bid using their proposed network of preferred pharmacies.
Q12	**RFP 1.2.1, Health Insurance Program Table 3. 2017 Plan Year Pharmacy Benefit Plan Design**	**8**	**The footnote below the Pharmacy Benefits table indicates certain cost shares would go towards the combined medical and prescription drug MOOP limits. Medicare advantage with Prescription drug plans accrue costs separately for medical services and prescription drugs, in alignment with CMS regulations. Please confirm**

			the proposed benefits will have separate Medical MOOP and Prescription Drug MOOP.
A12			Currently, any member cost share associated with the claim adjudicating through the PDP benefit (EGWP/ MedicareRx plan/etc.) **does not** accumulate to the Federal MOOP. However, any member cost share associated with the claim adjudicating through the Wrap benefit **does** accumulate to the Federal MOOP. Prescription drugs will not apply to the federal MOOP under the program described in the RFP.
Q13	**RFP 1.2.1, Health Insurance Program Premium Payments**	**9**	**A. If a Medicare eligible retiree leaves the State of Wisconsin Group Health Insurance Program(GHIP) in 2018 due to, for example, exhaustion of sick leave credits or another reason, would that retiree be eligible to re-enroll to the new GHIP MA plans during the 2019 open enrollment period?** **B. How many Medicare eligible retirees drop retiree Medical coverage each year?** **C. How many and what percentage retirees currently pay their retiree medical premiums via direct payments to the health Plan?** **D. Does the opt-out incentive apply to Medicare eligible retirees? If so, please provide details of the incentive plan and the number of retired Medicare eligible members who opted out for 2018.**
A13			**A.** Yes. **B.** ETF analyzed the change in enrollment from 2016 to 2017 and found that approximately 2,000 or 10% of Medicare eligible retirees terminated their coverage. This number does not include enrollment changes due to death. **C.** Approximately 1,200 subscribers, 4.72% of total State and local annuitants pay their premiums directly to a health plan. **D.** No, the opt-out incentive is only available to employees of the State and of locals where the employer has made it available.
Q14	**RFP 1.2, Current State and Background**	**9**	**Can the State of WI ETF confirm their plans to mandate enrollment in Medicare Advantage Employer Group plans beginning 1/1/19 – replacing the current Medicare carve out options?**
A14			See Question 1/Answer 1.
Q15	**RFP 1.2, Current State and Background**	**9**	**Can ETF clarify the expected savings of moving all of their annuitants to an EGWP program? How are the savings achieved?**
A15			No savings have been estimated. Savings are presumed based on other states' experience and the potential to offer alternative benefit designs.
Q16	**RFP 1.2, Current State and Background**	**9**	**Premium Payments: Please provide an estimate of the average percentage the retiree's premium is subsidized.**

A16			Retiree premiums are not subsidized. A State employee may convert unused sick leave to credits to pay for insurance in retirement. Once those credits are depleted, the retiree may pay their premiums from their retirement annuity or with direct payment to the health plan. A small number of retirees convert reduced life insurance benefits to pay for health insurance premiums after their sick leave credits are depleted. As stated in the RFP, previous research has shown that State employees can retire with sizable sick leave balances that will be used to pay premiums, typically 6-10 years into retirement. Some local employers may elect to subsidize their retirees premiums. No estimates are available on the average percent of premiums subsidized for such local employers.
Q17	**RFP 1.2, Current State and Background & Exhibit 1, 130A**	**9 Ex.1 22**	**Can ETF further clarify the premium payment methodology for the annuitant population? Specifically, will ETF be subsidizing any of the enrollee's premium or is it fully subsidized by the sick leave balance accrued during active employment?**
A17			See Question 16/Answer 16.
Q18	**RFP 1.2.1, Health Insurance Program Wellness Benefits**	**10**	**How does ETF envision the Medicare Advantage carrier to integrate and work, if at all, with Wisconsin's Wellness vendor, Stay Well? Does EFT have concerns about duplicity or confusion in messages concerning wellness and disease management since the Medicare Eligible retirees can access and engage with StayWell despite not receiving the $150 incentive?**
A18			Medicare Advantage enrollees have not been eligible for the Well Wisconsin incentive or fee based programs. 2017 enrollees were allowed to access the StayWell portal but did not receive promotional outreach from StayWell. ETF works closely with all vendors of the group health insurance program to ensure member messaging is clear and to eliminate duplication of programming.
Q19	**RFP 1.2.1, Health Insurance Program Wellness Benefits**	**10**	**Confirm that contractor can assume that there will be no changes to the scope of ETF's current Wellness program for 2019.**
A19			The Well Wisconsin incentive and fee based programs are not offered to ETF Medicare Advantage enrollees; therefore, future incentive requirements are not relevant to the Proposer. Use Section 7.4 to detail the programs that would be provided to ETF's Medicare Advantage population.
Q20	**RFP 1.3, Future State**	**11**	**Will current IYC Health Plan Medicare members be allowed to stay on those plans offered by current Health Plan vendors or will ALL Retirees with Medicare be forced to choose a new Medicare**

			Advantage Plan with benefits outlined in the (RFP) ETH0020?
A20			See Question 1/Answer 1.
Q21	**RFP 1.3, Future State: Project Scope and Objectives**	**11**	**For the Regional service areas within Wisconsin, are these regions defined?**
A21			Vendors are to propose their regions. This RFP does not define them.
Q22	**RFP 1.3, Future State**	**11 and 12**	**Our Plan currently offers a Medicare Cost Plan to ETF retirees eligible for Medicare Part A & B. The benefit design follows the prescribed benefit Plan of ETF. Will a Cost Plan be considered as an eligible Plan to submit a proposal?**
A22			A Medicare Cost Plan is not considered an eligible Plan under this RFP.
Q23	**RFP 1.3, Future State**	**11 and 12**	**Will the RFP move the "Medicare" portion of the ETF benefits to a separate process from that of active Employees, i.e. if the Plan does not participate in the RFP, will it no longer be able to offer to Medicare eligible retirees?**
A23			See Question 1/Answer 1.
Q24	**RFP 1.3, Future State**	**11-12**	**How many contractors may win in a given county?**
A24			As stated in RFP Section 1.3, the Board may award one Contract to serve the nationwide service area, and may also award multiple Contracts for a regional service area as a result of this RFP. An award is not guaranteed.
Q25	**RFP 1.3, Future State**	**11-12**	**Can a contractor potentially win in only a portion of their proposed service area?**
A25			For regional service area proposals, a Proposer has to meet the network access requirements outlined in Section 8.1 of the RFP in each county they propose to serve. If a Proposer fails to meet the access requirements in any county they propose to serve, they will not be selected to serve that county.
Q26	**RFP 1.3, Future State**	**11-12**	**Is ETF considering creating regions similar to the self-funding RFP process for the EGWP program?**
A26			See Question 21/Answer 21.
Q27	**RFP 1.3, Future State**	**12**	**Please confirm alternative plan designs may include alternative formularies or alternative pharmacy network arrangements.**
A27			Yes. Proposals should document all differences between the current Uniform Benefits designs as described in Tables 2 and 3 of the RFP and Section 400 of Exhibit 1. See RFP Question 8.2.2. Such differences and any other information about the alternative plan designs must be submitted to Segal via Segal's Secure File Transfer (SFT) system.
Q28	**RFP 1.3, Future State**	**12**	**Please describe the overall strategy or policy around providing alternative benefit designs. Is the goal to offer the alternative benefits designs**

			plans alongside of the Uniform Benefit Design MA Plan or in lieu of? Should the plan design be positioned as an additional choice for members to the Uniform Benefit Design MA Plan?
A28			The Board is open to offering alternative benefit designs alongside the Uniform Benefit Design or in lieu of the Uniform Benefit Design depending on which approach is in the best interest of the members and is consistent with the goals of the RFP. The Board will determine which approach depending on the results of the RFP.
Q29	**RFP 1.3, Future State**	**12**	**Please confirm that National PPO must be quoted as MAPD whereas the regional HMO's may be quoted MA or MAPD.**
A29			Yes.
Q30	**RFP 1.3, Future State**	**12**	**The RFP language suggests that the regional plans offered alongside the National PPO carrier could be non-Medicare Advantage plans (i.e. current regional Medicare supplement/secondary plans.) Is this a correct interpretation?**
A30			See Question 1/Answer 1.
Q31	**RFP 1.3, Future State**	**12**	**Will the board consider regional proposals that are not a Medicare Advantage Program? There are other plan options that are not Medicare Advantage but do accomplish the RFP objectives of lower monthly premium costs, high quality, high value services, and excellent benefit packages.**
A31			Only Proposals for employer group waiver programs for Medicare Advantage or Medicare Advantage with prescription drug benefits will be accepted under this RFP.
Q32	**RFP 1.3, Future State**	**12**	**The proposal request advises in Section 1 that the Plan submit two alternative benefit designs. Is the intent of the designs to include both MAPD designs (Integrated plan for Part C and D) and MA only designs, or should it only include MA only designs (Part C benefits)?**
A32			Regional service area Proposals that do not include a prescription drug benefit should include alternative benefit designs that are MA only designs. All other Proposals should submit alternative benefit designs that include both MA and prescription drug benefit designs.
Q33	**RFP 1.3, Future State & 8.3 Cost Proposal**	**12, 51 & 52**	**Will multiple plans be selected for Part D, or is the bid for Part D to be exclusively awarded to a single entity on a Stand Alone Part D?**
A33			As stated in RFP Section 1.3, the Board will not make an award for prescription drug benefits only. It is possible that more than one vendor will be selected

			that offers both Medicare Advantage and prescription drug benefits to its members.
Q34	**RFP 1.3, Future State & 8.3.1 Preliminary Premium Bid**	**12 & 51**	**The proposal request advises in Section 1 that a plan may bid on Part C or include Part D benefits. The layout of the document implies that the Part C (MA) and Part D benefits would be separate plans, with separate premium amounts, which is allowed under the EGWP Rules in Chapter 9 of the MMCM (Medicare Managed Care Manual). Is the correct interpretation that the Part C plan and the Part D plan would be separate Plans for the primary plan submission? Or does the proposal request support the filing of combined MAPD offerings with the Part D embedded to the benefits of the Plan, but still require the premium of each program to be broken out (per Section 8)?**
A34			The Section 8 submission documents break out the premium between Part C and Part D benefits to give the Board the maximum flexibility to make an award should it determine it wants to make an award for Medicare Advantage (Part C) benefits only. If the Board makes an award for both Part C and Part D benefits, it intends for the plan to be filed as a combined benefit plan.
Q35	**RFP 1.9, Calendar of Events**	**16-17**	**Would the State of WI ETF consider a three week extension to the RFP due date in light of the initial delay of the release of the RFP and the Segal data not being available immediately upon RFP release?**
A35			The state will not consider a three-week extension of the RFP due date.
Q36	**RFP 2.1, General Instructions**	**18**	**The Revised Premium Submission is due April 30, 2018. Does ETF expect to have a Best and Final Offer after April 30, 2018?**
A36			ETF may ask for a BAFO at any time during contract negotiations.
Q37	**2.4 Proposal Organization and Format, and Table 7. No Assumptions or Exceptions Allowed**	**22-23, 53**	**Please confirm Item numbers 8, 9, and 10 refer to Exhibit 3 (rather than Exhibit 2).**
A37			ETF confirms, item numbers 8, 9, and 10 in RFP Table 7 should refer to Exhibit 3 (not Exhibit 2).
Q38	**RFP 2.4, Proposal Organization and Format**	**22-23, 53**	**Please confirm Item numbers 11-19 refer to Exhibit 5 (rather than Exhibit 4).**

	Table 7. No Assumptions or Exceptions Allowed		
A38			ETF confirms, item numbers 11-19 in RFP Table 7 refer to Exhibit 5-Department Terms and Conditions (rather than Exhibit 4).
Q39	**RFP 2.4, Proposal Organization and Format Table 7. No Assumptions or Exceptions Allowed**	**22-23**	**It appears that items 8-10 should indicate "Exhibit 3" (instead of "Exhibit 2"), and items 11-19 should indicate "Exhibit 5" (instead of "Exhibit 4"). Is this correct?**
A39			Yes. ETF confirms, item numbers 8, 9, and 10 in RFP Table 7 should refer to Exhibit 3-DOA-3054-Standard Terms and Conditions (Request For Bids / Proposals) (not Exhibit 2), and numbers 11-19 in RFP Table 7 refer to Exhibit 5-Department Terms and Conditions (rather than Exhibit 4).
Q40	**RFP 6.3.1**	**30**	**Section 6.3.1 references a "dedicated" Account Manager yet (4) suggest that the Account Manager would oversee other accounts while assigned to manage GHIP implying a "designated" Account Manager model. Based on the aforementioned, please define "dedicated" as it relates to the Account Manager.** **Also, does ETF expect the Account Manager to be "dedicated" to the same degree to the State of Wisconsin account regardless of the offering environment or number of members (i.e. National PPO or Regional offering)?**
A40			ETF prefers that the Account Manager have a focus on the State program and a lesser involvement with other accounts. However, this does not require that the manager be responsible for no other accounts, especially if the expected quantity of State enrollees is relatively low.
Q41	**RFP 6.6.7**	**33**	**Clarify that reference to Medicare billing identifiers (MIB) –means Medicare Beneficiary Identifier (MBI)?**
A41			ETF confirms that the reference should be to Medicare beneficiary identifiers (MBI).
Q42	**RFP 6.6.3 & Exhibit 1, 205A**	**33 Ex.1, 41**	**For split families what information/identifiers will be submitted on the 834 file to the contractor? Please list what would be reported both for the Medicare Advantage Enrollee as well as the Group coverage Enrollee(s). Also, please identify if this will be different if the Group coverage is with a different contractor than the ETF Med Advantage coverage.**

A42			This is an administrative decision that will be determined once the Board has established available Medicare options.
Q43	**RFP 6.6.5 & 6.6.6**	**33**	**Please clarify for 6.6.5 and 6.6.6, does ETF want to know the adjusted premium rate due to either LEP or LIPS for all Med Advantage members? Or is this information only requested/required for Med Advantage members that are group bill, but not required for those that are direct bill?**
A43			Yes, ETF would like information on the adjusted premium rate due to either LEP or LIPS for all Medicare Advantage members.
Q44	**RFP 7.1, Provider Management**	**37**	**How does ETF define "sufficient choice of providers" regarding Provider Network adequacy? Please clarify how this will be measured using the non-CMS standards outlined in Section 8.**
A44			Refer to Exhibit 1, Section 230A Provider Access Standards as well as Section 8 of the RFP.
Q45	**RFP 7.1.3**	**38**	**Clarify provider steerage intent as contractor's IDN ownership concentrates MA-PD utilization to owner entities and other in-network providers. Is there a concern that contractor may have to direct to non-plan Providers if specialty care is required more quickly?**
A45			We are interested in Proposer's methods to steer care to specific providers that achieve the best outcomes in terms of quality and cost for in-network providers. If your members frequently use out-of-network providers, address those providers in your response.
Q46	**RFP 7.1.2-7.1.5**	**38**	**Should contractor's response be limited to efforts specific to Medicare Advantage product efforts only or can it include plan wide efforts applicable to other products?**
A46			ETF prefers responses that focus on Medicare Advantage. Proposers can include other efforts but should describe how their Medicare population benefits.
Q47	**RFP 7.2.3**	**39**	**Clarify that reporting capturing number of contractor providers who accept Medicare assignment is a one-time report? Is this a composite number for contractor's entire MA-PD service area?**
A47			The request for percentage of providers who accept Medicare assignment will be made only once during the RFP process. This number should be a composite of the entire service area. ETF may request the report again during the term of the Contract.
Q48	**RFP 7.2.4**	**40**	**Was it ETF's intent for question #3 to read, "For urgent and emergent out-of-network claims, how do you ensure that Participants are not responsible for balance billing from out-of-network providers?"**
A48			Yes. ETF intended to ask about balance billing for out-of-network providers.

Q49	**RFP 7.2.5**	**40**	**Should contractor's response be limited to efforts specific to Medicare Advantage product efforts only or can it include plan wide efforts applicable to other products?**
A49			ETF prefers responses that focus on Medicare Advantage. Proposers can include other efforts but should describe how their Medicare population benefits.
Q50	**RFP 7.3.9**	**41**	**Confirm scope of question and obtain an example of what type of clinical program is being referenced.**
A50			ETF is seeking a clinical professional who has full knowledge of all clinical programs for which the Medicare Advantage population could be enrolled. This could include case, disease, utilization management or any clinical quality improvement initiatives.
Q51	**RFP 7.4.3**	**42**	**The proposal documentation indicates that we should state any available benefits we offer for Silver Sneakers. Silver Sneakers is a gym and fitness option offered by one company. While we offer similar benefits as a Silver Sneakers program, it is through a different company. How should we indicate this in the proposal?**
A51			Include a detailed description of your program. Brief, direct marketing materials may also be included.
Q52	**RFP 7.5.6**	**43**	**7.5.6 Member Engagement Strategies: Is it a requirement to have a clinical program for each of the conditions listed (i.e. smoking cessation, diabetes, rheumatoid arthritis and multiple sclerosis) or are these simply examples?**
A52			The vendor is not required to address every listed program or condition. These are simply examples.
Q53	**RFP 7.5.1**	**43**	**Please provide details regarding what benefits ETF considers to be "wrap products," "wrap plans," or "wrap-around" benefits referenced on pages 4, 8, 43 and 45.**
A53			By this, ETF means products to provide supplemental coverage in the Medicare Part D coverage gap phase (donut hole) and in situations where members experience other out of pocket costs beyond current copay levels (e.g. the Medicare Part D deductible phase). As defined on Page 11 of the RFP, the "wrap" functions to align EGWP pharmacy benefit coverage with those pharmacy benefits available to active employees. Also, note that if the member cost share established by the plan exceeds the CMS limits (e.g. 40% plan coinsurance vs. 33% CMS limit for specialty tier), the excess cost share (17%) is then pushed to the Wrap for secondary coverage, in accordance with plan design. This is CMS compliant.
Q54	**RFP 7.8.1**	**46-47**	**Offering a National Service Area Proposal: CMS regulations for out-of-network pharmacy services**

			stipulate that the member is responsible for their standard cost-sharing under the plan plus the difference between the cash price and plan allowance, if the cash price is higher. Is this consistent with your expectation?
A54			Confirmed. Per the Rx Medicare Managed Care Manual, "Part D sponsors must ensure that their enrollees have adequate access to covered Part D drugs dispensed at OON pharmacies when those enrollees cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy, and when such access is not routine."
Q55	**RFP 8, Network Submission Requirements, Alternative Benefit Design, and Cost Proposal**	**47**	**Do the Section 8 attachments include experience data for this population? If not, will experience data be made available?**
A55			Yes, experience data was made available to vendors who submitted a signed NDA by the due date via Segal's Secure File Transfer (SFT) system.
Q56	**RFP 8, Network Submission Requirements, Alternative Benefit Design, and Cost Proposal**	**47-53**	**Please confirm contractors should submit the written responses to questions in section 8 within the hard copy technical proposal and only submit Attachments A, D, and E through Segal's Secure File Transfer system. If so, please update section 2.4 to reflect this.**
A56			Attachments A, D and E, and all answers, confirmations, attachments, reports, documentation, summaries, etc. requested within Section 8 must be submitted to Segal via Segal's Secure File Transfer (SFT) system. Do not include Section 8 materials in your written Proposal submitted to ETF or your electronic files submitted to ETF (as required under RFP Section 2.3).
Q57	**RFP 8.2, Alternative Benefit Designs**	**50**	**Is the intent that alternative designs be based on current EGWP business, or assumed to be "individual plans" which can be offered to group beneficiaries and are also available to the general individual MA market?**
A57			The intent of the alternative plan is to allow vendors to offer a plan design they feel would be beneficial to ETF retirees.
Q58	**RFP 8.2.1 & 8.2.2**	**50**	**Is there a template for sections 8.2.1 and 8.2.2 Alternative Benefit Designs or should contractors create the requested table on their own?**
A58			Use the format of the table provided in sections 8.2.1 and 8.2.2.
Q59	**RFP 8.2.1**	**50**	**Please confirm that ETF may allow different Alternative Benefit Plan design choices in years 2 or 3 from what is proposed and possibly offered for year 1.**

A59			Yes, this is confirmed.
Q60	**RFP 8.3, Cost Proposal**	**51**	**Will ETF be providing medical risk scores, similar to the pharmacy risk scores provided in the Segal data package? If not, cost proposals will not be comparable to each other as each contractor will make their own assumptions about medical risk scores and could result in large variations from contractor to contractor.**
A60			No, medical risk scores are not available. Vendors have all necessary claims data to determine an expected risk score.
Q61	**RFP 8.2.4**	**51**	**Please provide a definition of medical tourism.**
A61			Medical tourism is defined as a member traveling outside of their plan network area to obtain medical treatment.
Q62	**RFP 9, Contract Terms and Conditions**	**53**	**Will there be an order of preference or weight assigned to all of the documents which comprise the complete Contract, especially as it might relate to the resolution of any conflicts between the terms of the various documents? If so, please provide**
A62			Yes, see Exhibit 2, Pro Forma Contract by Authorized Board. An order of precedence will be listed in paragraph 4 of the final contract.
Q63	**Attachment A – Network Access**	**Provider listing tab**	**For the National PPO, should each carrier provide a list all providers in network in Wisconsin or all Providers in the entire National PPO network? Supplying all providers in the National PPO network would include the entire country. Alternatively, should only providers in states that ETF has membership be supplied?**
A63			For the National PPO, provide a list of all providers in the entire National PPO network.
Q64	**Attachment B – EGWP Formulary for Medicare Enrolled Participants as of September 1, 2017**		**Attachment B – EGWP Formulary for Medicare Enrolled Participants as of September 1, 2017: Does Formulary Tier = NC indicate "Not Covered"?**
A64			Yes, NC = Not Covered. An updated file confirming this information was uploaded to Segal's Secure File Transfer (SFT) system on 11/6/17.
Q65	**Attachment B – EGWP Formulary for Medicare Enrolled Participants as of September 1, 2017**		**Attachment B – EGWP Formulary and Attachment C – Formulary Companion Guide: "Drug Edits" referenced in Attachment C - Formulary Companion Guide are not identified in Attachment B – EGWP Part D + Wrap Formulary, Can you provide the formulary with these fields added? In particular, identification of drugs that qualify for the Specialty Pharmacy Incentive (ESP) is required to quote the pharmacy benefit.**
A65			A drug edit field was added to Attachment B – EGWP Formulary and loaded to Segal's Secure File Transfer (SFT) system on 11/6/17.

Q66	**Attachment F - Census Attachment G – Medical Claims**		**Is there going to be a way provided to link census data to the medical data?**
A66			No. This information is not available.
Q67	**Attachment F – Census**		**Attachment F – Census: Please provide an updated census to include current plan enrollment information.**
A67			A new file will not be issued. This procurement will likely result in a new Medicare retiree strategy and Proposers will need to estimate enrollment levels.
Q68	**Attachment F – Census**		**Could ETF / The Segal Company add to the census file the Medicare benefit plan option each member was enrolled in during the claims data period (i.e. IYC Medicare Plus, IYC Medicare Advantage, or IYC Health Plan – Medicare)? This would help to determine more likely sources of enrollment for a Medicare Advantage plan offering and help estimate how members' use of services in the base period may have been influenced by higher or lower levels of cost sharing.**
A68			A new file will not be issued.
Q69	**Attachment F – Census**		**Please provide the date the census file was created.**
A69			August 2017.
Q70	**Attachment F – Census**		**Please confirm if members under the age of 65 included in the census are retirees with Medicare Parts A&B as primary. If only a portion of these members are retired with Medicare Parts A&B as primary, please provide an updated census to include an indicator of which members are and are not Medicare primary.**
A70			Yes, this is confirmed.
Q71	**Attachment G – Medical Claims**		**Attachment G – Medical Claims: One year of claims data was provided. Please provide updated claims for a rolling 24 months, or provide the data for 2015 so we have a complete 24 months.**
A71			An updated claims file will not be provided.
Q72	**Attachment H – Pharmacy Claims**		**Attachment H – Pharmacy Claims: One year of claims data was provided. Please provide updated claims for a rolling 24 months, or provide the data for 2015 so we have a complete 24 months.**
A72			An updated claims file will not be provided.
Q73	**Attachment I – Monthly Claims Totals**		**Please indicate the incurred through and paid through dates on Attachment I Monthly Claims Totals. Please indicate if the medical claims data provided is on a paid or incurred basis.**

A73			Medical claims are paid through March 2017. Pharmacy claims are paid through August 2017.
Q74	**Attachment I – Monthly Claims Totals**		**Does the claims data in Attachment I include members that were enrolled a Medicare Advantage plan in 2016?**
A74			Yes.
Q75	**Attachment I – Monthly Claims Totals**		**Please indicate if the cost for the wellness and disease management programs has been included in the medical claims provided in Attachment I. If so, please provide the estimated costs of these programs that were charged by the current carriers**
A75			Administrative costs are not included in the medical claims in Attachment I.
Q76	**Form B – Mandatory Proposer Qualifications, 4.1**		**Will carriers be allowed to utilize off-shore services for enrollment and claims processing?**
A76			No.
Q77	**Form C – Subcontractor Information**		**Does the Department intend that Form C, Instruction Item 2, require a listing of all vendors who assisted Proposer with completion of this RFP? If not, please explain expected response and where the response should be indicated on Form C.**
A77			Yes, Item 2 requires a listing of all vendors who assisted Proposer with completing the Proposal. The purpose of Item 2 on FORM C is to ascertain who assisted the Proposer in authoring the Proposal to determine if there is a conflict of interest between any of the persons listed and a Proposal evaluator. Proposal assistance can come from an employee, a vendor, a contractor, etc., please list all those who assisted in authoring the Proposal.
Q78	**Form J – Non-Disclosure Agreement with Truven Health Analytics**	**N/A**	**Proposer, Department and Truven Health previously executed a non-disclosure agreement (NDA) that is nearly identical to the NDA listed under Form J. Form J is titled for applicability to the exchange of information under the RFP. But there are terms contained in Form J which appear to indicate application beyond the RFP process (ex. Sec. 1(A) "pursuant to terms of the State of Wisconsin Health Benefit Program Agreement…"). Regarding Form J: • Does the Department intend that Form J apply only to information disclosed during this RFP process? • If yes, is the Department willing to revise Form J terms accordingly? • If no, will the Department amend existing NDA terms to encompass disclosures made under this RFP and any Contract subsequently awarded?**

			• When does the Department expect that Proposers sign Form J?
A78			The Department's intent is that the terms of the NDA (Form J) apply to information that the department requests pursuant to terms of the State of Wisconsin Health Benefit Program Agreement between CONTRACTOR and DEPARTMENT (the "Contract"). It does not apply to information disclosed during the RFP process; the Department will not share information provided during the RFP process with Truven Health. The Department does not believe that Form J is titled for applicability to the exchange of information as part of the RFP process. Therefore, the Department will not amend the form. The form is expected to be signed by the contractor(s) at the time the Contract is signed by the Contractor(s).
Q79	**Exhibit 1, 105, Introduction**	**12**	**How does ETF interpret Wis. Stat. § 40.51 (6) as it relates to a single full replacement MA plan?**
A79			ETF will present recommendations to the Group Insurance Board that comply with the requirement that the State offer at least two health care coverage plans as required by Wis. Stat. § 40.51(6).
Q80	**Exhibit 1, 115(15)(a)** **General Requirements**	**15**	**What period of time does the reference to the "loss of fifteen percent (15%) or more of the Contractor's members" refer to? Please clarify this applies to contractor's members with ETF.**
A80			There is no specific timeframe, however, a period of the most recent 12 months is expected.
Q81	**Exhibit 1, 135B(3) Included Services, Pilot Programs**	**24**	**This section refers to Section 215(C), but there does not appear to be a corresponding section in the document. Was something inadvertently omitted regarding the services to be included?**
A81			ETF confirms, on page 24 of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement, in Section 135B(3), the reference should be to Section 225(6), not to 215C. The second subsection marked as number 5 in Section 225 should be marked as subsection 6, not 5. See revised Exhibit 1.
Q82	**Exhibit 1, 135B Included Services**	**24**	**In the draft contract, ETF notes that the production and delivery of enrollee materials cannot be charged to ETF. Does this mean that these costs cannot be included in our administrative fee charged for this product or is this stating that we cannot charge these fees separately to ETF?**
A82			The costs may be included in the administration fee.
Q83	**Exhibit 1, 140A Informational / Marketing Materials**	**24-27**	**Because ETF and CMS will be reviewing and approving enrollee materials, in the case of a**

	140B It's Your Choice Open Enrollment Materials		**dispute between the two agencies, who is the final arbiter of a decision?**
A83			ETF will work with the vendor on enrollee materials, to comply with CMS requirements while accommodating ETF requests. ETF will rely on the vendor's expertise to inform ETF if certain parts of published materials can be customized or must adhere to CMS requirements.
Q84	**Exhibit 1, 150A.2, Data Integration and Technical Requirements**	**30**	**Will ETF MA enrollments be included in the same 834 enrollment file as the rest of ETF?**
A84			This is an administrative decision that will be determined once the Board has established available Medicare options.
Q85	**Exhibit 1, 155E, Fraud and Abuse**	**38**	**Did the Department intend to include "Appeals Process Support" in another section of the Agreement, or does required support pertain only to fraud and abuse activities?**
A85			ETF confirms, Exhibit 1 that the "appeal" text in Section 155E(3) should be placed in Section 250E. See revised Exhibit 1.
Q86	**Exhibit 1, 155H(1)(a), Contract Termination**	**39**	**In the phrase "Any participant who is receiving benefits as an inpatient on the date of termination shall continue to receive all benefits otherwise available to inpatients until earliest of the following dates . . . the CONTRACT maximum is reached," should the term "CONTRACT" be replaced with "BENEFIT"?**
A86			Yes, the term should be "benefit," not "contract." ETF confirms, Exhibit 1 subsection 155H 1) a) should read as follows: The BENEFIT maximum is reached.
Q87	**RFP, Exhibit 1, 155H, Contract Termination**	**39**	**We did not locate a provision in the Contract that allows Contract termination (without cost or penalty to CONTRACTOR) in the event CONTRACTOR does not receive required regulatory approval to furnish coverage under the program. How does the Department plan to address?**
A87			There is no specific provision in the RFP that allows Contract termination (without cost or penalty to CONTRACTOR) in the event CONTRACTOR does not receive required regulatory approval to furnish coverage under the program. But under Section 6.2.1 of the RFP, Proposers must provide documentation that shows their organization is approved by the U.S. Centers for Medicare & Medicaid Services (CMS) to provide employer group waiver programs for Medicare Part C (and Part D, if appropriate) in Wisconsin, or that

			they are in the process of applying to CMS to provide such programs starting in the 2019 plan year. Per Section 3.9 of the RFP, the Board retains the right to accept or reject any Proposal, is not committed to paying any cost incurred with the preparation of a Proposal, and may negotiate the terms of the Contract with the selected Proposer prior to entering into a Contract. Therefore, if the Department so chooses, it may negotiate with Contractor for a provision relating to receipt of required regulatory approval. Additionally, the Board may refrain from signing a Contract until the vendor receives the required regulatory approvals, thus eliminating this contract termination concern.
Q88	**Exhibit 1, 205A, Enrollment Files**	**41**	**Please clarify if the Medicare Advantage Enrollees would be sent to the contractor on the same file as the ETF group coverage or separate?**
A88			This is an administrative decision that will be determined once the Board has established available Medicare options.
Q89	**Exhibit 1, 205C, Participant Information**	**42**	**PPO MAPD plans do not require a PCP to be selected. Please confirm the PCP selection and tracking requirement applies only to HMO plans.**
A89			The requirement to select a primary care provider applies to any plan regardless of whether it is an HMO or PPO.
Q90	**Exhibit 1, 210, Primary Care Provider**	**43**	**Please explain what you are hoping to accomplish with the collection of PCP data. We do not require our members to select a primary care provider (PCP) or a primary care clinic (PCC). Our relationships with providers are at the care delivery/clinic system level. We do require these provider groups to be responsible for the total cost of care and management for all of their patients. While we don't collect PCP or PCC data from our members, we do hold care delivery systems accountable by utilizing claims data to determine clinic attribution. While we don't collect PCP or PCC data from our members, clinics are responsible for furnishing their patients with the services described in section 210. Medical homes are also certified at the clinic level, not at the individual practitioner level, because the clinic system needs to hold accountability for all of their patient's care.**
A90			ETF's goal in requiring a PCP is to encourage the use of primary care and the use of primary care providers to manage care.
Q91	**Exhibit 1, 215A, Prior Authorizations**	**43-45**	**Will the Department issue a contract clarification document containing terms which clarify non-display of member out-of-pocket costs on authorizations in a manner similar to the "Exhibit A – Contract Clarifications" document (item 5) issued under its 2018 fully-insured contract?**

A91			Whether the Department issues a contract clarification document will be determined as a part of contract negotiations.
Q92	**Exhibit 1, 215B, Care Coordination**	**45-46**	**Will the Department issue a contract clarification document containing terms regarding care coordination diagnoses, documentation and reporting, and advance care planning reporting metrics, in a manner similar to the "Exhibit A – Contract Clarifications" document (items 7 and 11) issued under its 2018 fully-insured contract?**
A92			Whether the Department issues a contract clarification document will be determined as a part of contract negotiations.
Q93	**Exhibit 1, 220H, End Stage Renal Disease**	**47**	**Does the State of WI ETF request that Medicare Advantage Employer Group plans accept enrollment from ESRD participants or are we allowed to deny enrollment as is current practice with Medicare Advantage?**
A93			Proposers must accept any Medicare-enrolled members. ETF determines eligibility.
Q94	**Exhibit 1, Section 220J, Transfer of Benefit Maximums**	**48**	**Will there be any dental benefit accums that would be required to be transferred to the MAPD Contractor?**
A94			Uniform Benefits provides for coverage of dental implants, certain oral surgical procedures and TMJ treatments. Dental implants have a maximum Benefit Plan payment of $1,000 per tooth. These maximums are not transferred between vendors.
Q95	**Exhibit 1, 220L, Wellness**	**49**	**220L Wellness – Is the contractor responsible for paying for and then tracking and sending data on biometric screenings to the Wellness vendor?**
A95			Medicare Advantage enrollees are not eligible for fee based services provided by ETF's wellness vendor. Proposer must detail the wellness program that will be offered as part of this contract in Section 7.4 and, if applicable, any proposed vendor integration.
Q96	**Exhibit 1, 220N, Medicare Part D, EGWP Coverage**	**50**	**In regard to EGWP—A Medicare Cost Plan can do whatever an EGWP can do in terms of the flexibility that ETF wants without being an EGWP. Will ETF consider a Plan who participates without the Waiver?**
A96			A Medicare Cost Plan is not considered an eligible Plan under this RFP.
Q97	**Exhibit 1, 230, Provider Contracts**	**52**	**Please provide a sample report layout for the requirement that contractor "must, at a minimum, provide an annual update on provider discount negotiations efforts and outcomes to be included in the rate renewal reports". Confirm reporting requirement for those services that contractor would provide that are not covered at 100% of CMS as an additional benefit.**

A97			This is an administrative decision that will be determined once the Board has established available Medicare options.
Q98	**Exhibit 1, 230A, Provider Access Standards**	**53**	**Is it correct to say that as long as a Plan has >90% access for PCP's, hospitals and chiropractors in a given county, it is not necessary to have those providers/facilities in the major city in the county?**
A98			Yes.
Q99	**Exhibit 1, 230A, Provider Access Standards**	**53**	**If a Plan does not meet the ¬>90% threshold for one category only, would #1-#3 apply or would the major city requirement apply only to the category that does not meet that threshold?**
A99			If a Plan does not meet the 90% threshold for one provider type (e.g. inpatient hospital, PCP, Chiropractor) only, then requirements 1 – 3 would apply.
Q100	**Exhibit 1, 230A, Provider Access Standards**	**53**	**Medicare Advantage plans are subject to comprehensive CMS access standards. Agreement 230A references access standards contained in Wis. Stat. § 609.22. Please confirm CMS access standards will apply to this RFP and resulting contract.**
A100			As a Medicare Advantage plan, Proposers are expected to follow all appropriate CMS requirements. For purposes of this RFP, network access will be evaluated based on the access requirements described in Section 8.1 of the RFP and further defined in Exhibit 1, Section 230A.
Q102	**Exhibit 1, 230D, Provider Contracts Shall Include Compliance Plans**	**55**	**Confirm that contractor's existing MA-PD/CMS provider compliance training certification meets the requirements of ETF's plan.**
A102			The Proposer should include an explanation of their current program and certifications in their Proposal for evaluation.
Q103	**Exhibit 1, 230D, Provider Contracts Shall Include Compliance Plans**	**55**	**Will the Department issue a contract clarification document containing terms which clarify provider contract content regarding compliance in a manner similar to the "Exhibit A – Contract Clarifications" document (item 12) issued under its 2018 fully-insured contract?**
A103			Whether the Department issues a contract clarification document will be determined as a part of contract negotiations.
Q104	**Exhibit 1, 270D Item 1, Contractor Web Content**	**68**	**270D Contractor Web Content and Web-Portal: What level of customization is the State expecting for the participant website? Is a co-branded microsite in accordance with Program Requirement 270D, or does the State envision additional custom content, such as links and materials?**
A104			ETF expects to work with the Contractor to come to agreement on web content and web-portals.

Q105	Exhibit 1, 305, Reporting Requirements	75	**Was item #6 under section 305 intentionally left blank?**
A105			Row 6 of Exhibit 1, Section 305, was intentionally left blank in error. See revised Exhibit 1.
Q106	**Exhibit 1, 305, Reporting Requirements**	**75**	**Should number 6 be blank?**
A106			See Question 105/Answer 105.
Q107	**Exhibit 1, 310A, Deliverables to the Department**	**81**	**Was item #26 under section 310A intentionally left blank?**
A107			Exhibit 1, subsection 310A, #26 was included in error and should be deleted. See revised Exhibit 1.
Q108	**Exhibit 1, 310A, Deliverables to the Department**	**81**	**Should number 26 be blank?**
A108			See Question 107/Answer 107.
Q109	**Exhibit 1, 315, Performance Standards and Penalties**	**83**	**Does ETF want the performance standards combined with the fully funded performance standards, or submitted with the same reporting? If CMS standards are different, should we assume that we will follow CMS standards?**
A109			The Proposer should submit information about CMS standards in their bid for evaluation.
Q110	**Exhibit 1, 315, Performance Standards and Penalties**	**83**	**Does the Department intend to apply the penalty percentage cap of three percent (3%) to Advantage premium only? Please confirm.**
A110			Total premium means Medicare Advantage premiums that include pharmacy if offered and approved by the Board.
Q111	**Exhibit 1, 315, Performance Standards and Penalties**	**84-88**	**Please explain how the penalty will be calculated for any of the metrics that have a penalty calculated from each percentage point for which the standard is not met. For example, if the target is 95%, would the penalty apply if the result was 94.99% or would the penalty only apply if the metric result is below 94.00% (a full percentage point below the target)? In other words should the metrics result be rounded up to the nearest whole percentage point?**
A111			This is an administrative decision that will be determined.
Q112	**Exhibit 1, 315A, Account Management**	**84**	**Please confirm if this is an annual survey, if not; please provide additional details regarding frequency.**
A112			This is an administrative decision that will be

			determined.
Q113	**Exhibit 1, 400, Uniform Benefits**	**89**	**Are the MM folks eligible to enroll in the EGWP plans along with the ME folks?** **ME – Someone who is Medicare eligible and qualifies for a carve-out rate (Medicare would be the primary payor in this situation).** **MM – Someone who is Medicare eligible, but not qualified for a carve-out rate (Medicare would be the secondary payor in this situation).**
A113			Active employees will not be eligible for Medicare Advantage under the Contract.
Q114	**Exhibit 1, 400, Uniform Benefits**	**98**	**In describing Level 3 drug benefits there is a reference to "non-covered" prescription drugs. Please clarify what is meant by this term in the current plan.**
A114			A non-covered drug is a drug that is not considered part of the plan formulary. The plan will not pay any portion of the cost for a non-covered drug. If a member is prescribed a non-covered drug, the member would be liable for the full cost of the drug, unless coverage is approved through a grievance, appeal or IRO process.
Q115	**Exhibit 1, 400, Uniform Benefits**	**98**	**Please explain how the current PBM administers the Level 4 differential (including member cost, drug and service site) between preferred vs non-preferred specialty drugs?**
A115			A member who fills a preferred drug at a preferred pharmacy pays the lowest copay (currently $50 per fill). A member who fills a non-preferred drug at a preferred pharmacy, or fills any drug at a non-preferred pharmacy, pays the higher copay (40% up to $200 per fill).
Q116	**Exhibit 1, 400, Uniform Benefits**	**98**	**Related to the Wisconsin uniform benefits provisions, please confirm understanding that Medicare Advantage and Medicare Part D plans are underwritten and approved by CMS and administered on an individual basis, where deductibles and MOOPs cannot be aggregated beyond the individual level.**
A116			Yes, this is true for MAPD plans as well. The medical and prescription drug are administered as separate plans.
Q117	**Exhibit 1, 400, Uniform Benefits**	**98, 99, and Definitions page 107**	**Please comment on the applicability and expectations of plan requirements on accumulators to be managed to the federal MOOP for participants. Is there an expectation that we are cross referencing/combining benefit MOOPS according to the ACA limit for a Medicare plan including Part D and C?**

A117			Currently, any member cost share associated with the claim adjudicating through the PDP benefit (EGWP/ MedicareRx plan/etc.) **does not** accumulate to the Federal MOOP. However, any member cost share associated with the claim adjudicating through the Wrap benefit **does** accumulate to the Federal MOOP. Prescription drugs will not apply to the federal MOOP under the program described in the RFP.
Q118	**Exhibit 1, 400, Uniform Benefits**	**98, 99**	**In the Part D Benefits, please confirm that non-covered drugs (not on formulary) are intended to be paid for as a Level 3. Please comment on the extent of non-covered drugs. Does this include denials for OTC type, or OTC equivalents, and drugs that are non-covered for other reasons?**
A118			Non-covered drugs are not considered part of the plan formulary and the plan pays no portion of the cost of non-covered drugs. Non-preferred drugs may be covered at level 3, as well as drugs that are covered as the result of an appeal, grievance or IRO outcome. ETF expects the number of drugs covered at this tier to be minimal.
Q119	**Exhibit 1, 400, Uniform Benefits**	**98, 100**	**In Part D benefits, the Level 3 drugs indicate only a Federal MOOP. Please confirm there is no internal OOPL, and also confirm that the federal MOOP is assumed to be applied to Level 4 benefits (both types).**
A119			Currently, any member cost share associated with the claim adjudicating through the PDP benefit (EGWP/ MedicareRx plan/etc.) **does not** accumulate to the Federal MOOP. However, any member cost share associated with the claim adjudicating through the Wrap benefit **does** accumulate to the Federal MOOP. Prescription drugs will not apply to the federal MOOP under the program described in the RFP.
Q120	**Exhibit 1, 400, Uniform Benefits**	**148-153**	**Local / Wisconsin Public Employers (WPE) Medicare Retirees Only: In addition to the plan design requested for Medical and Pharmacy in Tables 2 and 3 and outlined in Exhibit 1, Section 400; Should we also create the plan design PO4/14 for Local / Wisconsin Public Employers (WPE) Medicare Retirees?**
A120			Yes.
Q121	**Exhibit 1, 400, Uniform Benefits**	**184**	**h) Mail order is available for many prescription drugs: What is the day-supply limit for self-administered injectables and narcotics at mail order?**
A121			The day supply can vary and is dependent on the drug. The biologics typically have a 28-day supply limit. For narcotics, the day supply depends on the drug.
Q122	**Exhibit 1, 400, Uniform Benefits**	**184-185**	**2) Insulin, Disposable Diabetic Supplies, Glucometers: Section b): Are both Medicare Part D and Part B Disposable Diabetic Supplies and**

			Glucometers applying to the Tier 2 annual OOPL for prescription drugs?
A122			Disposable diabetic testing supplies such as test strips, glucometers, lancets are only covered by Medicare Part B. There is no coverage for these products under Part D. Under the current benefit the Level 1 and Level 2 OOPL of $600/$1,200 does include all copayments from Level 1 and Level 2 products as well as covered diabetic testing supplies.
Q123	**Exhibit 3, Standard Terms and Conditions** **Exhibit 5, Department Terms and Conditions**		**Will the Department issue a contract clarification document containing terms to clarify items below in a manner similar to the "Exhibit A – Contract Clarifications" document (items 1-4) issued under its 2018 fully-insured contract?** **• dispute resolution;** **• indemnity expectations (Ex. 3, Section 32.0; Ex. 5, Sections 3.0 and 23);** **• liquidated damages; (Ex.5, Section 12.0); and** **• data security (Ex. 5, Section 28.0(i)(2)).**
A123			Whether the Department issues a contract clarification document will be determined as a part of contract negotiations.
Q124	**Exhibit 5, 12.0, Liquidated Damages**	**3**	**Will liquidated damages be capped?**
A124			The Department will not cap liquidated damages. Under Exhibit 5-Department Terms and Conditions, Section 12.0 (Liquidated Damages), liquidated damages will be negotiated and decided in the event Contractor fails to carry out the responsibilities of this Contract. Additionally, the Department intends for the Contractor to be able to utilize the process described in Exhibit 5-Department Terms and Conditions, Section 13.0 (Contract Dispute Resolution) prior to the Department imposing any Liquidated Damages.
Q125	**Exhibit 5, Section 16.0, Termination of this Contract**	**4**	**When or under what circumstances does Contractor have the right to terminate the Contract?**
A125			Contractor has the right to terminate the Contract for any reason if Contractor delivers written notice to the Department not less than 180 Calendar Days prior to termination. Contractor must also refund all payments made by the Department to the Contractor for work not completed or not accepted by the Department (see Exhibit 5-Department Terms and Conditions, Section 16.0 – Termination of This Contract). Contractor will also be required to perform the Services specified in a transition plan upon request of the Department. If Contractor terminates Contract, Contractor will not be considered for participation in the Health Benefit Program for a period of 3 calendar years. (Exhibit 1, Section 155H).

Q126	**General**	**N/A**	**Please confirm additional questions may be submitted after October 31, 2017 related to data and other important aspects of financial underwriting.**
A126			Additional questions related to Section 8 may be submitted to Segal after October 31, 2017.
Q127	**General**	**N/A**	**Please confirm that when Wisconsin state laws and Federal CMS rules governing Medicare Advantage are in conflict, CMS rules will control.**
A127			The Department confirms that Federal CMS rules control when they conflict with State law.
Q128	**General**	**N/A**	**Under the current IYC Health Plan-Medicare option contractors are required to administer split contracts for those Medicare eligible members that have under age 65 dependents. How does ETF intend to address these situations in a Medicare Advantage environment? Would current program be required to be offered to accommodate? Would ETF allow the Medicare eligible member select an MA option and the under age 65 dependent(s) enrolled under a separate IYC health plan?**
A128			Members who are not Medicare-eligible will not be enrolled in a program(s) contracted for pursuant to this RFP. Such members will have to be enrolled under other IYC health plan options.

END

This Addendum will be available on ETF's Extranet at http://etfextranet.it.state.wi.us/etf/internet/RFP/rfp.html.

Request for Proposal (RFP) ETH0020
Medicare Advantage Plans for Medicare-Enrolled Participants in the State of Wisconsin Group Health Insurance and Wisconsin Public Employer Programs

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

RFP Release Date: October 17, 2017

Revised: November 14, 2017

TABLE OF CONTENTS

TABLE OF CONTENTS 2
EXHIBITS AND APPENDICES 2
FORMS 3
SECTION 8 ATTACHMENTS 3
1 GENERAL INFORMATION 4
2 PREPARING AND SUBMITTING A PROPOSAL 18
3 PROPOSAL SELECTION AND AWARD PROCESS 24
4 MANDATORY PROPOSER QUALIFICATIONS 28
5 PROGRAM SPECIFICATIONS 29
6 GENERAL QUESTIONNAIRE 29
7 TECHNICAL QUESTIONNAIRE 38
8 NETWORK SUBMISSION REQUIREMENTS, ALTERNATIVE BENEFIT DESIGN, AND COST PROPOSAL 48
9 CONTRACT TERMS AND CONDITIONS 55

EXHIBITS AND APPENDICES

- Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement
- Exhibit 2 – Pro Forma Contract by Authorized Board (Pro Forma State of Wisconsin Contract)
- Exhibit 3 – Standard Terms and Conditions (DOA-3054)
- Exhibit 4 – Supplemental Standard Terms and Conditions for Procurement for Services (DOA-3681)
- Exhibit 5 – Department Terms and Conditions
- Appendix 1 – 834 Companion Guide
- Appendix 2 – Pharmacy Data Specifications
- Appendix 3a – Wellness Data Specifications – Disease Management
- Appendix 3b – Wellness Data Specifications – Biometric Screenings
- Appendix 3c – Wellness Data Specifications – Health Assessment
- Appendix 3d – Wellness Data Specifications – Lifestyle Management
- Appendix 4a – Claims Data Specifications – Medical
- Appendix 4b – Claims Data Specifications – Dental
- Appendix 5 – Provider Data Specifications
- Appendix 6 – Guidance for Department Initiatives
- Appendix 7 – State Employer Group Roster (ET-1404)

- Appendix 8 – Local Employer Group Roster (ET-1407)
- Appendix 9 – Current Financial and Utilization Data Submissions

FORMS

- FORM A – Proposal Checklist
- FORM B – Mandatory Proposer Qualifications
- FORM C – Subcontractor Information
- FORM D – Proposer Verification of Data Submission to Board Actuary
- FORM E – Designation of Confidential and Proprietary Information
- FORM F – Non-Disclosure Agreement with ETF and The Segal Company
- FORM G – Request for Proposal
- FORM H – Vendor Information
- FORM I – Vendor References
- FORM J – Non-Disclosure Agreement with Truven Health Analytics

SECTION 8 ATTACHMENTS

(provided by The Segal Company)

- Attachment A – Network Access
- Attachment B – EGWP Formulary for Medicare Enrolled Participants as of September 1, 2017
- Attachment C – Formulary Companion Guide
- Attachment D – Cost Proposal
- Attachment E – Performance Guarantees
- Attachment F – Census
- Attachment G – Medical Claims
- Attachment H – Pharmacy Claims
- Attachment I – Monthly Claims Totals
- Attachment J – Pharmacy EGWP Risk Scores

1 GENERAL INFORMATION

1.1 INTRODUCTION

The purpose of this Request for Proposal (RFP) is to provide interested and qualified vendors with information to enable them to prepare and submit competitive Proposals to administer Medicare Advantage plans for Medicare-enrolled participants in the State of Wisconsin Group Health Insurance Program (GHIP) and the Wisconsin Public Employer (WPE) programs for local government employees and retirees, managed by the Wisconsin Department of Employee Trust Funds (ETF). ETF intends to use the results of this solicitation to award a Contract(s) for such services.

The Contract(s) will be administered and managed by ETF, with oversight by the State of Wisconsin Group Insurance Board (Board). This RFP document and the awarded Proposal(s) shall be incorporated into the Contract(s).

1.2 CURRENT STATE AND BACKGROUND

ETF administers retirement, health, life, long-term disability, income continuation, and long-term care insurance programs for over 570,000 State and local government employees and annuitants.

1.2.1 Health Insurance Program

The GHIP and WPE programs, primarily fully-insured health plans administered by ETF and 10 contracted health plans, are for the employees of 58 State agencies, the State of Wisconsin Legislature, the University of Wisconsin (UW) System, the UW Hospital and Clinics, 368 local government employers' employees, retirees, and dependents. The GHIP and WPE programs make up one of the largest health plan groups in Wisconsin, spending $1.4 billion in health insurance premiums annually.

In 2018, most health insurance benefits (98%) offered through the GHIP and WPE programs will be administered through 10 competing, fully-insured health plans that offer a prescribed "uniform benefit" package called the "It's Your Choice (IYC) Health Plan." The IYC Health Plan is available to both active and retired state and local employees, including Medicare-enrolled retirees. The IYC Health Plan also has a high-deductible option, called the IYC High Deductible Health Plan (HDHP), which is not available to Medicare-enrolled participants. The health plans follow the Board's guidelines for eligibility and program requirements and participate in an annual premium rate bid process.

The pharmacy benefit program is self-insured and has been administered through a Pharmacy Benefit Manager (PBM) since 2004. This includes providing Medicare Part D benefits through an Employer Group Waiver Plan (EGWP) and additional wrap-around benefit since 2012.

The uniform dental benefit program is also self-insured as of 2016. Participants of the GHIP may opt out of dental coverage during the annual open enrollment period. Local employers that participate in the WPE program choose whether to offer the uniform dental benefit program to their group.

Medicare-Specific Options

Below is a description of the current plans available to Medicare-enrolled Members:

IYC Health Plan – Medicare

The IYC Health Plan – Medicare is the same health plan active employees enroll in but, for Medicare enrollees, the plan coordinates with Medicare coverage, meaning Medicare pays first and IYC Health Plan - Medicare pays second. Often, enrollees on this plan were enrolled in the plan prior to becoming eligible for Medicare. The IYC Health Plan – Medicare plan is available through each of the 10 competing, fully-insured contracted health plans.

IYC Medicare Advantage

In 2017, Humana administers the program's only Medicare Advantage offering. The current offering matches the Uniform Benefits offered by the other insurers under the IYC Health Plan – Medicare, with minor exceptions. This plan is a nationwide passive preferred provider option (PPO) product that allows participants to use any healthcare provider in the country that accepts Medicare. In 2018, the program will have no Medicare Advantage offering.

IYC Medicare Plus

This is a Medicare Supplement plan currently offered through the program on a self-insured basis through WPS Health Insurance, Inc. through December 31, 2017. Starting January 1, 2018, the IYC Medicare Plus plan will be administered by WEA Trust on a fully-insured basis. This plan is available to eligible retirees enrolled in Medicare and generally only pays Medicare deductibles and coinsurance. This plan permits participants to receive care from any qualified healthcare provider nationwide, or during worldwide travel, for treatment covered by the plan.

For more information on benefits for ETF's Medicare-enrolled Members, see the Retiree Decision Guide.

Table 1 shows the number of Medicare-enrolled members for both GHIP and WPE by Medicare plan for 2017.

Table 1. 2017 Enrollment in Medicare Plan Options

	Number of Medicare-Enrolled Members		
	State	WPE	Total
IYC Medicare Plus	8,062	180	8,242
IYC Medicare Advantage	2,623	112	2,735
IYC Health Plan – Medicare			
Dean Health Plan	5,996	407	6,403
Unity Health Plan	4,651	438	5,089
Physicians Plus	2,782	137	2,919
WEA Trust	1,751	43	1,794
GHC - South Central Wisconsin	1,196	60	1,256
All others	4,695	369	5,064
Total	**31,756**	**1,746**	**33,502**

Current Benefit Design

Medical Benefits

Below is a description of the IYC Medicare Advantage Plan benefit design available to Medicare-enrolled Participants in 2017:

Table 2. 2017 Medicare Advantage Benefit Design

IYC Medicare Advantage Benefit Design	
Annual Medical Deductible	**Plan pays:** Part A inpatient hospital deductible of $1,316 and Part B deductible of $183
	Participant pays: $0
Annual Medical Coinsurance	**Plan pays:** Part A-varying coinsurance for hospital inpatient and skilled nursing facility care Part B deductible and 20% coinsurance
	Participant pays: $0 except as listed below
Annual Medical Out-of-Pocket Limit	None
Outpatient illness/injury related services	**Plan pays:** Part B deductible and 20% coinsurance
	Participant pays: $0
Emergency Room Copayment	**Plan pays:** Part B deductible and 20% coinsurance
	Participant pays: $60 copayment (waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer)
Hospital	**Plan pays:** 100% as medically necessary, plan providers only. No day limit
	Participant pays: $0

Licensed Skilled Nursing Facility **Medicare covered services in a Medicare approved facility**	Plan pays: **After Medicare, 100% as medically necessary, for the first 120 days per benefit period, plan providers only** **Beyond 120 days, $0** **Participant pays:** $0 for the first 120 days, full cost after 120 days
Licensed Skilled Nursing Facility **(Non-Medicare approved facility licensed in a state) If admitted within 24 hours following a hospital stay**	**Plan pays:** 100% as medically necessary for the first 120 days per benefit period **Participant pays:** 0% for the first 120 days per benefit period. 100% after 120 days
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	**Plan pays:** If Participant has not met the Part B deductible, 80% If Participant has met the Part B deductible but has not met the $500 out-of-pocket limit (OOPL) per participant, 0% If Participant has met the Part B deductible and the $500 OOPL per participant, 20% **Participant pays:** 20% up to $500 OOPL per participant; after OOPL, $0
Home Health Services **Under an approved plan of care, part-time services of an RN, LPN or home health aide; physical, respiratory, speech or occupational therapy; medical supplies, drugs, lab services and nutritional counseling.**	**Plan pays:** 100% for reasonable and necessary visits **Participant pays:** Full cost of visits not covered by Medicare
Hearing Exam **For routine exams**	**Plan pays:** 100% **Participant pays:** $0

Hearing Exam **For illness or injury**	Plan pays: **Part B deductible and 20% coinsurance**
	Participant pays: $0
Hearing Aid (per year)	**Plan pays:** 80% for adults up to plan paid of $1,000 every three years (does not count toward OOPL)
	Participant pays: 20% coinsurance and 100% of costs exceeding plan payment of $1,000

Pharmacy Benefits

Pharmacy benefits are based on a four-tier design with various cost-sharing levels and applicable out-of-pocket limits (OOPL). This benefit is available to all GHIP and WPE Members in 2017 including Members enrolled in the IYC Medicare Advantage plan.

Table 3. 2017 Plan Year Pharmacy Benefit Plan Design

Copayments/Coinsurance		
Level 1	$5 Copayment	Preferred Generic Drugs and certain lower-cost Preferred Brand Name Drugs.
Level 2	20% Coinsurance ($50 max)	Preferred Brand Name Drugs and certain higher-cost Preferred Generic Drugs.
Level 3	40% Coinsurance ($150 max)	Non-covered, Non-Preferred Drugs for which alternative/equivalent Preferred Generic & Brand Name Drugs are covered.
Level 4 (Preferred)	$50 Copayment	Includes **only** Preferred Specialty Drugs filled at a Preferred Specialty Pharmacy.
Level 4 (Non-Preferred)	40% Coinsurance ($200 max)	Non-Preferred Specialty Drugs filled at a Preferred Specialty Pharmacy **and** all Specialty Drugs filled at a pharmacy **other than** a Preferred Specialty Pharmacy.
Out-of-Pocket Limits*		
Level 1 & 2	$600 individual / $1,200 family	
Level 3	$6,850 individual / $13,700 family	
Level 4 (Preferred)	$1,200 individual / $2,400 family	
Level 4 (Non-Preferred)	No Out-of-Pocket Limit*	

*In addition to the out-of-pocket limit (OOPL), all copayments/coinsurance apply toward the federal Affordable Care Act (ACA) annual combined medical and prescription drug maximum out-of-pocket (MOOP) limits; $7,150 for an individual and $14,300 for a family in 2017.

Participants have creditable coverage through an EGWP program administered by the current PBM and are also provided with a wraparound benefit to supplement the EGWP.

Premium Payments

State retirees are solely responsible for payment of their health insurance premiums. The State offers three ways for retirees to pay: 1) if eligible, they can use their accumulated sick leave credits; 2) deductions from their monthly annuity payments; or 3) direct payments to the health plan. Life insurance may also be converted to pay for health insurance premiums under certain circumstances. Previous research has shown that State employees can retire with sizable sick leave balances that will typically last 6-10 years into retirement.

Retirees from local public employers may have their premiums paid in one of the following ways: 1) their employer may contribute towards the premium; 2) they may have deductions taken from their annuity payment; or 3) they may make direct payments to the health plan.

Open Enrollment

Dates for the annual open enrollment period, known as "It's Your Choice" (IYC), are set by the Board each year and are typically in October - November. The 2018 open enrollment period runs from October 2-27, 2017. Program and benefit changes are primarily disseminated to employees and Participants via employer groups and the ETF website.

Benefit Consultant's Report on Program Reforms

In November 2015, the Board's benefit consultant, The Segal Company (Segal), presented a report containing analysis of the current GHIP and WPE programs and recommended strategies for program design that would contain future cost increases and improve health outcomes while increasing the efficient delivery of quality healthcare to Participants. A significant component of the report is a recommendation for a "total health management" model that includes driving engagement in wellness and disease management programming.

In addition, Segal's report recommended that the Board pursue an expansion of the Medicare Advantage model through both national and regional health plans to reduce costs for Medicare retirees while maintaining provider choice.

In response to these recommendations, in 2016, the Board approved solicitations for a third-party administrator of wellness and disease management programs, the development of a data warehouse, and proposals to evaluate self-insurance and regionalizing the health insurance program. Many of these initiatives have been implemented, or are in the process of being implemented. The exception is that in 2017, the Board approved a program restructuring that would have moved the program to a self-insurance and regionalization model. However, this model was rejected by the State Legislature.

Segal's November 2015 report can be found here: http://etf.wi.gov/boards/agenda-items-2015/gib1117/item3ar.pdf

Wellness Benefits

In 2013, the Group Insurance Board approved implementation of a uniform wellness incentive as part of the 2014 health plan contracts, which is referred to as the Well Wisconsin Program. A Member can earn a $150 incentive from their health plan after completing a health screening and

health survey. The primary subscriber and their enrolled spouse were both eligible to receive the incentive.

Due to the Centers for Medicare & Medicaid Services (CMS) restrictions that were in place at the inception of the incentive program, Medicare Advantage enrollees have not been eligible for the $150 incentive. In December 2014, CMS issued guidance which allowed greater flexibility for rewards and incentive programs. ETF has opted to continue excluding Medicare Advantage enrollees from being eligible for the $150 incentive due the complexity of aligning an incentive program primarily used by active employees with CMS restrictions.

In 2017, the Well Wisconsin Program has transitioned to a single wellness and disease management vendor, The StayWell Company, LLC (StayWell). StayWell manages all aspects of the incentive program and provides lifestyle and disease management programs to all non-Medicare Advantage subscribers and enrolled spouses. Medicare Advantage enrollees are currently allowed access to the StayWell Well Wisconsin wellness portal, but they are not eligible to participate in the health screenings, health coaching or to receive the $150 incentive.

Data Warehousing / Business Intelligence Vendor

As stated above, the Board approved the procurement for the purchase of a data warehouse solution in 2017, and the Board subsequently contracted with Truven Health Analytics to develop data warehouse and business intelligence tools. These tools are anticipated to be available in early 2018. Section 150 of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement, includes requirements related to data submissions and data integration with the data warehouse and business intelligence tools.

1.2.2 Additional Background Information

Table 4 provides links to additional background information. This information is provided to assist Proposers in completing an RFP response.

Table 4. Background Information

Title	Web Address
It's Your Choice Open Enrollment Materials	http://www.etf.wi.gov/members/IYC2018/IYC_home.asp
It's Your Choice 2018 Decision Guide for Retired State Employees	http://www.etf.wi.gov/publications/18et2108.pdf
Benefit Consultant November 10, 2015 Report to the Board (Second Report)	http://etf.wi.gov/boards/agenda-items-2015/gib1117/item3ar.pdf
Office of Strategic Health Policy February 9, 2016 Memo to the Board for Implementation of Benefit Consultant Recommendations	http://etf.wi.gov/boards/agenda-items-2016/gib0217/item5c.pdf

Office of Strategic Health Policy April 28, 2017 Memo to the Board on Medicare Advantage Proposals	http://etf.wi.gov/boards/agenda-items-2017/gib0524/item3e.pdf
Wisconsin Administrative Code: Chapter ETF 11 Appeals	http://docs.legis.wisconsin.gov/code/admin_code/etf/11
Wisconsin State Statutes Chapter 40	http://www.legis.state.wi.us/statutes/Stat0040.pdf
ETF Insurance Complaint Information	http://etf.wi.gov/publications/et2405.pdf
Information regarding registration and the sign-in process for the Wisconsin Department of Administration's eSupplier portal	https://vendornet.wi.gov/GenProcurement/StrategicSourcing.aspx

1.3 Future State: Project Scope and Objectives

The objectives of this RFP are to find health plans that will be strategic partners in providing services to our Members and to accomplish the following:

- Expand offerings to our Medicare-enrolled Members that have lower monthly premium costs;
- Deliver high quality, high value services;
- Offer excellent benefit packages; and
- Provide Participant choice.

The Proposer must be a partner with the Department in developing strategies to improve health among Members and must actively educate and engage Members in preventive healthcare, healthcare utilization, and wellness.

Proposals are being requested for health plans to administer an Employer Group Waiver Program (EGWP) Medicare Advantage plan and possibly a Medicare Part D prescription drug benefit program for Medicare-enrolled Members in the GHIP and WPE programs. An award will not be made for prescription drug benefits only.

Service Areas

Services are to be available in any of the following service areas:

1) Nationwide service area; or

2) Regional service areas within Wisconsin.

ETF's expectation is to obtain services, as specified in this RFP, with a Contract(s) between the selected Proposer(s) and the Board. The Board may award one Contract to serve the nationwide service area, and may also award multiple Contracts for a regional service area as a result of this RFP. An award is not guaranteed.

Proposals for the national passive PPO for the nationwide service area may include multiple pricing options. Proposers are encouraged to provide competitive quotes as a full replacement solution as well as a component of the overall program strategy. The Board will determine the overall program strategy based on RFP results, which could include one nationwide Medicare Advantage plan or one nationwide Medicare Advantage plan with regional Medicare Advantage plans and/or regional current plans.

Medicare Advantage Benefit Plan Proposals

All Proposers must be able to provide all services under Uniform Benefits, the current standard benefits package available to Medicare-enrolled Members described in Table 2 – 2017 Medicare Advantage Benefit Design, and further described in Section 400 of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement or as approved by the Board prior to January 1, 2019.

Pharmacy Benefit Plan Proposals

Proposers submitting a proposal for a nationwide service area must also be able to provide the pharmacy benefit plan available under Uniform Benefits described in Table 3 – 2018 Plan Year Pharmacy Benefit Plan Design, and further described in Section 400 of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement or as approved by the Board prior to January 1, 2019. Attachment D – Cost Proposal submitted under Section 8 must reflect this requirement.

Proposers submitting a Proposal for a regional service area within Wisconsin have the ***option*** of offering a pharmacy benefit. If a Proposer includes a proposal to offer a pharmacy benefit, it must be able to provide the pharmacy benefit plan available under Uniform Benefits described in Table 3 – 2018 Plan Year Pharmacy Benefit Plan Design, and further described in Section 400 of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement or as approved by the Board prior to January 1, 2019, and be able to match the current formulary. If offering such a benefit, Attachment D – Cost Proposal submitted under Section 8.3 must reflect this requirement.

Alternative Benefit Design Proposals

In addition, as described in Section 8.2, vendors *must* submit proposals to provide two alternative benefit designs that the vendor has found are most popular with Medicare beneficiaries.

The Proposer must be able to administer any alternative benefit design it proposes. However, the Board will decide what, if any, alternative benefit designs will be available to Participants starting in 2019 based on all available input from Proposers and other sources. The Board is not limited to the benefit designs proposed by the Proposer.

Proposers must be able to provide all other requirements requested in this RFP and shall remain responsible for Contract performance regardless of any work performed by the Proposer's Subcontractors.

The selected Proposal(s) will become part of the Contract. Information described in the Proposal response regarding programming and capabilities must be available to all eligible Participants unless otherwise noted in the Proposal. For example, a small pilot program shall be clearly described as such.

1.4 PROCURING AND CONTRACTING AGENCY

This RFP is issued for the State of Wisconsin by the Department of Employee Trust Funds on behalf of the State of Wisconsin Group Insurance Board. ETF is the sole point of contact for the State of Wisconsin in the selection process. The terms “State,” “ETF,” and “Department” may be used interchangeably in this RFP and its attachments.

Prospective Proposers are prohibited from contacting any person other than the individual listed below regarding this RFP. Violation of this requirement may result in the Proposer being disqualified from further consideration.

Express delivery:
Beth Bucaida
RFP ETH0020
Dept. of Employee Trust Funds
801 West Badger Road
Madison, WI 53713-2526

USPS Mail delivery:
Beth Bucaida
RFP ETH0020
Dept. of Employee Trust Funds
PO Box 7931
Madison, WI 53707-7931

Telephone: 608-266-2586
E-mail: ETFSMBProcurement@etf.wi.gov

1.5 DEFINITIONS AND ACRONYMS

Words and terms shall be given their ordinary and usual meanings. Where capitalized in this RFP, the following definitions and acronyms shall have the meanings indicated unless otherwise noted. The meanings shall be applicable to the singular, plural, masculine, feminine, and neuter forms of the words and terms.

Business Day means each Calendar Day except Saturday, Sunday, and official State of Wisconsin holidays (see also: Calendar Day, Day).

Calendar Day refers to a period of twenty-four (24) hours starting at midnight.

Calendar of Events means the schedule of events in RFP Section 1.9.

Confidential Information means all tangible and intangible information and materials being disclosed in connection with the Contract, in any form or medium without regard to whether the information is owned by the State of Wisconsin or by a third party, which satisfies at least one of the following criteria: (i) Personally Identifiable Information; (ii) Protected Health Information under HIPAA, 45 CFR 160.103; (iii) Proprietary Information; (iv) non-public information related to the State of Wisconsin’s employees, customers, technology (including data bases, data processing and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; (v) information expressly designated as confidential in writing by the State of Wisconsin; (vi) all information that is restricted or prohibited from disclosure by State or federal law, including Individual Personal Information and Medical Records as governed by Wis. Stat. § 40.07, Wis. Admin. Code ETF 10.70(1) and 10.01(3m); (vii) any material submitted by the Proposer in response to this RFP that the Proposer designates confidential and proprietary information and which qualifies as a trade secret, as provided in Wis. Stat. § 19.36 (5) or material which can be kept confidential under the Wisconsin public records law, and identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Cost proposals cannot be held confidential unless there are extenuating circumstances, e.g. government regulations or case law prohibit such release.

Contract means the written agreement resulting from the successful Proposal and subsequent negotiations that shall incorporate, among other things, this RFP and the successful Proposer's Proposal, and all modifications to the agreement, and in addition shall contain such other terms and conditions as may be required by the State of Wisconsin.

Contractor means the Proposer that is awarded the Contract.

CDT means Central Daylight Time covering a time period of mid-March to early November each calendar year.

CST means Central Standard Time covering all time periods not CDT.

Day means Calendar Day unless otherwise indicated.

Department or **ETF** means the Wisconsin Department of Employee Trust Funds.

Employer Group Waiver Program or EGWP refers to employer group sponsored Medicare Advantage and Medicare Prescription Drug programs for which the Centers for Medicare & Medicaid Services (CMS) have waived certain program requirements that do not apply.

GHIP means the State of Wisconsin Group Health Insurance Program.

GIB means the State of Wisconsin Group Insurance Board.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Individual Personal Information or **IPI** is defined in Wisconsin Administrative Code § ETF 10.70(1), and means all information in any individual record of the Department, including the date of birth, earnings, contributions, interest credits, beneficiary designations, creditable service, marital or domestic partnership status, address, and social security number, but does not include information in any statistical report, other report or summary in which individual identification is not possible.

Mandatory means the least possible threshold, functionality, degree, performance, etc. needed to meet the mandatory requirement.

Member or **Participant** means subscriber or any of the subscriber's dependents who are enrolled in both Medicare Parts A and B, are entitled to benefits under the GHIP and WPE programs, and are eligible to be enrolled in a Medicare Advantage plan included in this RFP.

Personally Identifiable Information or **PII** means information that is capable of identifying a particular individual through one or more identifiers or other information or circumstances.

Proposal means the complete response of a Proposer submitted on the approved forms and setting forth the Proposer's pricing for providing the Services described in this RFP, which includes all attachments, exhibits, appendices and all other documents referenced herein.

Proposer means any individual, company, corporation, or other entity that responds to this RFP. Used interchangeably with "Vendor," Proposer means a firm or individual submitting a Proposal in response to this RFP.

Protected Health Information or **PHI** is health information protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title 45 of the Code of Federal Regulations, Section 160.103.

RFP means Request for Proposal.

Services means all work performed, and labor, actions, recommendations, plans, research, and documentation provided by the Contractor necessary to fulfill that which the Contractor is obligated to provide under the Contract.

State means the State of Wisconsin.

State Statutes or **ss** or **Wisconsin Statutes** or **Wis. Stat.** means Wisconsin State Statutes referenced in this RFP, viewable at: http://www.legis.state.wi.us/rsb/stats.html.

Subcontractor means a person or company hired by the Contractor to perform a specific task or provide program content as part of the Contract.

USPS means the United States Postal Service.

UW means the University of Wisconsin System with 13 four-year campuses and 13 two-year campuses with locations throughout the State.

Vendor means a person or company that sells goods or provides services. Used interchangeably with "Proposer," Vendor means a firm or individual submitting a Proposal in response to this RFP.

WPE means Wisconsin Public Employer as defined under Wis. Stat. § 40.02 (28), other than the State, which has acted under Wis. Stat. § 40.51 (7), to make healthcare coverage available to its Employees.

See ETF's glossary at: http://etf.wi.gov/glossary.htm for additional definitions.

In addition, see all definitions located in Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement.

1.6 CLARIFICATION OF THE SPECIFICATIONS AND REQUIREMENTS

Proposers must submit any questions concerning this RFP via e-mail (no phone calls) to ETFSMBProcurement@etf.wi.gov. The subject line of the e-mail must state "**RFP ETH0020**" and the e-mail must be received on or before the date identified in Section 1.9 Calendar of Events for Proposer Questions. Proposers are expected to raise any questions they have concerning this RFP at this point in the process. Do not include any information within your questions that would identify your company as all submitted questions will be shared with all vendors who submit questions.

It is encouraged that Proposers submit any assumptions or exceptions during the above process. Any assumption or exception listed must contain a rationale as to the basis for the assumption/exception. The Department will inform the Proposers what assumptions or exceptions would be acceptable.

Questions must be submitted as a Microsoft Word document (not a .pdf or scanned image) using the format specified below:

Table 5. Format for Submission of Clarification Questions

No.	RFP Section	RFP Page	Question/Rationale
Q1			
A1			
Q2			
A2			

Q = Proposer's question; A = ETF's answer

Proposer's e-mail must include the name of the Proposer's company and the person submitting the question(s). A compilation of all questions and answers, along with any RFP updates, will be posted to **ETF's Extranet** (https://etfonline.wi.gov/etf/internet/RFP/rfp.html) on or about the date indicated in Section 1.9, Calendar of Events, for ETF Posts Responses to Proposer Questions.

If a Proposer discovers any significant ambiguity, error, conflict, discrepancy, omission, or other deficiency in this RFP, the Proposer should immediately notify the individual identified in Section 1.4 of such error and request modification or clarification of this RFP document.

If it becomes necessary to update any part of this RFP, updates will be published on ETF's Extranet at the URL listed above, which is part of ETF's website, and will not be mailed. Electronic versions of this RFP and all appendices and exhibits are available on ETF's Extranet.

1.7 PROPOSER CONFERENCE

There is no scheduled Proposer conference. A Proposer conference is an opportunity for Proposers to ask questions. If ETF decides to hold a Proposer conference, a notice will be posted on ETFs Extranet at http://etfextranet.it.state.wi.us/etf/internet/RFP/rfp.html. Note, unless this notice is posted, no conference will be held.

1.8 REASONABLE ACCOMMODATIONS

ETF will provide reasonable accommodations, including the provision of informational material in an alternative format, for qualified individuals with disabilities, upon request.

1.9 CALENDAR OF EVENTS

Listed below are the important dates by which actions related to this RFP must be completed. If the Department finds it necessary to change any of the specific dates and times in the Calendar of Events listed below, it will do so by issuing a supplement to this RFP via the ETF Extranet listed in Section 1.6. No other formal notification will be issued for changes in the estimated dates. Note the Contract start date is May 15, 2018, while the benefit period will begin January 1, 2019. This is intentional, as the Contractor will assist with the implementation, transition, and Member communication involved with any program structure change.

ETF recognizes that the Proposals are due prior to the release of the CMS Final Call Letter in April 2018. Selected Proposers will be asked to submit an updated Premium Submission once the Final Call Letter is released, as described in Section 8.6.

Table 6. Calendar of Events*

Date	Event
October 17, 2017	ETF Issues RFP
October 31, 2017	Proposer Questions and FORM F – ETH0020 Non-Disclosure Agreement with ETF and The Segal Company Due Date
November 14, 2017	ETF Posts Responses to Proposer Questions

November 28, 2017 2:00 PM CDT	Proposal Due Date and Time
March, 2018	Group Insurance Board meeting
April 30, 2018 2:00 PM CDT	**Revised Premium Submission Due Date and Time**
May 15, 2018	Contract Start Date

All dates are estimated except the submission dates for Proposer Questions, FORM F and Proposals.

1.10 CONTRACT TERM

The Contract term for providing services for group Medicare Advantage health coverage will commence on the Contract start date and shall extend through December 31, 2021. The Board retains the option, by mutual agreement of the Board and the Contractor, to renew the Contract for two (2) additional two (2) year periods extending the Contract through December 31, 2025, subject to the satisfactory negotiation of terms, including pricing. Premiums will be reviewed and negotiated annually. See Section 130B of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement.

1.11 NO OBLIGATION TO CONTRACT

The Board reserves the right to cancel this RFP for any reason prior to the issuance of a notice of intent to award a Contract. The Board does not guarantee to purchase any specific dollar amount. Proposals that stipulate that the Board shall guarantee a specific quantity or dollar amount will be disqualified.

1.12 WI DEPARTMENT OF ADMINISTRATION ESUPPLIER REGISTRATION

The Wisconsin Department of Administration's eSupplier Portal is available to all businesses and organizations that want to do business with the State. The eSupplier Portal allows vendors to see details about pending invoices and payments, allows vendors to receive automatic, future official notices of bid opportunities, and, in some cases, allows vendors to respond to State solicitations. Note: the eSupplier Portal is not being used for this solicitation for Proposer responses.

For more information on the eSupplier Portal, go to:
https://esupplier.wi.gov/psp/esupplier/SUPPLIER/ERP/h/?tab=WI_BIDDER

1.13 RETENTION OF RIGHTS

All Proposals become the property of ETF upon receipt. All rights, title and interest in all materials and ideas prepared by the Proposer for the Proposal to ETF shall be the exclusive property of ETF and may be used by the State of Wisconsin at its discretion.

2 PREPARING AND SUBMITTING A PROPOSAL

2.1 GENERAL INSTRUCTIONS

The evaluation and selection of a Contractor(s) will be based on the information received in the submitted Proposal(s) plus the following optional review methods, at ETF's discretion: reference checks, Proposer presentations, interviews, demonstrations, responses to requests for additional information or clarification, any on-site visits, and/or best and final offers (BAFOs), where requested. Such methods may be used to clarify and substantiate information in the Proposals.

Failure to respond to each of the requirements in this RFP may be the basis for rejecting a Proposal. Failure to provide a complete response to Section 8, Network Submission Requirements, Alternative Benefit Design, and Cost Proposal, may result in rejection of a Proposal.

Elaborate Proposals (e.g., expensive artwork), beyond that sufficient to present a complete and effective Proposal, are neither necessary nor desired. Marketing or promotional materials should only be provided where specifically requested. If providing such materials, please indicate which question the materials apply to.

All Proposals must be in English.

2.2 INCURRING COSTS

The State of Wisconsin and ETF are not liable for any costs incurred by Proposers in replying to this RFP, making requested oral presentations, or demonstrations.

2.3 SUBMITTING THE PROPOSAL

Proposers must submit the following, including all materials required for acceptance of their Proposal:

- One (1) original hard copy Proposal, clearly labeled "ORIGINAL;"
- Five (5) identical hard copy/paper copies of the original paper Proposal, marked as "COPY." Indicate the copy number on the cover of each copy (for example: 1 of 5, 2 of 5, etc.); and
- One (1) USB flash drive, which includes the following:
    - One (1) file folder of all electronic Proposal files in Microsoft Word/Microsoft Excel, and/or Adobe Acrobat 9.0 (or above) format. The Department requires that all files have optical character recognition (OCR) capability (not a scanned image). OCR is the conversion of all images typed, handwritten or printed text into machine-encoded text. The file folder must be labeled "**[Proposer Name] PROPOSAL**". **Exclude all Section 8 attachments from this file folder.**
    - One (1) file folder of all electronic Proposal files in Microsoft Word/Microsoft Excel, and/or Adobe Acrobat 9.0 (or above) format **EXCLUDING or REDACTING** all confidential and proprietary information/documents. This file folder must be labeled **"[Proposer Name] REDACTED PROPOSAL."** This is the file that will be submitted to requestors for open records requests. Note that no matter what the method the

Proposer uses to redact, ETF is not responsible for checking that the redactions match the Proposer's **FORM E – ETG0013 Designation of Confidential and Proprietary Information**. Proposers should be aware that ETF may need to electronically send the redacted materials to members of the public and other Proposers when responding appropriately to open records requests. ETF is not responsible for checking that redactions, when viewed on-screen via electronic file, cannot be thwarted. ETF is not responsible for responding to open records requests via printed hard copy, even if redactions are only effective on printed hard copy. ETF may post redacted Proposals on ETF's public website in exactly the same file format the Proposer provides, and ETF is not responsible if the redacted file is copied and pasted, uploaded, e-mailed, or transferred via any electronic means, and somehow loses its redactions in that process. **Exclude all submissions required in Section 8 from this file folder**. In addition to the above:

  - Redact only material the Proposer authored. For example, do not redact the question the Proposer is responding to, only the answer.
  - Do not redact page numbers. Page numbers should remain visible at all times, even if the whole page is being redacted.
  - All electronic files, including the redacted electronic file, must have the same pagination as Proposer's original hard copy Proposal.
  - Sign Form E – Designation of Confidential and Proprietary Information only once. Add as many lines/pages as necessary.

- Clearly mark the exterior of the USB flash drive with Proposer's name and the RFP number.
- Do not password protect the USB flash drive. Flash drives must be free of all malware, ransomware, viruses, spyware, worms, Trojans, or anything that is designed to perform malicious operations on a computer.

Proposers must submit the Proposal to the address listed in Section 1.4, Procuring and Contracting Agency, by the due date and time listed in Section 1.9, Calendar of Events. Refer to Section 8 for instructions on submitting Section 8 attachments. **Do not submit Section 8 attachments with your Proposal.**

Proposals received after the date and time specified in Section 1.9 Calendar of Events will not be accepted and shall be disqualified. Receipt of a Proposal by the State of Wisconsin mail system does not constitute receipt of a Proposal by ETF, for the purposes of this RFP. All required parts of the Proposal must be submitted by the specified due date and time; if any portion of the Proposal is submitted late, the entire Proposal will be disqualified. Proposers may request, via an email to the address listed in Section 1.4, the time and date their Proposal was received by ETF.

Proposals submitted via fax or e-mail will not be accepted.

The Proposal must be packaged, sealed and show the following information on the outside of the package:

- Proposer's Company Name and Address;
- Title: ETH0020 Medicare Advantage Plans; and
- Proposal Due Date specified in Section 1.9, Calendar of Events.

Refer to Section 8 for instructions on submitting Section 8 attachments.

2.4 Proposal Organization and Format

Proposers responding to this RFP must comply with the following format requirements. ETF reserves the right to exclude any Proposals from consideration that do not follow the required format as instructed below.

Proposals must be typed and submitted on 8.5 by 11-inch paper and bound securely.

Only provide promotional materials if they are relevant to a specific requirement of this RFP. If provided, all materials must be included in the Proposal section with the response to the relevant requirement and clearly identified as "promotional materials." Electronic access to such materials is preferred, which includes flash drives and web links.

Proposers responding to this RFP must comply with the following format requirements:

Front Cover — **Front Cover Requirements**

Include at a minimum the following information:

- Proposer's Company Name; and
- Title of the following: *Proposal Response for the Wisconsin Department of Employee Trust Funds RFP ETH0020 Medicare Advantage Plans.*

TABLE OF CONTENTS — **Table of Contents Requirements**

Include at a minimum the following information:

- Listing of each TAB number;
- Listing of each TAB description; and
- Listing of each TAB page number.

TAB 1 — **General Information and Forms**

Provide the following in the following order:

- Page 1 of ADDENDUM No. 1: Completed and signed Page 1 of Addendum No. 1.
- TRANSMITTAL LETTER: A signed transmittal letter must accompany the Proposal. The transmittal letter must be written on the Proposer's official business stationery and signed by an official that is authorized to legally bind the Proposer. Include in the letter:

  1) Name, title, and signature and of Proposer's authorized representative;
  2) Name and address of firm;
  3) Telephone number and e-mail address of representatives who will be responsible for providing Services under this RFP;
  4) RFP number and title: ETH0020 Medicare Advantage Plans;
  ~~4)~~5) Type of Proposal being submitted: "National PPO with Pharmacy," "Regional Plan with Pharmacy," or "Regional Plan without Pharmacy;" and,
  ~~5)~~6) Executive Summary.

- FORM A – Proposal Checklist
- FORM B – Mandatory Proposer Qualifications
- FORM C – Subcontractor Information
- FORM D – Proposer Verification of Data Submission to Board Actuary (must also be emailed to ETF at ETFSMBProcurement@etf.wi.gov upon submission of the Section 8 Attachments to Segal)
- FORM E – Designation of Confidential and Proprietary Information
- FORM F – Non-Disclosure Agreement with ETF and The Segal Company (must also be emailed to ETF via e-mail to ETFSMBProcurement@etf.wi.gov to gain access to Section 8 attachments and data files)
- FORM G – Request for Proposal
- FORM H – Vendor Information
- FORM I – Vendor References
- FORM J – Non-Disclosure Agreement with Truven Health Analytics
- Current Form W-9 Request for Taxpayer Identification Number and Certification (obtain form from the Department of the Treasury, Internal Revenue Service: https://www.irs.gov/pub/irs-pdf/fw9.pdf)

TAB 2 **Response to Sections 6 (GENERAL QUESTIONNARE) and 7 (TECHNICAL QUESTIONNAIRE)**

Provide a point-by-point response to each and every statement in Section 6 and Section 7. The response must follow the same numbering system, use the same headings, and address each point or sub-point listed in this RFP.

Include the documents requested in Sections 6 and 7 at the end of the section in your Proposal that corresponds to the Section in the RFP in which the document is requested. Label the document provided with the section number it applies to.

TAB 3 **Assumptions and Exceptions**

If the Proposer has no assumptions or exceptions to any RFP term, condition, exhibit, appendix, form or attachment, provide a statement in Tab 3 to that effect.

If the Proposer has assumptions and/or exceptions to any RFP term, condition, exhibit, appendix, form or attachment, follow the following instructions:

Instructions:

- Regardless of any proposed assumption or exception, the Proposal as submitted must reflect all Services under the Contract.
- If the Proposer cannot agree to a term or condition as written, the Proposer must make its specific required revision to the language of the provision by striking out words or inserting required language to the text

of the provision. Any new text and deletions of original text must be clearly color coded or highlighted, which requires the Proposer's response be printed in color. Proposers shall avoid complete deletion and substitution of entire provisions, unless the deleted provision is rejected in its entirety and substituted with substantively changed provisions. Wholesale substitutions of provisions shall not be made in lieu of strategic edits required to reflect Proposer-required modifications.

- Immediately after a proposed revision, the Proposer shall add a concise explanation concerning the reason or rationale for the required revision. Such explanations shall be separate and distinct from the marked-up text and shall be bracketed, formatted in italics and preceded with the term "[*Explanation:*]."
- All provisions on which no changes are noted shall be assumed accepted by the Proposer as written and shall not be subject to further negotiation or change of any kind unless otherwise proposed by ETF.
- Submission of any standard Proposer contracts as a substitute for language in the terms and conditions is not a sufficient response to this requirement and may result in rejection of the Proposal. An objection to terms or conditions without including proposed alternative language will be deemed to be an acceptance of the language as applicable.
- ETF reserves the right to negotiate contractual terms and conditions other than those in the Contract when it is in the best interest of the State of Wisconsin to do so.
- Exceptions to any RFP terms and conditions may be considered by ETF during Contract negotiations if it is beneficial to ETF.
- ETF may or may not consider any of the Proposer's suggested revisions. ETF reserves the right to reject any proposed assumptions or exceptions.
- Clearly label each assumption and exception with one of the following labels:
  - Terms and Conditions Assumptions and Exceptions
  - RFP (Excluding Section 8) Assumptions and Exceptions
  - Section 8 Assumptions and Exceptions

Supplemental Information – IMPORTANT

ETF will not allow any assumptions or exceptions by the Proposer to any of the items listed in Table 7 below. Any Proposal with an assumption or exception to any of the items listed in Table 7 may be rejected.

Table 7. No Assumptions or Exceptions Allowed

No.	Document	Item/Section
1	Exhibit 1	155B and 315 Performance Standards and Penalties

2	Exhibit 1	155D Audit and Other Services
3	Exhibit 1	155F Privacy Breach Notification
4	Exhibit 1	155H Contract Termination
5	Exhibit 1	220 Benefits
6	Exhibit 1	250 Grievances
7	Exhibit 1	400 Uniform Benefits
8	Exhibit 3~~2~~	15.0 Applicable Law and Compliance
9	Exhibit 3~~2~~	17.0 Assignment
10	Exhibit 3~~2~~	32.0 Hold Harmless
11	Exhibit 5~~4~~	6.0 Audit Provision
12	Exhibit 5~~4~~	13.0 Contract Dispute Resolution
13	Exhibit 5~~4~~	14.0 Controlling Law
14	Exhibit 5~~4~~	16.0 Termination of this Contract
15	Exhibit 5~~4~~	17.0 Termination for Cause
16	Exhibit 5~~4~~	18.0 Remedies of the State
17	Exhibit 5~~4~~	22.0 Confidential Information and HIPAA Business Associate Agreement
18	Exhibit 5~~4~~	23.0 Indemnification
19	Exhibit 5~~4~~	28.0 Data Security and Privacy Agreement
20	Form J	Non-Disclosure Agreement with Truven Health Analytics (entire document~~s~~)

2.5 WITHDRAWAL OF PROPOSALS

Proposals shall be irrevocable until the Contract is awarded unless the Proposal is withdrawn. Proposers may withdraw a Proposal in writing at any time up to the date and time listed in Section 1.9, Calendar of Events, for the Proposal Due Date or upon expiration of three (3) Calendar Days after the Proposal Due Date and time, if received by ETF. To accomplish this, the written request must be signed by an authorized representative of the Proposer and submitted to the contact listed in Section 1.4, Procuring and Contracting Agency. If a previously submitted Proposal is

withdrawn before the Proposal Due Date, the Proposer may submit another Proposal at any time up to the Proposal Due Date and time.

3 PROPOSAL SELECTION AND AWARD PROCESS

3.1 PRELIMINARY EVALUATION

Proposals will initially be reviewed to determine if Mandatory requirements are met and if all required Proposal components are received. Failure to submit a complete Proposal may result in rejection of the entire Proposal. Failure to meet Mandatory requirements as stated in FORM B - Mandatory Proposer Qualifications, or failure to follow the required instructions for completing the Proposal as specifically outlined in this RFP may result in rejection of the Proposal. Failure to provide a complete response to Section 8 in this RFP will result in rejection of a Proposal.

3.2 CLARIFICATION PROCESS

ETF may request Proposers to clarify ambiguities or answer questions related to information presented in their Proposal. Clarifications may occur throughout the Proposal evaluation process. Clarification requests will include appropriate references to this RFP or the Proposal. Responses shall be submitted to ETF in writing within the time required. Failure to provide responses as instructed may result in rejection of a Proposal.

3.3 PROPOSAL SCORING

Proposals that pass the preliminary evaluation may be reviewed by an evaluation committee. The evaluation committee may review written Proposals, references, additional clarifications, oral presentations, site visits and other information to score Proposals. ETF may request reports on a Proposer's financial stability, (this includes ETF's request for Proposers to furnish audited financial statements), and if financial stability is not substantiated, may reject a Proposer's Proposal. ETF may request demonstrations of the Proposer's proposed products(s) and/or service(s), and review results of past awards to the Proposer by the State.

A Proposer may not contact any member of the RFP evaluation committee.

The evaluation committee's results will be tabulated and Proposals will be ranked based on the numerical scores received.

The evaluation committee reserves the right to stop reviewing a Proposal at any point during the evaluation process and remove the Proposal from further consideration.

3.4 EVALUATION CRITERIA

Proposals will be evaluated based upon the proven ability of the Proposer to satisfy the requirements specified in this RFP in an efficient, cost-effective manner, taking into account quality of service. Proposals will be scored using the following criteria:

Table 8. Evaluation Criteria

RFP SECTION	DESCRIPTION	TOTAL POINTS	%
6	General Questionnaire	300	30%
7	Technical Questionnaire	500	50%
8.3-8.5	Uniform Benefit Cost Proposal	200	20%
	Total	**1,000**	**100%**
TOP PROPOSERS ONLY	**DESCRIPTION**	**TOTAL POINTS**	**%**
	Proposer Demonstration	500	-

The Network Submissions component of Section 8 will not be scored. Proposers whose Network submissions do not meet the access standards specified in Section 8.1 will not be passed on to the Board for consideration.

3.5 METHOD TO SCORE COST PROPOSALS

For nationwide service area Proposals, the lowest Cost Proposal for the Uniform Benefit Design will receive the maximum number of points available for the cost category. Cost Proposals from other nationwide service area Proposers for the Uniform Benefit Design will receive prorated scores based on the proportion that the costs of the Proposals vary from the lowest Cost Proposal. The scores for the cost category will be calculated with a mathematical formula.

For regional service area Proposals, costs will be evaluated against a benchmark of non-Medicare Advantage offerings already available in the area for Participants using a mathematical formula.

Scoring of the Cost Proposals will be performed by the Board's consulting actuary.

3.6 ORAL PRESENTATIONS, DEMONSTRATIONS, AND/OR SITE VISITS

The top scoring Proposers, based on the evaluation of their written Proposal in the general and technical questions of this RFP only (Sections 6 and 7), may be required to participate in oral presentations, interviews and/or site visits to supplement the Proposals, if requested by ETF. This may include demonstrations of Proposer's key tools, reporting capabilities and interviews with key ETF staff, evaluation committee members, and Board members.

Not all Proposers may be invited for oral presentations, demonstrations, and/or site visits. ETF will make every reasonable attempt to schedule each oral presentation or demonstration at a time and location that is agreeable to the Proposer. Failure of a Proposer to interview or permit a site visit on the date scheduled may result in rejection of the Proposer's Proposal.

By submitting a Proposal in response to this RFP, the Proposer grants rights to ETF to contact or arrange a visit with any or all of the Proposer's clients, Subcontractors, and/or references.

3.7 CONTRACT AWARD

Proposals will be presented to the Board for award based on the results of the technical and initial cost evaluations. The Proposal(s) determined to best meet the goals of the State's insurance program may be selected by the Board for further action. The Board reserves the right not to award a Contract. If Contract negotiations with the Proposer selected for the nationwide service area cannot be concluded successfully, the Board may negotiate a Contract with another Proposer(s). Contract negotiations will include revised premium bids based on the CMS Final Call Letter as described in Section 8.6 and any proposed benefit designs approved by the Board. If Contract negotiations with a Proposer selected for a regional service area cannot be concluded successfully, that Proposer's plan will not be available in that service area.

3.8 BEST AND FINAL OFFER (BAFO)

ETF reserves the right to solicit a BAFO and conduct Proposer discussions, request more competitive pricing, clarify Proposals, and contact references from the finalists, should it be in the State's best interest to do so. ETF is the sole determinant of its best interests.

If a BAFO is solicited, it will contain the specific information on what is being requested, as well as submission requirements and a timeline with due date for submission. Any BAFO responses received by ETF after the stated due date may not be accepted. Proposers that are asked to submit a BAFO may refuse to do so by submitting a written response, indicating their response remains as originally submitted. Refusing to submit a BAFO will not disqualify the Proposer from further consideration.

3.9 RIGHT TO REJECT PROPOSALS AND NEGOTIATE CONTRACT TERMS

This RFP does not commit the Board to awarding a Contract, or paying any cost incurred in the preparation of a Proposal in response to this RFP. The Board retains the right to accept or reject any or all Proposals, or accept or reject any part of a Proposal deemed to be in the best interest of the Board. The Board shall be the sole judge as to compliance with the instructions contained in this RFP.

The Board may negotiate the terms of the Contract, including the award amount and the Contract length, with the selected Proposer prior to entering into a Contract. The Board reserves the right to add contract terms and conditions to the Contract during contract negotiations and subsequent renewals.

3.10 NOTIFICATION OF INTENT TO AWARD

All Proposers who respond to this RFP will be notified in writing of the Board's intent to award a Contract as a result of this RFP. All decisions and actions under this RFP are solely under the authority of the Board. This procurement is authorized under Chapter 40 of the Wisconsin State Statutes. Procurement statutes and rules that govern other State agencies may not be applicable.

3.11 APPEALS PROCESS

Protests of the Board's intent to award a contract must be made in writing. The appeal must state the RFP number, detailed factual grounds for the objection to the Contract award, and must

identify any Wisconsin Statutes and/or Wisconsin Administrative Codes that are alleged to have been violated. Protestors can only submit one appeal per award.

A written notice of intent to protest the notice of intent to award the contract must be filed with:

Express/Common Carrier Delivery:	**USPS Delivery**
Group Insurance Board c/o Robert J. Conlin, Secretary Wisconsin Department of Employee Trust Funds 801 West Badger Road Madison, WI 53713-2526	Group Insurance Board c/o Robert J. Conlin, Secretary Wisconsin Department of Employee Trust Funds PO Box 7931 Madison WI 53707-7931

This notice must be received in the ETF office no later than five (5) Business Days after the Notice of Intent to Award is issued. Fax and e-mail documents will not be accepted. The written protest must be received within ten (10) Business Days after the Notice of Intent to Award the Contract is issued.

The decision of the Group Insurance Board regarding any protests or appeals is final and the subjective judgment of evaluators is not appealable.

4 MANDATORY PROPOSER QUALIFICATIONS

This section is pass/fail. (0 points)

Use FORM B – Mandatory Proposer Qualifications to respond.

The following requirements are Mandatory for any Proposer who submits a Proposal. Failure to comply with one or more of the Mandatory qualifications may disqualify the Proposer. A response to each item in FORM B – Mandatory Proposer Qualifications is a Mandatory qualification.

Conditions of the Proposal that have the word “must” or “shall” describe a Mandatory qualification.

If the Proposer cannot agree to each item listed, the Proposer must so specify and provide the reason for the disagreement in Tab 3 – Assumptions and Exceptions – of Proposer’s response.

4.1 Pursuant to Wis. Stat. § 16.705 (1r), the Services must be performed within the United States.

4.2 Proposer agrees that any work products developed by Proposer as part of the project described in this RFP (e.g. all written reports, drafts, presentations and meeting materials, etc.) shall become the property of ETF.

4.3 The Proposer shall have no conflict of interest with regard to any other work performed by Proposer for the State of Wisconsin.

4.4 The Proposer shall not be suspended or debarred from performing federal or State government work.

4.5 During the past five (5) years, the Proposer must not have been in bankruptcy or receivership or been involved in any litigation alleging breach of contract, fraud, breach of fiduciary duty or other willful or negligent misconduct. If the Proposer provides a response of “DISAGREE,” provide details of any pertinent judgment, criminal conviction, investigation or litigation pending against the Proposer.

5 PROGRAM SPECIFICATIONS

This section is NOT scored. (0 points)

ETF will execute Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement with the awarded Contractor(s).

All terms, standards, specifications and conditions listed in the Contract are **Mandatory** requirements.

Failure to comply with any term, standard, specification or condition within the Contract may disqualify the Proposer.

If the Proposer cannot agree to each item listed, the Proposer must so specify and provide the reason for the disagreement in Tab 3 – Assumptions and Exceptions – of Proposer's response.

6 GENERAL QUESTIONNAIRE

This section is scored. (300 total points)

The purpose of this section is to provide ETF and the Board with a basis for determining the Proposer's capability to undertake the Contract.

All Proposers must respond to the following by restating each question or statement and providing a detailed written response. Instructions for formatting the written response to this section are found in Section 2.4, Proposal Organization and Format.

The Proposer must be able to perform Services according to the requirements contained in this RFP.

Information described in the Proposal response regarding programming and capabilities must be available to all eligible Participants unless otherwise noted in the Proposal.

The Proposer must provide sufficient detail for the evaluation committee, the Board, and ETF to understand how the Proposer will comply with each requirement. If the Proposer believes that the Proposer's qualifications go beyond the minimum requirements or add value, the Proposer should indicate those capabilities in the appropriate section of the Proposal. **Fees related to any Services specified in your Proposal must be noted in Attachment D – Cost Proposal only. Do not include cost/pricing information in any other section of the Proposal.**

6.1 EXPERIENCE

The Proposer's Proposal package, at a minimum, must address the following items, organized as indicated below:

6.1.1	Provide a general description of your organization/company, including: 1) Primary line of business. 2) Description of experience in primary line(s) of business. 3) Number of employees.

	4) City and state locations of the following: headquarters, account manager, customer service, claims processing, IT support, implementation team, and other key staff. 5) Description of experience with public and private large group accounts (≥10,000 covered lives), including complex groups and/or groups with multiple locations/subgroups. 6) Description of experience in administering group Medicare Advantage plans and, for Medicare Part D prescription drug benefits if submitting a Medicare Part D alternative benefit design Proposal. 7) Provide the same information above for any Subcontractor that will be providing Medicare Part D benefits as part of your Proposal, if appropriate.
6.1.2	Describe any acquisitions, and/or mergers or other material developments (e.g., changes in ownership, personnel, business, etc.) pending now or that occurred in the past five (5) years with your organization/company. Disclose any potential mergers or acquisitions that have been recently discussed by senior officials, and could potentially take place within the next three (3) years after the Contract start date.
6.1.3	Submit your company's audited financial statements for the two (2) most recent fiscal years including the audit opinion, balance sheet, statement of operations, and notes to the financial statements.
6.1.4	1) Provide the names of your two largest employer groups that offer Medicare Advantage plans. 2) Complete the tables below illustrating your organization's enrollment and clients as of July 1, 2017. For clients that are comprised of multiple employer groups, count them as one employer in your response.

Group Medicare Advantage Book of Business:

Total # of Covered Lives	# of Public Sector Employers	# of Private Sector Employers
Less than 500		
≥ 500 < 2,000		
≥ 2,000 < 10,000		
≥ 10,000		

Group Medicare Part D Book of Business:

Total # of Covered Lives	# of Public Sector Employers	# of Private Sector Employers
Less than 500		
≥ 500 < 2,000		
≥ 2,000 < 10,000		
≥ 10,000		

	Individual Medicare Advantage Book of Business:		
		Wisconsin	**United States**
	Total Covered Lives		

6.2 CMS Approval and Oversight

6.2.1	Provide documentation that shows your organization is approved by the U.S. Centers for Medicare & Medicaid Services (CMS) to provide employer group waiver programs for Medicare Part C (and Part D, if appropriate) in Wisconsin, or that you are in the process of applying to CMS to provide such programs starting in the 2019 plan year. If not approved to provide services statewide in Wisconsin, identify the specific counties in which you are CMS-approved or have applied for approval.
6.2.2	Provide the findings of any CMS Part C or D audits conducted in the last five (5) years, including the overall audit score and any enforcement actions applied.
6.2.3	Indicate if your organization has been identified as "poor performing" or an "outlier" by CMS as part of a past performance review in the last five (5) years. If so, explain why and indicate whether CMS denied any part of your organization's application to expand Medicare Advantage or Medicare Part D services as a result.
6.2.4	Provide a list of all the reports your organization provides to CMS for the plan you are offering under your Proposal, including enrollment, network access, quality performance, compliance, customer service, risk adjustment, service utilization or other reports. Identify what types of information are included in those reports, the frequency and format of those reports and an indication of whether those reports would be available to ETF.

6.3 Staff Qualifications

6.3.1	Describe the qualifications of the dedicated Account Manager who will be assigned to the Contract and provide his/her resume. In your description, include: 1) The skills and attributes of the Account Manager that will ensure that the requirements of the Contract wil be met; 2) Information about the Account Manager's professional qualifications; 3) A detailed description of the types of group Medicare Advantage or group Medicare Part D accounts that the Account Manager has been, or currently is, managing. Include the total number of group Medicare Advantage and Medicare Part D groups along with the number of years of experience in managing these types of accounts; 4) Number of other accounts, and their size, for which the Account Manager will be overseeing when also assigned to manage the GHIP/WPE Group Medicare Advantage and Medicare Part D program; and

	5) A specific example of how the Account Manager has resolved a general administrative problem identified by a client.
6.3.2	1) Provide a list of the key, qualified staff who will assist in fulfilling the requirements of the Contract. At a minimum, include the back-up to the Account Manager and at least one staff person in enrollment, customer service, claims, medical management, provider relations, and other key areas. For each staff person, list the following: a) Name, job title, and location (city, state); b) Primary responsibilities; c) Years of related experience; and d) Top two (2) strengths. 2) Provide an organizational chart that shows the reporting structure for the key staff.

6.4 CUSTOMER SERVICE

6.4.1	Explain how your company plans to meet the customer service requirements as specified in Sections 270C and 315C of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement.
6.4.2	Provide examples of reports that demonstrate how your organization would meet the requirements specified in Sections 270C and 315C of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement.
6.4.3	Describe your organization's policies and procedures for handling member contacts (e.g., calls, emails, etc.) during times of peak volume (e.g., open enrollment, new plan year). Describe how your organization handles after-hour member contacts.
6.4.4	Patients demonstrate a wide range of understanding and ability with regard to understanding their benefits, using their health coverage, choosing providers, and engaging with care. Describe your organization's efforts to address health literacy issues and promote informed decision-making skills and active patient participation in their healthcare. Responses should address the following topics: 1) Health literacy policies and practices; 2) Evaluation of effectiveness of oral, printed, and web communications (including billing statements, benefit and enrollment materials, and information on provider network); and 3) Initiatives to increase patient engagement. Provide at least one (1) example.
6.4.5	The Medicare population is more likely to have different customer service needs than a commercial population. Describe your understanding of the different needs of this population. Describe how your organization's customer service staff are trained to meet the needs of the Medicare population and how your technology, policies, and procedures are specifically designed to meet those needs.

6.4.6	Describe how your organization meets the communication needs of your visually and hearing impaired Medicare members. Specifically address how your customer service staff are trained to meet their needs and how you make your written and electronic materials, including your website available to meet their needs.
6.4.7	Confirm you will provide one full-time employee to work in ETF's office at your expense to work with ETF staff to resolve Participants' escalated eligibility, enrollment, premium, and claim issues and to assist with communications and training, and resolve operational issues by being a liaison with the main office. This person should be solely dedicated to ETF.

6.5 IMPLEMENTATION

6.5.1	Submit a detailed implementation plan identifying the tasks necessary to fulfill the requirements of the Contract, such as staff roles, programming changes, Subcontractors involved, timeline, etc. Refer to Sections 270 and 315A of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement.
6.5.2	Provide a detailed explanation of how your organization will be available to support ETF staff during implementation.
6.5.3	Indicate whether you plan to implement any major computer system upgrades or conversions, major staff relocations, or telephone system changes during 2018 or the first six months of 2019. If any are planned, identify the specific measures you will be taking to ensure that such changes will not affect the implementation of the Contract. What assurances can you provide that no unanticipated changes will develop between submission of your Proposal and Contract implementation that could impact the implementation.

6.6 ENROLLMENT AND COMMUNICATION

The Board expects the Awarded Proposer(s) to provide a significant multi-faceted effort to educate Participants about: the enrollment process leading up to and during open enrollment, Medicare Advantage plans in general, their specific organization and the benefits and providers available under the specific plans being offered, and the various methods Members can use to get more information.

6.6.1	Submit a detailed communication and enrollment plan for Members that includes a timeline starting prior to open enrollment through enrollment and payment of premiums.
6.6.2	Provide examples of Member communication materials that explain the enrollment process, covered benefits and cost-sharing, available providers, and methods for obtaining more information. Include any materials CMS requires you to send to Members during enrollment, a sample Subscriber identification card, explanation of benefits statement, and a billing invoice for Participants that are direct billed. If proposing an alternative pharmacy benefit, communication materials should include any materials related to that benefit as well.

6.6.3	Describe how your organization can support the Department handling of split-family contracts where some family members are Medicare enrolled and some family members are not.
6.6.4	Describe what happens to medical and prescription drug coverage for Participants who: 1) Have Medicare Part A but do not have Medicare Part B coverage. 2) Drop Part B coverage after enrolled in your plan. 3) Enroll in another Medicare Part D plan. 4) Enroll in Medicare late and fail to enroll when that member turns 65 years of age. Identify who is responsible for any associated late penalties? How do you ensure such individuals do not have a gap in coverage? In your answers, be sure to describe how your organization verifies Medicare enrollment and describe all communications to the Participant and to the Department.
6.6.5	Describe your process for applying a Participant's Late Enrollment Penalty (LEP). In your response, include how the LEP will be billed and how this will be communicated to the Department and to the Participant.
6.6.6	Describe your low income premium subsidy (LIPS) reimbursement process. How do you propose to assist ETF with LIPS reimbursements? Please outline what you would require of ETF as part of this this process.
6.6.7	Please describe in detail your plan to address and manage the elimination of Health Insurance Claim Numbers (HICN) and replacement with Medicare ~~billing~~ beneficiary identifiers (~~MIB~~MBI) through the transition period and effective date.
6.6.8	Describe your ability to co-brand Member communication materials, including web, print and any other electronic/digital materials. Describe any limits, including colors, logo size and format, etc.

6.7 DATA SECURITY

6.7.1	**Hosting Environment** 1) Provide a detailed description of the hardware, software, communication mediums, and other infrastructure necessary to support the information technology requirements for the Contract, excluding any features not included in the Cost Proposal. 2) Provide a description of the physical security controls, such as, but not limited to, cameras, guards, doors, locks, authentication types, procedures, etc., that are enforced at the privately hosted datacenter(s) or the datacenter(s) hosted by a third-party cloud provider that will be used to provide Services under the Contract. 3) Describe in detail how your network is architected to secure the data and thwart unwanted/unknown access to your applications or systems. At a minimum, cover:

	a) Overview of network access controls such as, Virtual Local Area Networks (VLANs), subnets, and firewall controls; b) Security devices used to protect the infrastructure; c) Change control processes for all systems; d) Security updates and patch management for all systems; e) Explanation of how much of the infrastructure/systems is owned and managed by the Proposer and if it is hosted, how much control the Proposer has or does not have to change the configuration on each system (servers, switches, routers, firewalls, Security Information Event Management (SIEM), Intrusion Protection Systems (IPS), Intrusion Detection System (IDS), etc.); and f) Encryption between systems and any Public Key Infrastructure (PKI).
6.7.2	**Application Architecture** 1) Provide a description of the high-level architecture for the solution, supported with diagrams depicting the interactions among the system components. The purpose of these diagrams is to ensure that ETF understands the essential design of the proposed solution and can determine that the design is generally consistent with the budget, scope, and capabilities represented in this RFP. Diagrams should include architectural views that reflect the application architecture, information architecture and related data models, and corresponding software and hardware architectures. 2) Include a discussion of the specific industry standards that are incorporated in the application architecture. If proprietary standards or interfaces are used, include the rationale and describe the advantage over current industry standards. 3) Include a discussion of the standard web technologies, frameworks and software platforms adopted in the development of the web user interface (e.g. JQuery, JavaScript, Hypertext Preprocessor (PHP), Ajax, Python, C#, Java, .Net). 4) Include a discussion of the Software Development Life Cycle (SDLC) process for the system. Identify methodologies that you employ and tools you use for operations in your software development processes, including, but not limited to, the following: a) Unit testing; b) Code coverage; c) Static code analysis; d) Code reviews; e) Development standards; f) Continuous integration; g) Build and deployment strategies; h) Integration testing; i) Stress testing; and, j) Performance testing.

	5) Include a discussion of the how the SDLC incorporates the application security principles outlined by Open Web Application Security Project (OWASP) (http://www.owasp.org) to protect against common web application vulnerabilities which include, but are not limited to: a) Cross-Site Scripting (XSS); b) Cross-Site Request Forgery (CSRF); c) Remote Code Execution; and d) Structured Query Language (SQL) Injection.
6.7.3	**User Cyber Security Awareness Training** 1) Provide details to explain your policies and procedures for user cyber security awareness training for all your staff. This is a separate question from HIPAA training policies and procedures. At a minimum, cover: a) Programs used to train employees and content of the programs; b) How often trainings occur; and, c) Any processes used to validate that employees are retaining what they learned.
6.7.4	**Account/Identity Management** 1) Describe how the solution will provide for secure access for Participants in the system. Describe the user registration process, the association of user accounts to Participant information provided by ETF. Describe how you would prevent users from intentionally or unintentionally accessing other Participants' information. Describe how the solution is designed to prevent accidental or incidental access. 2) Describe the account management and account recovery process. 3) Provide details to explain how passwords and user accounts are managed to protect against unauthorized access to any systems or applications. At a minimum, cover: a) Password complexity requirements for all accounts (web-portal administrator accounts, Proposer employee accounts, administrator accounts and service/shared accounts); b) Onboarding process for employees and contractors; and c) Off boarding process for employees and contractors. 4) Describe the technical solution and the authentication standards that will be implemented to integrate with other third party providers.
6.7.5	**Auditing and Logging** ~~6)~~7) Describe in detail your logging and auditing policies and procedures. At a minimum, cover: a) What fields are recorded; b) Log retention; c) Logging practices;

	d) Syslog or SIEM; e) Auditing practices and procedures in each area of technology (web, application, operating system, database); f) User and administrator auditing; g) Service or shared account auditing; h) Audit history reporting practices to clients, such as ETF; and, i) Cooperation practices with clients to do forensics for security incident response situations.
6.7.6	**Vulnerability Management and Penetration Testing** 1) Provide details on your vulnerability management program and penetration testing practices and procedures. At a minimum, cover: a) Vulnerability scanning practices; b) Vulnerability scanner tools; c) Remediation practices; d) Vulnerability reporting policy and practices to clients, such as ETF; e) Penetration testing practices; f) Depth of the penetrating tests, such as, how much is done (social engineering, password cracking, Denial of Service (DOS), etc.); and, g) Penetration testing reporting policy and practices to clients, such as ETF.
6.7.7	**HIPAA Security** 1) Describe how your company will maintain confidentiality and comply with HIPAA security, privacy, and electronic data interchange requirements. Address the data security of data centers, networks, the web-portal, vendor to vendor transfers, and at onsite events. 2) Describe any incidents of a breach of PII and/or PHI in the past three (3) years that impacted at least twenty-five (25) Participants. For each incident, list a summary of the incident, the root cause, action taken to rectify, and steps taken to prevent future occurrences. Describe the applicable communication policies and procedures and to what degree they were followed.
6.7.8	**Corporate and Remote Networks** 1) It is as important to secure the corporate networks or remote networks that have direct access to the datacenter infrastructure as it is the datacenter(s) itself. Describe how you have implemented security practices for your corporate or remote networks that have direct access to the datacenter(s). At a minimum, cover: a) Network segregation controls (VLANs, subnets, firewalls) for all users (business, administrators, contractors, and guests); b) Host-based firewall protection for employee workstations; c) Anti-malware protection for employee workstations;

	d) Bring your own device (BYOD) or any non-Proposer owned and managed devices; e) Email security protecting PII/PHI; f) Type of wireless networks (Line of Business (LOB), administrators, guests, etc.) and wireless security; and, g) Network access controls (NAC), 802.1x authentication, etc.
6.7.9	**Information Security Controls Standards** 1) Indicate if your organization uses a set of industry standard information security controls to inform its approach to system security? (Applicable publications include NIST CyberSecurity Framework, ISO 27001/27002, and the Twenty Critical Security Controls for Effective Cyber Defense.) If yes, which security control set is used? And, how often does your organization assess or audit itself against your chosen information security control set? 2) Indicate if the audits are internally administered, or if they are conducted by a third party. If a third party is used for audits, which organization has been most recently used?

7 TECHNICAL QUESTIONNAIRE

This section is scored. (500 total points)

The purpose of this section is to provide ETF and the Board with a basis for determining the Proposer's capability to undertake the Contract.

All Proposers must respond to the following by restating each question or statement and providing a detailed written response. Instructions for formatting the written response to this section are found in Section 2.4 Proposal Organization and Format.

The Proposer must be able to perform Services according to the requirements contained in this RFP.

Information described in the Proposal response regarding programming and capabilities must be available to all eligible Participants unless otherwise noted in the Proposal.

The Proposer must provide sufficient detail for the Board and ETF to understand how the Proposer will comply with each requirement. If the Proposer believes their qualifications go beyond the minimum requirements or add value, the Proposer should indicate those capabilities in each section. Associated costs should be listed in the Cost Proposal only.

7.1 PROVIDER MANAGEMENT

The Proposer must provide strong network management that not only provides the necessary network oversight, but that also demonstrates leadership in network development, innovation, collaboration, and overall patient quality of care. Because Medicare Advantage plans service a particular population, Proposers are also expected to provide networks that meet the needs and expectations of this population, including having a sufficient choice of providers, and particular types of providers.

7.1.1	Explain the approach for determining the breadth of the provider network to be offered so that provider access standards in Section 230A of Exhibit 1 State of Wisconsin Medicare Advantage Program Agreement are met. Describe the current approach to developing high quality, cost-competitive provider networks, including a description of the specific quality and cost criteria used and plans to expand or enhance.
7.1.2	Describe efforts to leverage data and technology and/or collaborate with providers on initiatives and pilot programs to address current population health issues. 1) Include in the description any collaboration and data sharing with external vendors (e.g., pharmacy benefit manager(s), data warehouse vendor(s), etc.). 2) Include how you track and evaluate the success of the programs. 3) Provide a specific example in which a troubling trend was identified, the action taken, and the results of the action taken; include the results of any such actions to date. 4) If the initiative or pilot was part of a CMS pilot or demonstration, provide a copy of any reports provided to CMS on the outcomes of the initiative or pilot, if available.
7.1.3	Describe the methods (e.g., benefit design, data and technology, communications, etc.) to steer care toward providers that achieve the best outcomes in terms of quality and cost.
7.1.4	Provide a detailed explanation of the process to track, compare, and give feedback to providers regarding practice patterns relative to their peers and best practices for the categories listed below. Include frequency, communication method(s), and the types of providers (e.g., specialty, certain provider groups versus all providers, etc.) to which the process applies. If applicable, include: 1) Prescription drug prescribing patterns; 2) Rates of diagnostic procedures ordered (e.g., lab, imaging, etc.); 3) Rates of high cost procedures; 4) Rates of infection (e.g. pneumonia, urinary tract infections, cellulitis and other skin infections); and 5) Repeat procedures within given timeframes.
7.1.5	1) Provide a detailed description of your model for engaging primary care providers to improve patients' quality of care, including a description of any innovative payment methods used. 2) How do you measure success with your model? 3) Describe any planned initiative to improve your model. 4) Include specific outcomes associated with your model (e.g., increase in appropriate preventive screenings/vaccinations/visits, patient satisfaction, etc.).
7.1.6	1) Provide a detailed description of your model for ensuring adequate access to specialists that focus on the needs of the Medicare-enrolled population, including geriatricians, palliative care, and behavioral health as well as home health providers.

	2) How do you measure success with your model? 3) Describe any planned initiatives to improve your model. 4) Describe any innovative payment models used to improve costs and outcomes for Participants seen by these specialists.
7.1.7	Describe any innovative approaches to network management that you have implemented that were not yet addressed in this subsection, and specifically describe how those efforts have improved the quality of care and/or reduced costs.

7.2 PROVIDER REIMBURSEMENT

7.2.1	Identify the percentage of your Medicare Advantage contracts paid under the reimbursement methods listed below. Describe a) the reimbursement method in detail, b) the length of time the reimbursement method has been in force, c) the impact on the quality and efficiency of care delivered, d) how it is anticipated to impact plan costs, and e) the criteria to determine payment and/or evaluate success. Specify any methods that are not currently in place, but are planned for implementation prior to January 1, 2019. Indicate if you believe any of these payment arrangements are not allowed under a Medicare Advantage program. 1) Tiered/narrow provider networks; 2) Bundled payments; 3) Reference value/pricing; 4) Pay for performance (describe specific performance measure(s) used); 5) Patient Centered Medical Homes (PCMH); 6) Risk sharing; 7) Capitation (partial or global); 8) Centers of Excellence (COE); 9) Retrospective episode-based reimbursement; 10) Shared savings/incentives for health outcomes; and 11) Other.
7.2.2	Describe specific provisions in your provider contracts used to incent providers to contribute towards improvement in your ratings in the CMS Star Ratings. Indicate whether such incentives are awarded at the system, clinic or practitioner level. Identify the percent of providers under such contract incentives.
7.2.3	Indicate the percentage of providers in your network that accept Medicare assignment. Describe your method for ensuring that Participants are not responsible for any balance billing.
7.2.4	1) Identify the percentage of claims that are reimbursed out-of-network. 2) Describe your out-of-network reimbursement methodology (e.g., percentage of Medicare, percentile of Usual and Customary). For the methodology used, provide

	the appropriate percentage or percentile used and the most recent year on which the rates are based. 3) For urgent and emergent out-of-network claims, how do you ensure that Participants are not responsible for balance billing from out-of-network providers.
7.2.5	Describe any innovative approaches to provider reimbursement that you have implemented that were not yet addressed in this subsection and specifically describe how those efforts have improved the quality of care and/or reduced costs.

7.3 Medical Management and Quality of Care

The Board is committed to the concept of effective cost containment for which documented savings can be provided and to improvement in the quality of care which improves Participants' health. Each Proposal must contain a detailed description of the medical management programs you administer, which include case management, complex case management, and other initiatives to improve the quality of care.

7.3.1	1) Describe all case and complex case management programs you currently administer, including: a) How long the programs have been operating; b) How your programs have been specifically tailored to meet the needs of the Medicare population; c) The elements or triggers to identify and screen potential candidates (e.g., predictive modeling, risk stratification, etc.); d) The enrollment and/or outreach process for potential candidates; e) The activities and interventions provided to enrollees; f) Where the case management primarily takes place (e.g., phone, clinic, home, etc.); g) How the program is integrated with behavioral health management; and h) The criteria used for discharging/graduating an enrollee from the program. 2) Provide one specific de-identified actual example for complex case management including its documented oucome.
7.3.2	For each program described in 7.3.1, provide the following outcomes: 1) Percent of enrollment of those targeted for participation; 2) Percent of completion; 3) Impact on health status; and 4) Return on investment (ROI) and how it was calculated.
7.3.3	For each program described in 7.3.1, indicate whether your programs are accredited by a nationally recognized body, such as Utilization Review Accreditation Commission (URAC) or the National Committee for Quality Assurance (NCQA). If accreditation is currently being sought, provide the status.

7.3.4	Provide your Star ratings for each measure and domain included in the CMS Star Rating for each of the last three years and your overall Star Rating for the plan you are offering in your Proposal.
7.3.5	Describe your organization's Star Maximization program in detail, including a description of the data and tools you use to drive your strategy and how it has changed over time.
7.3.6	Describe any initiatives you have implemented specifically to communicate with members about, and educate them on the use of, advanced care plans. Describe the goals of the initiative, how long it has been in operation, how it has changed over time, provide any participation statistics and results to date.
7.3.7	Describe any initiatives or programs you have implemented that are specifically related to supporting palliative care. Describe the goals of the initiative/program, and what services are available, how patients are identified as eligible for the program, what training is provided to staff, and how long the program has been in operation and how it has changed over time. Provide any participation statistics and results to date.
7.3.8	Describe, in detail, any CMS Medicare pilots or demonstrations your organization is currently participating in related to cost containment and/or quality of care involving providers or members in Wisconsin. Indicate whether Participants in the plan you are proposing would be eligible to participate in such pilots or demonstrations. Include the results of any such initiatives to date.
7.3.9	Confirm that you will provide a designated clinical manager at no cost to the Department for both medical and pharmacy programs for this population, who will have full knowledge of all clinical programs in effect as well as all clinical programs offered by your organization. Confirm that the clinical managers will have sufficient resources to efficiently and effectively handle the workload.
7.3.10	Describe any innovative approaches to medical management and quality of care improvement that you have implemented that were not yet addressed in this subsection and specifically describe how those efforts have improved the quality of care and/or reduced costs.

7.4 TOTAL HEALTH MANAGEMENT AND WELLNESS

The Board seeks Vendors to assist in further engaging Participants in the management of their health. This includes education and outreach by the Proposer, with transparency tools to help Participants select quality, efficient care, and engage Participants in their health and well-being.

7.4.1	Describe the tools available to Participants to support healthcare decisions, such as self-management of at least one chronic condition, cost estimators, tools to find less expensive drug options (when providing a drug benefit), provider selection, quality comparisons, and shared decision making tools. If you work with a Subcontractor to provide these tools, include Subcontractor information in your response. For each tool, provide the following information:

	1) Identify the specific services included on the tool, if appropriate; 2) Provide the percentage of your members that have access to the tools and currently use them; 3) Explain how the effectiveness of the tool evaluated; 4) For any comparison tool, provide the methodology used; 5) Describe how such tools are enabled for mobile devices and integrated with your other platforms (e.g., web-portal, provider locator, etc.); ~~and~~ 6) Explain how the tools are promoted to participants, specifically Medicare-enrolled participants~~.~~; and 7) Indicate whether Participants under the plan you are proposing would be eligible for the tools described.
7.4.2	Describe any participant financial incentive programs you currently offer to encourage participants to get appropriate and timely care, steer patients to certain providers, or other desired behavior. Describe how these efforts improved health outcomes and how such programs are tailored to Medicare beneficiaries in particular. Indicate whether Participants under the plan you are proposing would be eligible for these incentive programs.
7.4.3	Describe your wellness and disease management programs(s) that would be available to Participants under the plan you are proposing. In your response, detail each of the following; 1) Available Participant incentives and rewards; 2) Discount programs available to Participants; 3) Engagement strategies; 4) Participation rates of your Medicare Advantage participants; and 5) Program evaluation methods to measure health outcomes. Be sure to indicate if your Proposal includes the Silver Sneakers® program and to include this cost in your premium submission described in Section 8.
7.4.4	Describe your strategies for Participant education and access to: a) preventive services and annual wellness visits; and b) disease management services and programs. Provide samples of educational materials available to Medicare Advantage participants.
7.4.5	Describe any CMS demonstrations or pilot programs related to wellness, disease management or healthcare utilization your organization is currently participating in. In your description, provide the following: 1) The purpose; 2) When it started and when it is expected to end; 3) Who is eligible to participate; 4) Whether Participants in the plan you are proposing will be included in the program; and

	5) Outcome of the demonstration or pilot to date, if available.
7.4.6	Describe any innovative approaches to "total health management" or wellness that you have implemented that were not yet addressed in this Section 7.4 and specifically describe how those efforts have improved the quality of care, improved health and/or reduced costs.

7.5 Pharmacy Programs

7.5.1	Provide details on any wrap products that your organization offers as a standard benefit to Medicare Part D-enrolled members. Describe your ability to customize these products to meet GHIP/WPE program specifications. See Section 220M and 220N of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement for program requirements.
7.5.2	Identify any Subcontractor that would be used to provide Medicare Part D coverage to Participants. Note that the Board reserves the right to approve the Subcontractor. Describe your ability to work with other subcontractors if the Board rejects your proposed subcontractor.
7.5.3	Describe how your organization integrates the medical and pharmacy benefits and program administration to improve the Participant's health and overall experience.
7.5.4	Describe your communication policy regarding formulary changes and your procedures for notifying and educating members and prescribers. Include the frequency of formulary changes and the minimum amount of notification time provided to affected individuals. Provide a sample of a formulary change notification/educational communication materials.
7.5.5	Describe the prescriber engagement strategies your organization employs to encourage adherence to formulary design. Include your methods and means of outreach to prescribers, frequency of contact, and any direct opportunities for engagement given to prescribers and/or responsible prescriber team members (e.g. meetings, conferences, direct outreach, etc.). Describe the impact on prescribing adherence trends and quantify impact on program costs.
7.5.6	Describe the member engagement strategies your organization employs to encourage members to utilize medications in the lowest possible cost sharing tier and to take non-covered medications as little as possible. Include means of contact, timing, level of detail provided, and any other information communications strategies that your organization has found successful. Include an example of such member communication for smoking cessation, diabetes, rheumatoid arthritis, multiple sclerosis, and any other conditions for which you have programs, and describe the impact on member engagement, outcomes, and cost savings for members and the plan administrator.
7.5.7	Describe your Drug Utilization Review program including retrospective, concurrent and prospective. Include in your description the program enables the pharmacist to work with other health professionals and Members work together to achieve the Members' targeted outcomes and the goal of safe and effective use of medications.

	Provide a specific example of the outcomes the program assists the Participants in achieving both in terms of health and program cost objectives.
7.5.8	Describe your Medication Therapy Management program and include how the program enables the pharmacist to work with other health professionals and members to achieve the members' targeted outcomes and to achieve the goals of safe and effective use of medications. Provide a specific example of the outcomes the program assists the Participants in achieving both in terms of health and program cost objectives.
7.5.9	Describe any additional clinical or member engagement programs designed to help members manage their drug utilization and costs and improve their health. Provide specific examples for each that demonstrates how the program achieves its objectives.
7.5.10	Describe how your organization uses network incentives to reward quality, safety, patient satisfaction, and achieving established clinical measures, such as improved generic utilization or consultation provided for specific drug classes. Provide specific program examples and program outcomes.
7.5.11	Describe your organization's approach to managing Member use of specialty drugs, including formulary and plan design approaches. Highlight any specific disease states you have addressed using separate formulary or plan design and outcomes of your approach. Describe the impact on cost and adherence.
7.5.12	Describe the specialty pharmacy network that will be available to Participants. Explain the organizational structure of these pharmacies, including ownership, and detail how these pharmacies handle first fill of specialty drugs and/or immediate access needs. Include whether access to these pharmacies is exclusive, or if not how access to other, non-preferred specialty pharmacies is provided.
7.5.13	Describe any limitations on access to compound medications. If your organization limits access, describe the impact on cost and the access and outreach strategy to Members regarding those limitations. If there is a path to coverage of compound medications, specify what pricing methodology is used to determine Member cost sharing and plan cost.
7.5.14	Provide your clinical prior authorization criteria for specialty drugs in the following categories: • Anti-TNF Inhibitors; • Hepatitis C; and • PCSK9s.
7.5.15	Describe, in detail, any CMS Medicare Part D pilots or demonstrations your organization is currently participating in related to pharmacy programs and indicate whether Participants in the plan you are proposing would be eligible to participate in such pilots or demonstrations. Include the results of any such initiatives to date.

7.6 DATA INTEGRATION AND COLLABORATION

7.6.1	Describe your experience working collaboratively with your plan sponsor clients, providers, pharmacy benefit managers, wellness vendors and other health plans on strategic initiatives using data-driven insights to improve population health, clinical quality, and member engagement. Describe the attributes of such collaborations that are necessary for success. Describe any attributes of such collaborations that provide challenges or hinder progress. Provide a specific example of a particularly successful initiative that was the result of such a collaboration. Include in your description, the team members that would work with ETF on such collaborations.
7.6.2	Describe your ability to integrate information from electronic medical records (EMR) and electronic health records (EHR) into the data used for predictive modeling, risk stratification, and identification for medical management services. 1) Include the percentage of your providers' EMRs/EHRs that are currently integrated into your data analytics systems. 2) Include a description to any barriers to integration and how your organization will overcome them within the first year of the Contract. 3) How is the integrated information used? Describe how it has improved the quality of care and the impact on costs.
7.6.3	Describe the accessibility and compatibility of EMRs/EHRs across providers in your network and providers referred to, whether within your network or outside your network, in order to coordinate care for Participants. Describe any barriers and how your organization will overcome them within the first year of the Contract.
7.6.4	Describe the accessibility to EMRs/EHRs from providers outside your network, which are required to coordinate care for Participants (e.g. via partnerships such as the Wisconsin Statewide Health Information Network). Describe any barriers and how your organization will overcome them within the first two years of the Contract.
7.6.5	Describe how your organization will be able to leverage access to integrated, detailed, identified pharmacy, dental, and medical claims data with wellness data through the ETF's data warehouse and visual business intelligence tools. Describe how Member health outcomes will be improved or how you will be able to better manage costs. Describe specific uses or programs that will be enhanced by having access to such data.
7.6.6	Describe any innovative approaches to data integration and technology that you have implemented that were not yet addressed in this subsection, and specifically describe how those efforts have improved the quality of care and/or reduced costs.
7.6.7	Confirm that your organization will cooperate with ETF's data warehouse vendor to submit the required claims and provider data as required by ETF. See requirements in Section 150B of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement.

7.7 Cost Containment and Revenue Maximization Strategies

7.7.1	Describe your approaches to risk adjustment for both your medical and pharmacy programs, if appropriate. Include in your response any innovative programs you use to improve the accuracy of your risk scores. Be sure to include in your response how you maximize risk scores for individuals aging into Medicare. Include in your response any increase in scores you have been able to achieve in the last three years.
7.7.2	Describe any initiatives your organization has to educate providers on the importance of complete medical record documentation to support the data used for risk adjustment.
7.7.3	For plans submitting a pharmacy benefit proposal, describe strategies that your organization would employ to help maximize available funds from the Medicare Part D catastrophic phase without unduly burdening Members financially. Include the impact that these strategies have had on Member populations, both in terms of Member cost and access. Be sure to address impact on program costs.
7.7.4	Describe the controls that are in place to ensure the following related to the data submitted to CMS: 1) All required data is sent for each data collection period; 2) Only valid risk adjustment codes are submitted; 3) Only valid provider types are submitted; and 4) Ineligible duplicate transactions are not submitted.
7.7.5	For plans submitting a pharmacy benefit proposal, provide your book of business prescription drug event (PDE) error rate for the last two years.

7.8 Plan Design

Proposers must be able to provide all services under Uniform Benefits, the current standard benefits package available to Medicare-enrolled Members described in Table 2 – 2017 Medicare Advantage Benefit Design and Table 3 - 2017 Plan Year Pharmacy Benefit Plan Design, and further described in Section 400 of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement or as approved by the Board prior to January 1, 2019.

The national service area plans should function as a passive PPO that provides the same level of benefits for Participants when they see a provider outside the network that accepts Medicare. Both the national and regional plans must meet all CMS requirements, and any benefits not delineated in the plan design must be covered at least at the minimum requirement set by CMS. Proposers may not deviate downward from these plan designs in any manner other than to meet CMS requirements. Any supplemental benefits and/or enhanced benefits available no cost to the Department and Participants should be identified in Section 8.2 under Alternative Benefit Designs.

7.8.1	If offering a national service area proposal, confirm that your organization will be able to replicate Uniform Benefits, the current medical and pharmacy standard benefits

	package described in Table 2 – 2017 Medicare Advantage Benefit Design, and Table 3 - 2017 Plan Year Pharmacy Benefit Plan Design, and further described in Section 400 of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement, with the same benefits for services rendered in-network and out-of-network.
7.8.2	If offering a regional service area proposal, confirm that your organization will be able to replicate Uniform Benefits, the current standard benefits package described in Table 2 – 2017 Medicare Advantage Benefit Design, and, if proposing a pharmacy benefit, the pharmacy Uniform Benefit as described in Table 3 - 2017 Plan Year Pharmacy Benefit Plan Design, and further described in Section 400 of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement.
7.8.3	Are there any CMS filing limitations that would impact benefit coverage levels for any benefit design elements? If yes, please explain in detail.
7.8.4	If proposing a pharmacy benefit plan, are there any CMS filing limitations that would impact ETF's current formulary? If yes, please explain in detail.
7.8.5	Describe how your plan covers emergency services incurred outside of the U. S.

8 NETWORK SUBMISSION REQUIREMENTS, ALTERNATIVE BENEFIT DESIGN, AND COST PROPOSAL

Only the Uniform Benefit Cost Proposal in this section is scored. (200 total points)

This section contains the submission requirements required to be submitted by the Proposer.

Attachments A, D and E, and all answers, confirmations, attachments, reports, documentation, summaries, etc. requested within Section 8 must be submitted to Segal via Segal's Secure File Transfer (SFT) system.

Submission of FORM F – Non-Disclosure Agreement with ETF and The Segal Company is Required for Access to Section 8 Attachments and Data Instructions

Each Proposer must submit a signed **FORM F – ETH0020 Non-Disclosure Agreement with ETF and The Segal Company** to ETF to gain access to Section 8 attachments and data files. FORM F must be sent via e-mail to ETFSMBProcurement@etf.wi.gov. The e-mail subject line must be in the following format: *RFP ETH0020 - NDA: [Vendor's name]*. The e-mail must contain the name and e-mail address of the individual designated to receive the Section 8 attachments and data.

FORM F must be received by ETF up to and by the due date listed in Section 1.9, Calendar of Events for FORM F – ETH0020 Non-Disclosure Agreement with ETF and The Segal Company Due Date.

ETF will inform Segal of NDA receipt. Segal will issue to the Proposer's designated recipient, a secure link to Segal's Secure File Transfer system. The designated recipient may access the secure site and download Section 8 attachments and data. Segal will not release any worksheets or data files to the Proposer without a signed FORM F – ETH0020 Non-Disclosure Agreement with ETF and The Segal Company.

For informational purposes, the Segal point of contact is as follows:

Jennifer Slutzky
JSlutzky@segalco.com

Submission of Section 8 Attachments and Proposer Verification Submission Form Instructions

Each Proposer must submit **Attachment A – Network Access, Attachment D – Cost Proposal, and Attachment E – Performance Guarantees** through Segal's Secure File Transfer system up to and by the due date and time listed in Section 1.9, Calendar of Events for Proposal Due Date and Time.

Upon submission of **Attachment A – Network Access, Attachment D – Cost Proposal, and Attachment E – Performance Guarantees** to Segal, each Proposer must submit **FORM D – Proposer Verification of Data Submission to Board Actuary** to ETF at ETFSMBProcurement@etf.wi.gov. The e-mail subject line shall be in the following format: *RFP ETH0020 – FORM D: [Vendor's name]*. The form must be received by ETF up to and by the due date listed in Section 1.9, Calendar of Events for Proposal Due Date and Time.

8.1 NETWORK SUBMISSION (PASS/FAIL)

The Board is interested in meeting Participant's needs for cost-effective plans that meet their expectations for provider choice. ETF will accept proposals for HMO networks which are provided with regional service area submissions, or a national passive preferred provider option (PPO) network, as approved by CMS, which are provided with nationwide service area proposals.

Responses to the Network Submissions questions will be reviewed and evaluated on a pass/fail basis. Responses that do not meet the access criteria identified below will not be passed on to the Board for consideration.

8.1.1 Access Reports

Proposers are required to submit an accessibility report (Optum™, GeoAccess®, GeoNetworks or comparable software) for each program being proposed. For national passive PPO services, report on a national basis for contracted providers only (i.e., do not include all providers that accept Medicare). For regional HMO service area proposals, the report must be submitted by county.

Proposers are required to provide a summary of Participants with and without access to network providers/facilities within the established mileage parameters listed below:

Provider Type	Urban	Non-Urban
Facilities		
Hospitals	*1 within 20-mile radius*	*1 within 35-mile radius*
Ambulatory Surgical Centers	*1 within 20-mile radius*	*1 within 35-mile radius*
Urgent Care facilities	*1 within 20-mile radius*	*1 within 35-mile radius*
Imaging Centers	*1 within 20-mile radius*	*1 within 35-mile radius*

Inpatient Behavioral Health Facilities	*1 within 20-mile radius*	*1 within 35-mile radius*

Professional Services		
Primary Care		
General/Family Practitioner (includes Internal Medicine, Family Medicine, and General Medicine)	*2 within 10-mile radius*	*2 within 20-mile radius*
OB/GYN (female Members, age 12 and older)	*2 within 10-mile radius*	*2 within 20-mile radius*
Pediatrician (birth through age 18)	*2 within 10-mile radius*	*2 within 20-mile radius*
Specialists		
Endocrinologist	*2 within 20-mile radius*	*2 within 35-mile radius*
Urologist	*2 within 20-mile radius*	*2 within 35-mile radius*
Cardiologist	*2 within 20-mile radius*	*2 within 35-mile radius*
Dermatologist	*2 within 20-mile radius*	*2 within 35-mile radius*
Allergist	*2 within 20-mile radius*	*2 within 35-mile radius*
Psychologist/Psychiatrist	*2 within 20-mile radius*	*2 within 35-mile radius*
General Surgeon	*2 within 20-mile radius*	*2 within 35-mile radius*
Hematologist/Oncologist	*2 within 20-mile radius*	*2 within 35-mile radius*
Chiropractor	*2 within 20-mile radius*	*2 within 35-mile radius*

The submitted access reports (mapping and accessibility analysis) must demonstrate provider availability for EACH provider group type listed above in the provider network access standard table. In the production of the reports, note the following: Proposer must utilize Optum™, GeoAccess®, GeoNetworks or comparable software.

- The access report must indicate those Participants with access and those without access according to provider network access standards above, by county.

Proposer must submit the summary grids, included in Attachment A – Network Access, along with the actual access report(s). The summaries are separate for counties defined as Urban or Non-Urban, as applicable.

8.1.2 Access for National Passive PPO Service Area Proposals

8.1.2.1	Does your organization meet CMS's MA coordinated care network adequacy requirement for ETF's Medicare-eligible retiree membership (the 51% rule)? Discuss how you are able to meet this requirement.
8.1.2.2	What is your percentage of network adequacy with regard to the 51% rule based on ETF's membership?
8.1.2.3	In which counties in Wisconsin are you filed as an EGWP?

8.1.3 Access for Regional HMO Service Area Proposals

8.1.3.1	Proposers offering a regional HMO service area proposal are required to submit a summary of the number of providers by county and category, consistent with the accessibility reports from 8.1 in Attachment A.
8.1.3.2	Proposers offering a regional HMO service area proposal are required to submit a listing of the entire proposed provider network in Attachment A – Network Access.
8.1.3.3	In which counties in Wisconsin are you filed as an EGWP?

8.2 ALTERNATIVE BENEFIT DESIGNS (NOT SCORED)

Proposers will be evaluated based on their bid for the Uniform Benefit design identified in Table 2 and Table 3 and as described in Section 400 of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement. Benefits may not deviate from this plan design other than to meet CMS requirements. In addition, proposers are required to submit bids for two alternative benefit designs. The alternative benefit designs must meet the goals of this RFP; lower monthly premium costs; high quality, high value services; excellent benefit packages; and participant choice. Proposers will not be evaluated on their Alternative Benefit Design submissions.

8.2.1 Alternative Medical Benefit

Identify your proposed alternative medical benefit designs as Alternative Medical Benefit 1 and Alternative Medical Benefit 2. The description should include a comparison for each alternative benefit design that identifies all differences with the Uniform Benefits identified in Table 2 of this RFP and Section 400 of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement. The comparison should be presented in a table in the following format:

Benefit Description	Uniform Benefit	Alternative Medical Benefit 1	Alternative Medical Benefit 2

Only differences should be included in the table. If coverage is the same across the plans, do not include in the table.

8.2.2 Alternative Pharmacy Benefit

For Proposers offering a pharmacy benefit, identify your Alternative Pharmacy Benefit 1 and Alternative Pharmacy Benefit 2. Provide a comparison for how this benefit compares to the current Uniform Pharmacy Benefit identified in Table 3.

Benefit Description	Uniform Benefit	Alternative Pharmacy Benefit 1	Alternative Pharmacy Benefit 2

<table>
<tr><td></td><td><table><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table>Only differences should be included in the table. If coverage is the same across the plans, do not include the benefit in the table.

Identify any differences between the formulary you are offering and the current formulary included in Attachment B – EGWP Formulary for Medicare Enrolled Participants as of September 1, 2017, including any prescription drugs that are included in your formulary that are not available in the current formulary, any prescription drugs in the current formulary that are not on your formulary and any differences in the tiering.</td></tr>
<tr><td>8.2.3</td><td>ETF expects the Contractor to negotiate discounted benefits on its behalf, at the member's expense. Describe any discount programs your organization is able to offer on services such as vision or dental programs.</td></tr>
<tr><td>8.2.4</td><td>Are you able to provide coverage for medical tourism either as a supplemental benefit or a separate rider? If so, be sure to include the per member per month cost in your Cost Proposal in Section 8.3.</td></tr>
</table>

8.3 Cost Proposal

The Board intends to award contract(s) to Proposers that offer lower monthly premiums with high quality benefits and services to Participants. A Proposers' Cost Proposal will be comprised of its premium bid for the first year of the Contract, its rate guarantees for the second and third year of the Contract and any implementation credits it proposes. A Proposer's premium bid must include rates for Uniform Benefits as described in Table 2 and Table 3 and Section 400 of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement, any Wellness programs it proposes to offer Participants, and the Alternative Benefit Designs described in Section 8.4. Proposers will not be evaluated on their premium bids for their Alternative Benefit Designs.

8.3.1 Preliminary Premium Bid

Proposers shall submit pricing in the format described below, based on the terms and conditions set forth in this RFP. Failure to submit pricing as provided in this section may render Proposer's entire offer non-responsive and ineligible for award.

Pricing shall be submitted in the following format: Provide the fully-insured per member monthly premium rates for 2019 (first year of the Contract: January 1, 2019 - December 31, 2019) based on the services required as specified in this RFP by completing Attachment D – Cost Proposal. It is understood that if CMS requires a certain benefit level that is superior to what is listed in this RFP, then the CMS benefit should be applied and noted. The premium rate quoted is to cover all services Proposer must provide as described in this RFP.

Proposer is required to break out its price between the medical (MA) and prescription drug (PD) components of the plan. Plans not submitting a prescription drug proposal should ignore the prescription drug component of Attachment D – Cost Proposal. Proposer must further break out the two components into the claims components and the non-claims components as described in the Cost Proposal instructions included in Attachment D.

Proposers should also identify in the Cost Proposal any pricing implications of CMS filing limitations identified under 7.8.3 or 7.8.4 above.

Proposer's Cost Proposal: Attach additional pages if necessary or if the format of pricing specified requires additional pages.

Proposer's price for calendar year 2019: Proposer must complete Attachment D - Cost Proposal.

ETF is seeking a partner to provide Medicare Advantage and Prescription Drug services as a viable long-term solution for its Medicare population. This requires pricing throughout the Contract term that recognizes the need for reasonable year over year increases in premiums. While ETF recognizes certain provisions of the pricing is dependent on CMS pricing terms released annually, ETF also believes organizations should be able to price for such fluctuations in a three-year contract. Therefore, ETF requests Proposers to provide annual total premium rate guarantees for each succeeding year under the Contract.

Subsequent annual premium rates will be based on claims experience of those enrolled in each plan, verified demographics, other documented actuarial factors, and projected health care cost trends. Subsequent annual premium rates will be negotiated annually and reflected in a written amendment to the Contract executed by both parties. See Section 130B of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement.

This RFP requires that pricing be based on ETF's actual Medicare allowed claims data as provided in Attachment G – Medical Claims and Attachment H – Pharmacy Claim (claims line detail) as well as ETF's Uniform Benefit plan, Section 400 of Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement. Data included in Attachment G and H are based on current financial and utilization data submitted by current health plans during annual renewal submissions (see Appendix 9 – Current Financial and Utilization Data Submissions). Proposals based upon manual rates will not be accepted. In your Proposal, confirm your agreement with this requirement.

In your Proposal, confirm your pricing is based on ETF's current medical and prescription drug Uniform Benefits plan design as well as ETF's current formulary.

In your Proposal, confirm that pricing will not include any taxes unless accompanied by proof that ETF is subject to the tax. If necessary, Proposers may request ETF's tax exemption number and federal tax exemption information.

8.4 IMPLEMENTATION CREDITS

Are you willing to provide a one-time implementation allowance to fund, as approved by ETF, implementation support, pre-implementation audits, readiness assessments, communication plans, outside printing costs, etc.? What dollar amount are you willing to provide?

8.5 PERFORMANCE GUARANTEES

ETF is interested in negotiating performance standards on financial performance results with the selected Proposer(s) to encourage the Proposer to provide superior performance. Proposer's failure to meet the performance guarantee(s) would result in financial penalties. Please review and complete Attachment E – Performance Guarantees. Higher assessments than required are encouraged.

In your Proposal, confirm your agreement with the proposed service level targets and associated guarantees.

8.6 FINAL PREMIUM BID

If the Board elects to make an award, and if any Alternative Benefit Design(s) are selected for 2019, the selected Proposer(s) must submit final premium bids for the final benefit designs by the date and time listed in Section 1.9, Calendar of Events, for Revised Premium Submission. Segal will provide the spreadsheet for submitting the final premium submission to the selected Proposers.

8.7 ADDITIONAL ATTACHMENTS

The following Attachments are specifically for use with Section 8, and will be made available to Proposers by Segal after ETF receives Proposer's FORM F – Non-Disclosure Agreement with ETF and The Segal Company:

Attachment A – Network Access

Attachment B – EGWP Formulary for Medicare Enrolled Participants as of September 1, 2017

Attachment C – Formulary Companion Guide

Attachment D – Cost Proposal

Attachment E – Performance Guarantees

Attachment F – Census

Attachment G – Medical Claims

Attachment H – Pharmacy Claims

Attachment I – Monthly Claims Totals

Attachment J – Pharmacy EGWP Risk Scores

Note: only Attachments A, D, and E must be returned to Segal.

9 CONTRACT TERMS AND CONDITIONS

This section is NOT scored. (0 points)

The Department will execute a Contract with the awarded Contractor(s). A Pro Forma State of Wisconsin Contract is located in Exhibit 2. Exhibit 1 – State of Wisconsin Medicare Advantage Program Agreement becomes part of the Contract. The Contract and any subsequent renewal(s) will incorporate all terms and conditions in this RFP including the following documents listed below, and Contractor's Proposal.

- Exhibit 2 - Standard Terms and Conditions (DOA-3054);
- Exhibit 3 - Supplemental Standard Terms and Conditions for Procurement for Services (DOA-3681); and
- Exhibit 4 – Department Terms and Conditions.

9.1 BOARD AND DEPARTMENT AUTHORITY

This solicitation is authorized under Chapter 40 of the Wisconsin State Statutes. All decisions and actions under this RFP are solely under the authority of the State of Wisconsin Group Insurance Board. Procurement statutes and rules that govern other State agencies may not be applicable. The Department is acting as an agent of the Board in carrying out any directives or decisions relating to this RFP, the Contract and subsequent awards. All references to the "Department", "ETF," "State of Wisconsin," "State" or "Board" in any term, condition, or specification shall have the same authority as one entity. The Department is the sole point of contact for Board contracting.

ETF is the sole point of contact for Board contracting.

9.2 PAYMENT TERMS

By the end of each month, ETF will transmit payment to the Contractor for that month's premium based on the number of enrolled subscribers per ETF's records. ETF will deduct any premium for pharmacy benefits, unless the Contractor is administering pharmacy benefits for that enrollee and his/her dependents, dental premium if applicable, and other fees required by the Board.

EXHIBIT 1

State of Wisconsin
Medicare Advantage Program Agreement

Issued by the State of Wisconsin

Department of Employee Trust Funds

On behalf of the Group Insurance Board

~~October 17, 2017~~

Revised: November 14, 20017

ETH0020

TABLE OF CONTENTS

Table of Contents **2**
000 Definitions **7**
100 General **12**
105 Introduction 12
110 Objectives 12
115 General Requirements 13
120 Board Authority 17
125 Eligibility 18
125A General 18
125B Medicare-Eligible but not enrolled PARTICIPANTS 21
125C Dependent Coverage Eligibility 21
125D Change to Family Coverage 21
125E No Double Coverage 21
125F Local Annuitants 22
125G Notice of Qualifying Event 22
130 Premiums 22
130A Medicare Participant Premiums 22
130B Annual Rate-Setting Process .... **Error! Bookmark not defined.**
135 Financial Administration 23
135A Prohibited Fees 23
135B Included Services 24
135C Recovery of Overpayments 24
135D Subrogation and Other Payers 24
135E Amounts Owed by Contractor 24
135F Automated Clearinghouse (ACH) 24
140 Participant Materials and Marketing 24
140A Informational / Marketing Materials 24
140B It's Your Choice Open Enrollment Materials 26
140C Required PARTICIPANT and PRESCRIBER Outreach for Formulary Changes 27
140D Required PARTICIPANT Educational Materials 27
145 Information Systems 28
150 Data Requirements 29

150A Data Integration and Technical Requirements........29
150B Data Submission Requirements........32
155 Miscellaneous General Requirements........34
155A Reporting Requirements and Deliverables:........34
155B Performance Standards and Penalties........35
155C Nondiscrimination Testing........35
155D Audit and Other Services........35
155E Fraud and Abuse........36
155F Privacy Breach Notification........38
155G Department May Designate Vendor........39
155H Contract Termination........39
155I Transition Plan........40
155J Insolvency........40
200 Program Requirements........41
205 Enrollment........41
205A Enrollment Files........41
205B Identification (ID) Cards........41
205C Participant Information........42
205D Disabled Child Eligibility........42
205E Date of Death........43
205F Coordination of Benefits (COB)........43
210 Primary Care Provider........43
215 Medical Management........43
215A Disease Management / Prior Authorizations / Utilization Review (UR)........43
215B Department Initiatives........45
220 Benefits........46
220A Overview........46
220B Telehealth / Nurse Line........46
220C Emergency / Urgent / Catastrophic Care........46
220D Inpatient When Changing Coverage........46
220E Federal / State Requirements........47
220F Out-of-Network Services for Passive Preferred Provider Organization (PPO) Network Plans........47
220G Medicare........47

220H End Stage Renal Disease - Medicare Participants 47
220I Ancillary Services 47
220J Transfer of Benefit Maximums / Deductible / Out-of-Pocket Limits 48
220K Coordination / Non-Duplication 48
220L Wellness 48
220M PHARMACY BENEFIT PLAN Specifications 49
220N MEDICARE PART D/EGWP Coverage 50
225 Quality 50
230 Provider Contracts 52
230A Provider Access Standards 53
230B CONTRACTOR Provider Directory 53
230C Continuity of Care 54
230D Provider Contracts Shall Include Compliance Plans 55
235 Pharmacy Network Administration 55
235A Pharmacy Network Access 56
235B Pharmacy Network Directory 56
235C Pharmacy Network Contracts Shall Include Compliance Plans 57
240 Claims 57
245 Data 57
250 Grievances 58
250A Grievance Process Overview 58
250B Claim Review 59
250C Participant Notice 59
250D Investigation and Resolution Requirements 59
250E Notification of Department Administrative Review Rights 59
250F External Review 60
250G Provision of Complaint Information 60
250H Department Request for Grievance 61
250I Notification of Legal Action 61
250J Penalty for Noncompliance 61
255 Cancellation of Participant Coverage 61
260 Direct Pay Premium Process 61
265 Continuation 62
265A Right to Continue Coverage 62

265B Subscriber Nonpayment of Premiums 62
265C Conversion 62
265D Surviving Dependents 62
270 Miscellaneous Program Requirements 63
270A Implementation 63
270B Account Management and Staffing 65
270C Customer Service 66
270D Contractor Web Content and Web-Portal 68
270E Patient Rights and Responsibilities 71
270F Errors 71
270G Examination of Records 72
270H Record Retention 73
270I Disaster Recovery and Business Continuity 73
270I Other 73
270J Gifts and/or Kickbacks Prohibited 73
270K Conflict of Interest 74
300 Deliverables 75
305 Reporting Requirements 75
310 Deliverables 77
310A Deliverables to the Department 77
310B Deliverables to Participants 81
315 Performance Standards and Penalties 83
315A Account Management 84
315B Claims Processing 84
315C Customer Service 85
315D Data Management 85
315E Enrollment 86
315F Other 87
400 Uniform Benefits 89
I. Schedule of Benefits 90
State of Wisconsin and Wisconsin Public Employer Medicare Retirees: 91
Local / Wisconsin Public Employers (WPE) Medicare Retirees Only: 94
II. Definitions 100
III. Benefits and Services 112

A. Medical/Surgical Services 112
B. Institutional Services 124
C. Other Medical Services 125
D. Prescription Drugs and Other Benefits Administered by the PHARMACY BENEFIT MANAGER (PBM) 128
IV. Exclusions and Limitations 132
A. Exclusions 132
B. Limitations 140
V. Coordination of Benefits and Services 142
A. Applicability 142
B. Definitions 142
C. Order of Benefit Determination Rules 143
D. Effect on the Benefits of THIS PLAN 145
E. Right to Receive and Release Needed Information 145
F. Facility of Payment 145
G. Right of Recovery 146
VI. Miscellaneous Provisions 147
A. Right to Obtain and Provide Information 147
B. Physical Examination 147
C. Case Management/Alternate Treatment 147
D. Disenrollment 148
E. Recovery of Excess Payments 148
F. Limit on Assignability of Benefits 148
G. Severability 149
H. Subrogation 149
I. Proof of Claim 150
J. Grievance Process 150
K. Appeals to the Group Insurance Board 151

000 DEFINITIONS

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

AGREEMENT means this State of Wisconsin Medicare Advantage Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

ALTERNATIVE BENEFIT DESIGN as defined in UNIFORM BENEFITS

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

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

LOCAL ANNUITANT means:

1) Any currently insured retired EMPLOYEE of a participating EMPLOYER: receiving an immediate annuity under the Wisconsin Retirement System, or a long-term disability benefit under Wis. Adm. Code § ETF 50.40, or a disability benefit under Wis. Stat. § 40.65, or a person with twenty (20) years of creditable service who is eligible for an immediate annuity but defers application, or a person receiving an annuity through a program administered by the DEPARTMENT under Wis. Stat. § 40.19 (4) (a).

2) 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).

BALANCE BILLING means an OUT-OF-NETWORK provider's practice of billing a patient for the difference between what the patient's health plan's standard reimbursement for a covered service and that provider's usual charge if the health plan's standard reimbursement is less than the provider's usual charge.

BENEFITS means those items and services as listed in UNIFORM BENEFITS. A PARTICIPANT'S right to BENEFITS is subject to the terms, conditions, limitations and exclusions of the HEALTH BENEFIT PROGRAM.

BOARD means the Group Insurance Board.

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

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

CONFINEMENT as defined in UNIFORM BENEFITS.

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

CONTRACT means this document which includes all exhibits, attachments, supplements, and endorsements or riders.

CONTRACTOR means the licensed insurer who is the legal signatory to this AGREEMENT.

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

DAY means calendar DAY unless otherwise indicated.

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

DEPENDENT as defined in UNIFORM BENEFITS.

EFFECTIVE DATE as defined in UNIFORM BENEFITS.

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

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

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

> **STATE EMPLOYEE** means an eligible EMPLOYEE of the State of Wisconsin as defined under Wis. Stat. § 40.02 (25) (a), 1., 2., or (b), 1m., 2., 2g., or 8.
>
> **LOCAL EMPLOYEE** means an eligible EMPLOYEE as defined under Wis. Stat. § 40.02 (46) or 40.19 (4) (a), of an EMPLOYER as defined under Wis. Stat. § 40.02 (28), other

than the state, which has acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its EMPLOYEES.

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

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

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

HEALTH BENEFIT PROGRAM means the group MEDICARE ADVANTAGE Program that provides group MEDICARE ADVANTAGE BENEFITS to Medicare PART A and B-enrolled State of Wisconsin and participating LOCAL ANNUITANTS and CONTINUANTS and their Medicare-enrolled DEPENDENTS participating in the Group Health Insurance Program and Wisconsin Public Employers Program in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

HOSPITAL as defined in UNIFORM BENEFITS.

IN-NETWORK refers to a provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The 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.

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

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

MINIMUM PROVIDER ACCESS STANDARDS means those as defined under Wis. Stat. § 609.22 and Wis. Admin. Code INS 9.32.

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

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

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

MEDICARE PART D means the prescription drug insurance program defined under Title 18, Part D of the U.S. Social Security Act of 1965, as amended and partially covers the cost of many outpatient prescription drugs for enrolled individuals.

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

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

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

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

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

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

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

PRODUCT means a brand or generic prescription medication, a medication not requiring a prescription, and/or medical supplies and equipment.

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

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

RETIREE HEALTH INSURANCE UNIT is a business unit within the ETF Employer Services Section that handles health insurance enrollment and premium issues for PARTICIPANTS in the HEALTH BENEFIT PROGRAM.

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

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

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

UNIFORM BENEFITS means the BENEFITS described in Section 400 that are administered to PARTICIPANTS enrolled in the HEALTH BENEFIT PROGRAM.

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

100 GENERAL

105 Introduction

This State of Wisconsin Health Benefit Program Agreement ("AGREEMENT") is for the purposes of administering the HEALTH BENEFIT PROGRAM. The HEALTH BENEFIT PROGRAM is the umbrella term used to describe the program in whole, including the State of Wisconsin Group Benefits Program and the Wisconsin Public Employers Group Benefits Program, herein referred to as "state" and "LOCAL", respectively. The HEALTH BENEFIT PROGRAM is administered for the Group Insurance Board (BOARD) by the State of Wisconsin Department of Employee Trust Funds (DEPARTMENT).

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

Eligible PARTICIPANTS have the opportunity to choose a benefit plan design. A minimum of two (2) competing benefit plans is required per Wis. Stat. § 40.51 (6).

Throughout this AGREEMENT, provisions and requirements that apply specifically to the provision of the PHARMACY BENEFIT PLAN only apply if the BOARD has elected to contract with the CONTRACTOR to provide the PHARMACY BENEFIT PLAN to PARTICIPANTS.

110 Objectives

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

1) To deliver high-quality, high value services to PARTICIPANTS at a competitive price.

2) To provide PARTICIPANTS a choice of excellent benefit options.

3) To provide excellent customer service to PARTICIPANTS.

4) To offer networks of high value providers, and to incent PARTICIPANTS to choose benefit plan designs with high value providers.

5) Management and delivery of health care services to PARTICIPANTS through contracted networks that provide for high-quality, cost-effective care.

6) Accurate, timely and responsive administration of health care and pharmacy claims.

7) Assist the BOARD in achieving strategy goals of:

    a) Managing total costs.

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

c) Promoting behavior change and accountability.

d) Retain managed care elements that provide value.

8) To offer tools for PARTICIPANTS to increase engagement, including:

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

9) To ensure quality population health programs, including case management and disease management, which promote proactive management of PARTICIPANT health concerns.

10) To continuously evaluate and incorporate innovative approaches to health care delivery.

115 General Requirements

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

1) Share data, claims information and other operational information as necessary for the smooth functioning of the program, for example to the BOARD'S Pharmacy Benefit Manager (PBM), consulting actuary, DEPARTMENT'S data warehouse and the wellness and disease management vendor, using the most recent file and data specifications provided by the DEPARTMENT.

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

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

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

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

6) 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 EGWP plans. In cases where CMS requirements and the non-Medicare requirements of this AGREEMENT differ, the more rigorous standard shall supersede.

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

8) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT, including but not limited to, initial determination of eligibility for DEPENDENTS for disabled and full-time student status.

9) Apply effective methods for containing costs for medical services, HOSPITAL CONFINEMENTS or other BENEFITS to be provided with effective peer and utilization review mechanisms for monitoring health care costs and the administration of Coordination of Benefit (COB) provisions.

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

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

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

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

11) 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.

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

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

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

15) Provide notification of all significant events:

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

    b) In addition, any change in the ownership of or controlling interest in the CONTRACTOR, 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 BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

    c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the HEALTH BENEFIT PROGRAM and its PARTICIPANTS. The BOARD agrees to keep the information disclosed as required under paragraph (b) above, confidential under Wis. Stat. § 19.36 (5) of the Wisconsin Public Records Law until the earliest of one of the dates noted

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

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

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

ii) The date such action becomes effective.

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

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

16) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT. Any costs incurred by the DEPARMENT because of CONTRACTORS failure to comply with this requirement will be paid by the CONTRACTOR.

17) Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32.

18) Provide coverage for both state and LOCAL PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

19) 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.

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

21) Comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the DEPARTMENT upon request.

120 Board Authority

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

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

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

4) In cases where data submitted by the CONTRACTOR is deemed to be inadequate by the BOARD, 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.

5) In the event a CONTRACTOR becomes or is at risk for becoming insolvent, experiences a significant event or significant loss of primary providers and/or HOSPITALS, or no longer meets the MINIMUM PROVIDER ACCESS STANDARDS in this AGREEMENT, or if the BOARD so directs due to a significant event as described in Section 115, the BOARD may do any of the following, including any combination of the following:

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

    b) Authorize a special enrollment period and require that each SUBSCRIBER enrolled in a benefit plan administered by the CONTRACTOR change to another benefit plan.

    c) 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.

    d) Close the benefit plan administered by the CONTRACTOR to any new enrollments for the remainder of the CONTRACT period.

e) Require that prior to making a selection between benefit plans, prospective SUBSCRIBERS be given a written notice describing the BOARD'S concerns.

f) Take no action.

6) 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(s), or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

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

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

9) The BOARD must be notified of any major system changes to the CONTRACTOR’S administrative and/or operative systems.

125 Eligibility

125A General

For HEALTH BENEFIT PROGRAM purposes, eligible SUBSCRIBERS are ANNUITANTS and CONTINUANTS who are enrolled in MEDICARE PARTS A and B and are eligible for enrollment in a MEDICARE ADVANTAGE plan. Eligible DEPENDENTS must also be enrolled in MEDICARE PARTS A and B and eligible for enrollment in a MEDICARE ADVANTAGE plan.

EMPLOYEES include:

1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS), as described in Wis. Stat. § 40.02 (25) (a).

2) Elected state officials (Wis. Stat. § 40.02 (25) (a) 2).

3) Members or EMPLOYEES of the legislature (Wis. Stat. § 40.02 (25) (a) 2).

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

5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance, as described in Wis. Stat. § 40.02 (40).

6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave as described in Wis. Stat. § 40.02 (40).

7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority (Wis. Stat. § 40.02 (25) (b)):

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

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

   c) Certain visiting faculty members in the UW System.

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

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

   f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of twenty-eight 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.

8) LOCAL EMPLOYEES as described in Wis. Stat. § 40.02 (46) or 40.19 (4) (a).

9) ANNUITANTS and CONTINUANTS (Wis. Stat. § 40.02 (25) (b)), which includes the following:

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

b) The surviving spouse of a SUBSCRIBER.

c) The surviving insured domestic partner of a SUBSCRIBER.

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

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

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

g) Any retired LOCAL EMPLOYEE under Wis. Stat. § 40.02 (25) (b) 11, who 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)), 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).

h) Any LOCAL ANNUITANT receiving an annuity through a program administered by the DEPARTMENT under Wis. Stat. § 40.19 (4) (a).

i) PARTICIPANTS who meet federal or state continuation provisions. See Section 260.

10) Disabled persons entitled to benefits under Wis. Adm. Code § ETF 50.40 or Wis. Stat. § 40.65 include:

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.

125B Medicare-Eligible but not enrolled PARTICIPANTS

CONTRACTOR shall ensure that all PARTICIPANTS are enrolled in both MEDICARE PARTS A and B by the PARTICIPANT's coverage EFFECTIVE DATE. If a PARTICIPANT disenrolls from MEDICARE PARTS A or B after the EFFECTIVE DATE, the CONTRACTOR shall notify the DEPARTMENT on the day the CONTRACTOR identifies the PARTICIPANT as having disenrolled from PARTS A or B and the effective date.

125C Dependent Coverage Eligibility

Individual coverage covers only the SUBSCRIBER. All eligible DEPENDENTS listed on the application are covered under a family contract. A SUBSCRIBER cannot choose to exclude any eligible DEPENDENT from family coverage, unless that DEPENDENT is already covered under the HEALTH BENEFIT PROGRAM. Any eligible DEPENDENTS not eligible for a MEDICARE ADVANTAGE plan will not be enrolled in the CONTRACTOR's plan under this AGREEMENT. The CONTRACTOR is required to notify the DEPARTMENT on the day the CONTRACTOR determines that an eligible DEPENDENT is not eligible for a MEDICARE ADVANTAGE plan.

125D Change to Family Coverage

An ANNUITANT or CONTINUANT eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the DEPARTMENT or EMPLOYER within thirty (30) DAYS after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. LOCAL ANNUITANTS and CONTINUANTS for whom their former employer makes a premium contribution must submit the application to their EMPLOYER.

125E No Double Coverage

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

125F Local Annuitants

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

125G Notice of Qualifying Event

Upon discovery, the CONTRACTOR shall report to the DEPARTMENT any qualifying event that makes a PARTICIPANT ineligible for BENEFITS, such as divorce. The CONTRACTOR must provide information including aggregate claim amounts or other documentation, as requested by the DEPARTMENT.

130 Premiums

For most ANNUITANTS, SUBSCRIBER PREMIUM payments will be arranged through deductions from, accumulated sick leave account (STATE EMPLOYEES only), annuity, or conversion of life insurance under certain circumstances. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255. For changes in coverage effective after the 1st of the month, the difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month.

130A Medicare Participant Premiums

A reduction in PREMIUM shall be effective on the first DAY of the calendar month, which begins on or after the date the PARTICIPANT is eligible for MEDICARE PARTS A and B BENEFITS as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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

Except in cases of fraud which shall be subject to Section 155F, coverage for any PARTICIPANT enrolled in Medicare coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with UNIFORM BENEFITS and shall be disenrolled from the HEALTH BENEFITS PROGRAM covered in this AGREEMENT per procedures developed by the DEPARTMENT. However, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six (6) months. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity.

Also see Section 220H.

130B Annual Rate-Setting Process

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 as 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.

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. See Appendix 6. If the premium is community-rated then the CONTRACTOR should give some indication of the percentage the STATE and LOCAL EMPLOYEE groups represent of the total covered community. 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.

Rates shall be uniform statewide, or nationwide if appropriate, except that CONTRACTORS 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.

The DEPARTMENT reserves the right to audit, at the expense of the CONTRACTOR, the financial and utilization data and other data the organization 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.

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.

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.

135 Financial Administration

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

135A Prohibited Fees

The CONTRACTOR is prohibited from including in their premium rates:

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

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

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

135B Included Services

The CONTRACTOR may not charge an additional fee for the following services:

1) Expert services. 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.
2) Mailing & Postage. The CONTRACTOR will pay for all mailing, postage and handling costs for the distribution of materials as required by Section 140, or by other express provisions of this CONTRACT.
3) Pilot Programs. At the request of the DEPARTMENT, the CONTRACTOR shall enter into a pilot or limited-term trial. See Section 225(6)~~Section 215C~~.

135C 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.

135D 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.

135E Amounts Owed by Contractor

Funds owed to the BOARD must be paid within thirty (30) calendar DAYS from notification of penalties or monies owed. The CONTRACTOR has thirty (30) calendar DAYS to document any dispute of amounts owed. After thirty (30) 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.

135F Automated Clearinghouse (ACH)

The CONTRACTOR shall support an ACH mechanism that allows for the DEPARTMENT to submit premium payments.

140 Participant Materials and Marketing

140A Informational / Marketing Materials

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

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

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

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

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

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

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

The notice is as follows:

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

[Name of CONTRACTOR]:

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

If you need these services, contact [Name of CONTRACTOR’S Civil Rights Coordinator].

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

grievance, [Name and Title of Civil Rights Coordinator] is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

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

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

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

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

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

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

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

140B It's Your Choice Open Enrollment Materials

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

1) The CONTRACTOR shall issue written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those 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.

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

   a) CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and website address.

   b) Content for the CONTRACTOR'S plan description page, including available features.

   c) Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory and pharmacy network, if appropriate.

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

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

140C Required PARTICIPANT and PRESCRIBER Outreach for Formulary Changes

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

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

140D Required PARTICIPANT Educational Materials

Each CONTRACTOR will be required to prepare informational materials in a form and content acceptable to the BOARD, as determined by the DEPARTMENT, to educate PARTICIPANTS on the following:

1) The availability and importance of getting preventive services and use of primary care;
2) Self-management of chronic conditions; and
3) The importance and value of Advance Care Planning.

These materials should be made available to PARTICIPANTS through multiple channels, such as in-person meetings, mailings, and on-line throughout the plan year and targeted to PARTICIPANTS as appropriate. The CONTRACTOR shall keep records of its distribution of such materials and provide documentation of distribution to the DEPARTMENT upon request.

145 Information Systems

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

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

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

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

    a) A minimum of eight (8) characters,

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

    c) Requires users to change passwords at least every sixty (60) DAYS,

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

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

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

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

        iii) Numeric (0 - 9),

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

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

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

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

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

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

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

150 Data Requirements

150A Data Integration and Technical Requirements

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

issued by the DEPARTMENT. During 2018, a series of modules are scheduled for implementation. Planning on the next phase of the project will start during 2018, for implementation at a later date.

2) 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 CONTRACTORS failure to comply with this requirement will be paid by the CONTRACTOR.

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

4) The CONTRACTOR'S system(s) must be able to accept and accommodate a HIPAA 834 file transfer from the DEPARTMENT, per the most recent 834 Companion Guide (see Appendix 1) as issued by the DEPARTMENT.

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

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

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

      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. The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the DEPARTMENT.

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

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

a) Claims Data - The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Medical and Pharmacy Claims Data Specifications document (see Appendix 4a and 4b), all claims processed for PARTICIPANTS. At least ninety-five percent (95%) of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred percent (100%) of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

b) Provider Data – The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Provider Data Specifications document (see Appendix 5), the specified data for all IN-NETWORK providers including subcontracted providers. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

c) Pharmacy Claims Data – The CONTRACTOR must establish a data transfer process to retrieve pharmacy claims data from the DEPARTMENT'S data warehouse for its PARTICIPANTS receiving benefits from the Department's PBM and integrate the data as required under Section 245. The pharmacy claims data is based on data provided by the PBM to the DEPARTMENT'S data warehouse. If directed by the DEPARTMENT, the CONTRACTOR must also be able to accept and accommodate a daily file from the DEPARTMENT'S PBM that will be in a file format compliant with the most recent Pharmacy Data Specifications (see Appendix 2) provided by the DEPARTMENT in consultation with the PBM.

d) Wellness and Disease Management Data – The CONTRACTOR must establish a data transfer process to retrieve this data from the DEPARTMENT'S data warehouse for its PARTICIPANTS and integrate the data into its medical management program. This data includes results from biometric screenings, health risk assessments, and unique PARTICIPANT enrollment in wellness health coaching and/or disease management programs as provided by the wellness and disease management vendor to the

DEPARTMENT'S data warehouse. If directed by the DEPARTMENT, the CONTRACTOR must also be able to accept and accommodate a weekly file from the wellness and disease management vendor that will include this data. The file format must comply with the most recent Wellness Data Specifications (see Appendix 3a-3d) as provided by the DEPARTMENT.

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

f) Benefit Accumulator Data - On each BUSINESS DAY, the CONTRACTOR must submit and retrieve data files with the vendor designated by the DEPARTMENT for the purpose of calculating the benefit accumulator for medical and pharmacy benefits. The CONTRACTOR must retrieve the pharmacy accumulator data and apply it to any combined deductibles and/or maximum out-of-pocket amounts for PARTICIPANTS. The CONTRACTOR must work with the DEPARTMENT to audit the benefit accumulator against the DEPARTMENT'S PBM to ensure the accumulator amounts are in sync.

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

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

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

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

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

150B Data Submission Requirements

The CONTRACTOR shall cooperate with the DEPARTMENT's designated data warehouse vendor by submitting to the vendor all of the following data on a schedule to be determined by the DEPARTMENT:

1) Data on payments for BENEFITS provided to PARTICPANTS under this CONTRACT. Payment data shall include claim payments made or denied, capitation or per-member

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

2) Data on other financial transactions associated with claim payments, including charged amount, allowed amount, and charges to members as co-payments, coinsurance, and deductibles; and

3) Data on the providers of those BENEFITS provided under this CONTRACT; and

4) Other data, as specified by the DEPARTMENT.

The CONTRACTOR shall comply with the DEPARTMENT'S specifications for submission of the required data elements in the standard formats attached to this CONTRACT.

To comply with the data submission requirements, the CONTRACTOR must follow the specified data file layout and formatting of all data elements within it and the DEPARTMENT'S specifications for data filtering and extraction. The CONTRACTOR must submit documentation on its data files including a data dictionary. The data files must use the valid values specified in the data dictionary. The claim adjustment data the CONTRACTOR submits must follow the logic the CONTRACTOR defines in the documentation. The CONTRACTOR must provide the DEPARTMENT'S eight (8)-digit member ID on all claim files. On all provider and claim files, the CONTRACTOR must supply the 10-digit National Provider Identifier (NPI) as issued by the US Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System (NPPES).

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

The CONTRACTOR shall follow the data transmission instructions provided by the DEPARTMENT'S data warehouse vendor, which shall include industry-standard electronic transmission methods via secure Internet technology.

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

The CONTRACTOR must submit data and corrected data when necessary by the dates indicated by the DEPARTMENT'S data warehouse vendor.

The CONTRACTOR agrees to financial penalties for failure to submit data in accordance with this AGREEMENT, 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 will be deducted from a future payment(s) owed the CONTRACTOR.

During the initial implementation of the DEPARTMENT'S data warehouse, the CONTRACTOR will have two chances to submit acceptable data. The DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the second submission not accepted by the DEPARTMENT'S data warehouse vendor and a penalty for each data file submitted more than one (1) BUSINESS DAY after the deadline for data file submission.

During the ongoing operation of the DEPARTMENT'S data warehouse, the DEPARMENT will charge the CONTRACTOR a penalty for each data file submitted after the first submission not accepted by the DEPARTMENT'S data warehouse vendor and a penalty for each data file submitted after the deadline for submission.

During the ongoing operation of the DEPARTMENT'S data warehouse, the DEPARMENT will charge the CONTRACTOR a per occurrence penalty for any failure to communicate to the DEPARTMENT'S data warehouse vendor a change to the valid values or data fields in the CONTRACTOR's next data file submission by ten (10) BUSINESS DAYS before the next data file submission deadline.

The penalties assessed in Section 150B apply to the penalty maximum described in Section 315.

155 Miscellaneous General Requirements

155A Reporting Requirements and Deliverables:

1) The CONTRACTOR must submit all reports and deliverables, and comply with all material requirements set forth in this AGREEMENT.

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

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

    b) Be delivered on or before scheduled due dates,

    c) Be submitted as directed by the DEPARTMENT,

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

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

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

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

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

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

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

155B Performance Standards and Penalties

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

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

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 or not the CONTRACTOR meets a performance standard.

155C Nondiscrimination Testing

The CONTRACTOR shall work in conjunction with the DEPARTMENT or its designee to complete Internal Revenue Code (IRC) Sec. 105 (h) compliant nondiscrimination testing for the DEPARTMENT at least annually. The DEPARTMENT or its designee will provide a schedule, process for testing, and data requirements. The CONTRACTOR shall complete any necessary requirements by the due date(s) specified by the DEPARTMENT or its designee.

155D Audit and Other Services

The CONTRACTOR shall be required to maintain sufficient documentation to provide for the financial/management audit of its performance under this AGREEMENT. These shall include, but are not limited to, program expenditures, claim processing efficiency and accuracy, and customer service.

At its discretion, the BOARD may require independent third party audit or review of any function relating to the HEALTH BENEFIT PROGRAM, including a pre-implementation configuration audit. The BOARD may also designate a common vendor which shall provide the annual description of BENEFITS and such other information or services it deems appropriate.

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.

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.

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.

The CONTRACTOR shall agree to a Service Organization Control (SOC) 1, Type 2 audit of internal controls conducted by an independent CPA firm at the CONTRACTOR'S expense that is in accordance with the Statement of Standard for Attestation Engagements (SSAE) 18 and provide a copy of the CPA's report to the DEPARTMENT. The DEPARTMENT will allow time on a case-by-case basis to provide this information if the CONTRACTOR doesn't currently have a completed SSAE 18 audit. The audit report must be submitted annually.

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

The CONTRACTOR shall submit financial stability documentation 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).

The CONTRACTOR must also 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.

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.

155E Fraud and Abuse

1) Participant Fraud

    a) Policy on Participant Fraud

        No person other than a PARTICIPANT is entitled to BENEFITS under this AGREEMENT. The SUBSCRIBER or any of his or her DEPENDENTS are not authorized by this AGREEMENT to assign or transfer their rights under the AGREEMENT, aid any other

person in obtaining BENEFITS to which they are entitled or knowingly present or cause a false or fraudulent claim. The SUBSCRIBER'S rights to coverage under the HEALTH BENEFITS PROGRAM are forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise falsely or fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment rights may be limited as determined by the BOARD.

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

b) Contractor Responsibility Related to Participant Fraud

Upon discovery, the CONTRACTOR shall report to the DEPARTMENT any suspected or identified PARTICIPANT fraud. The CONTRACTOR must cooperate with the investigation of fraud and provide information including aggregate claim amounts or other documentation, as requested by the DEPARTMENT. Fraud may result in the reprocessing of claims and recovery of overpayments. See Section 135C.

2) CONTRACTOR Provider, Pharmacy and PRESCRIBER Review Requirements

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

Examples of potential provider fraud that could be included in QUARTERLY reviews:

a) Billing for items or services not rendered;

b) Billing for work already reimbursed by another insurer;

c) Overcharging for services or supplies;

d) Completing an unjustified Certificate of Medical Necessity (CMN) form;

e) Double billing resulting in duplicate payment;

f) Misrepresenting medical diagnoses or procedures to maximize payments;

g) Inappropriate use of place of service codes;

h) Knowing misuse of provider identification numbers resulting in improper billing;

i) Providing medically unnecessary services;

j) Routinely waiving deductibles/coinsurances;

k) Submitting bills exceeding the limiting charge;

l) Unbundling (billing for each component of the service instead of billing or using an inclusive code);

m) Up-coding the level of service provided;

n) Billing for a known work-related injury;

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

p) Duplicate Therapy: Identification of PARTICIPANTS who are prescribed multiple drug regimens of related medications for more than one condition, by more than one provider;

q) Evidence of claims testing, excessive claim rejections and/or overcharge for cost of drug or PARTICIPANT cost-share amount by a PARTICIPATING PHARMACY; and

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

~~3) **Appeal Process Support**.~~

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

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

155F Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of the terms and conditions of the CONTRACT. The CONTRACTOR shall comply with all provisions of the Department Terms and Conditions regarding "Contractor Reporting of Breach or Suspected Breach or Disclosure to ETF". This includes but is not limited to, the requirement that 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.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as required by the Department Terms and Conditions.

155G Department May Designate Vendor

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

155H Contract Termination

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

1) Any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

   a) The ~~CONTRACT~~ BENEFIT maximum is reached.

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

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

   d) CONFINEMENT ceases.

2) If the BOARD terminates this CONTRACT, then all rights to BENEFITS 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 termination date. Such arrangements may include, but are not limited to: transferring the patient to another facility; billing the BOARD a fee for service rendered; 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.

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

4) The CONTRACTOR must submit claims data as specified in Section 150 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 not later than ninety (90) days following the contract termination date, unless there are issues receiving timely run-out claims data.

5) If the CONTRACTOR terminates this 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.

155I Transition Plan

Upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks and activities, including those identified by the DEPARMENT. The transition plan must be approved by the DEPARTMENT prior to the transition begin date. Also see the Department Standard Terms and Conditions.

155J Insolvency

The CONTRACTOR shall maintain appropriate bonding and/or reinsurance and shall submit documentation 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 this CONTRACT, bonding or reinsurance exists to pay those obligations. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT then confined as an INPATIENT, BENEFITS shall continue until the CONFINEMENT ceases, the attending physician determines CONFINEMENT is no longer medically necessary, the end of 12 months from the date of insolvency, or the CONTRACT maximum is reached, whichever occurs first. The DEPARTMENT will establish enrollment periods during which SUBSCRIBERS may transfer coverage to another CONTRACTOR.

200 PROGRAM REQUIREMENTS

205 Enrollment

CONTRACTORS must participate in the annual IT'S YOUR CHOICE OPEN ENROLLMENT offering. The IT'S YOUR CHOICE OPEN ENROLLMENT period is scheduled for each fall prior to the covered program year. During the IT'S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR will accept any SUBSCRIBER who transfers from one benefit plan to another without requiring evidence of insurability, or waiting periods, or exclusions as defined in Wis. Adm. Code INS 3.31 (3) and any eligible EMPLOYEE or state retiree under Wis. Stat. § 40.51 (16) who enrolls.

Although the DEPARTMENT is responsible for eligibility determination and enrollment, the CONTRACTOR shall maintain an enrollment/eligibility system to support the HEALTH BENEFIT PROGRAM. The Board expects the CONTRACTOR to play an active role in member education and outreach prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period to ensure that PARTICIPANTS understand the benefits and providers available under the HEALTH BENEFIT PROGRAM and how to access additional information about the program.

205A Enrollment Files

The daily and full file compare of the DEPARTMENT'S HIPAA 834 enrollment files must be fully tested and are ready for program operation no later than forty-five (45) calendar DAYS prior to the effective (i.e., "go-live") date. Also see Section 150A.

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

205B Identification (ID) Cards

The CONTRACTOR must provide PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts, if applicable. The CONTRACTOR must issue new ID cards upon enrollment and BENEFIT changes that impact the information printed on the ID cards.

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

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

2) For elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR shall issue ID cards by December 15 (or a later date as approved by the

DEPARTMENT) for enrollment additions or changes effective the following January 1, as submitted on enrollment files generated on the first DAY of the IT'S YOUR CHOICE OPEN ENROLLMENT period through December 10. The CONTACTOR must notify the DEPARTMENT Program Manager of any delays with issuing the ID cards. The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager in January indicating the date(s) the ID cards were issued.

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

205C Participant Information

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

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

2) 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.

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

4) A description of PHARMACY BENEFIT PLAN features, including an overview of benefits, a description of how the formulary is developed, and information about the web site.

5) A brochure about mail-order pharmacy benefits.

6) 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 Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process described in Section 140B.

The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required form 1095-Cs.

205D Disabled Child EligibilityThe CONTRACTOR shall report to the DEPARTMENT at least annually the results from its process to verify the eligibility of adult 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, and

2) Support and maintenance requirement is met, and

3) Child is not married.

205E Date of Death

The CONTRACTOR shall collect and track the date of death and report it to the DEPARTMENT as needed.

205F Coordination of Benefits (COB)

The CONTRACTOR shall collect from SUBSCRIBERS COB information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and report this information to the DEPARTMENT at least annually.

210 Primary Care Provider

SUBSCRIBERS and DEPENDENTS shall be required to select a primary care provider (PCP). The PCP may be a physician, physician assistant, nurse practitioner or other provider as approved by the BOARD. Modifications to this list may be approved by the DEPARTMENT. The PCP furnishes primary care-related services, arranges for and coordinates referrals for all medically necessary specialty services, and is available for urgent or emergency care, directly or through on-call arrangements, twenty-four (24) hours a DAY, seven (7) DAYS a week. Primary care includes ongoing responsibility for preventive health care, treatment of illness and injuries, and the coordination of access to needed specialty providers or other services. The PCP shall either furnish or arrange for most of the PARTICIPANT'S health care needs, including well check-ups, office visits, referrals, out-patient surgeries, hospitalizations, and health-related services.

The CONTRACTOR must monitor all PARTICIPANT records to ensure there is an assigned, IN-NETWORK PCP at all times. If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR will assign a PCP, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP.

If PARTICIPANTS select a PCP that is OUT-OF-NETWORK, the CONTRACTOR must contact the PARTICIPANTS within five (5) BUSINESS DAYS to assist them in selecting an IN-NETWORK PCP. Also see Section 265E.

The CONTRACTOR must have a process to allow a PARTICIPANT to change PCPs in a reasonable time and to communicate to the PARTICIPANT how to make this change. The CONTRACTOR will assist the PARTICIPANT in selecting a PCP.

215 Medical Management

215A Disease Management / Prior Authorizations / Utilization Review (UR)

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

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

The CONTRACTOR shall utilize data provided by the PBM, wellness and disease management vendor, and DEPARTMENT'S data warehouse for identifying PARTICIPANTS suitable for case, complex case, and/or disease management programs.

The CONTRACTOR 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 CONTRACTOR 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 DEPARTMENT. The CONTRACTOR shall also include details on the HEALTH BENEFIT PROGRAM'S experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the CONTRACTOR believes will be useful to DEPARTMENT staff and the BOARD in understanding the source of cost and utilization trends in a format as determined by the DEPARTMENT.

Examples of the minimum utilization review UR procedures that CONTRACTORS shall have in place include the following:

1) Written guidelines that providers must follow to comply with the CONTRACTOR'S UR program.

2) Formal UR program consisting of preadmission review, concurrent review, discharge or transition of care and post-service medical review and individual case management.

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

4) Authorization procedure for referral to OUT-OF-NETWORK providers and monitoring of physician referral patterns.

5) Procedure to monitor emergency admissions to OUT-OF-NETWORK HOSPITALS.

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

7) If PARTICIPANTS are identified as having a disease and/or condition that would place them into a moderate or high risk category, have a process to enroll the PARTICIPANTS into the

appropriate wellness, disease management, or chronic care management programs. The CONTRACTOR must coordinate this effort with the program(s) offered by the DEPARTMENT'S wellness and disease management vendor.

Failure to provide effective UR may be grounds for BOARD action.

Prior Authorizations
The CONTRACTOR must also offer an integrated prior authorization process that provides PARTICIPANTS with a consolidated medical and benefit (such as deductible, coinsurance and copayment) determination. Prior authorizations with out-of-pocket cost sharing information, including the possibility of balance billing if applicable, must be provided to PARTICIPANTS in writing. In urgent situations, prior authorizations may be provided verbally, as long as the PARTICIPANT is notified of cost sharing responsibilities, and it is documented in the PARTICIPANT'S records/file. The CONTRACTOR must still follow up with a written notice. This provision also applies when a provider is seeking the prior authorization on the PARTICIPANT'S behalf.

If the cost sharing is not disclosed at the time of prior authorization, the CONTRACTOR shall hold the PARTICIPANT harmless for out-of-pocket amounts above that of an equivalent IN-NETWORK service, and shall not charge this difference to the DEPARTMENT.

The CONTRACTOR shall work with the DEPARTMENT to develop strategies for OUT-OF-NETWORK costs, including, but not limited to, the use of PARTICIPANT incentives, prior authorization, and negotiating provider fees.

The CONTRACTOR shall be responsible for the full cost of any services not covered under this CONTRACT for which the CONTRACTOR provides written prior authorization to the PARTICIPANT and/or provider for the non-covered service.

215B Department Initiatives

The CONTRACTOR is required to implement and report on the DEPARTMENT Initiatives. 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.

The current DEPARTMENT Initiatives applicable to the HEALTH BENEFIT PROGRAM are:

1) 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.

2) 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.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in UNIFORM BENEFITS to all PARTICIPANTS. BENEFITS are reviewed annually and any BENEFIT changes must be implemented as directed by the BOARD. This shall include developing the necessary reporting and/or data transfers needed by the DEPARTMENT and other vendors to administer the change.

The CONTRACTOR will offer the ALTERNATIVE BENEFIT DESIGN described in UNIFORM BENEFITS to all enrolled PARTICIPANTS.

220B Telehealth / Nurse Line

1) The CONTRACTOR must provide telehealth services as directed by the DEPARTMENT.

2) The CONTRACTOR must provide a twenty-four (24)-hour nurse line available at no cost to all PARTICIPANTS.

220C Emergency / Urgent / Catastrophic Care

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

The CONTRACTOR will work with OUT-OF-NETWORK providers to manage and reduce medical claim costs incurred in emergency and urgent situations. The CONTRACTOR must coordinate care in these situations, including directing care IN-NETWORK, and/or a transfer to a more suitable facility when appropriate.

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

220D Inpatient When Changing Coverage

The CONTRACTOR will administer claims and medical management services for any PARTICIPANT who is CONFINED as INPATIENT at the time of a transfer of coverage to another CONTRACTOR, when the facility in which the PARTICIPANT is CONFINED is not part of the succeeding CONTRACTOR'S network. In this instance, the CONTRACTORS will work together

to facilitate a seamless transition in claims administration, medical management services, if applicable, and transferring the PARTICIPANT to an IN-NETWORK facility, if appropriate.

Except when a PARTICIPANT'S coverage terminates because of voluntary cancellation or non-payment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if CONFINED as an INPATIENT, but only until the attending physician determines that CONFINEMENT is no longer medically necessary, the maximum BENEFIT is reached, the end of twelve (12) months after the date of termination, or the CONFINEMENT ceases, whichever occurs first.

220E Federal / State Requirements

The CONTRACTOR must meet any and all applicable state or federal requirements concerning BENEFITS and cost-sharing which may be imposed on EMPLOYERS participating in the HEALTH BENEFIT PROGRAM, the CONTRACTOR, a federally qualified health benefit program, or as contained in this AGREEMENT.

220F Out-of-Network Services for Passive Preferred Provider Organization (PPO) Network Plans

CONTRACTORS offering a 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.

220G Medicare

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 two (2) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare.

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

220H End Stage Renal Disease - Medicare Participants

If the ANNUITANT, CONTINUANT or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, the HEALTH BENEFIT PROGRAM shall pay as the primary payer for the first thirty (30) months after he or she becomes eligible for Medicare due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT is enrolled in Medicare. If the ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty (30) month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer.

220I Ancillary Services

If the PARTICIPANT receives anesthesiology, radiology or pathology (includes all lab tests) services at an IN-NETWORK clinic or HOSPITAL, it will be covered at the IN-NETWORK level of benefits even if that care is not provided by an IN-NETWORK provider.

220J Transfer of Benefit Maximums / Deductible / Out-of-Pocket Limits

PARTICIPANTS may have the opportunity to change benefit plans during a benefit period in certain situations (e.g., due to a change in residence).

1) Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPLs under UNIFORM BENEFITS will continue to accumulate for the benefit period in the following situations:

   a) If a PARTICIPANT changes the level of coverage (e.g., single to family), or changes benefit plans, but does not change CONTRACTORS.

   b) If a PARTICIPANT has a spouse-to-spouse transfer resulting in a change of SUBSCRIBER, but does not change CONTRACTORS.

2) Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPLs under UNIFORM BENEFITS will start over at zero ($0) dollars as of the EFFECTIVE DATE of the change if a PARTICIPANT changes from being a PARTICIPANT of the state program to the LOCAL program, or vice versa.

3) Accumulations to the annual pharmacy and uniform dental (if applicable) benefits continue to accumulate for the benefit period regardless of a benefit plan/CONTRACTOR change.

The CONTRACTOR must cooperate with the DEPARTMENT and the new CONTRACTOR to transfer BENEFIT accumulations upon a PARTICIPANT'S mid-year transfer to coverage under a new CONTRACTOR. The CONTRACTOR shall provide the PARTICIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of an explanation of benefits.

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

220K Coordination / Non-Duplication

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

220L Wellness

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

2) The CONTRACTOR must participate in collaboration efforts between the DEPARTMENT, its wellness and disease management vendor, and other vendors, as directed by the DEPARTMENT.

3) The CONTRACTOR must accept PARTICIPANT level data transfers from the DEPARTMENT'S wellness and disease management vendor.

4) 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.

5) The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the PARTICIPANT level data at stated in 4) above and in Section 215A.

6) The CONTRACTOR must report, as directed by the DEPARTMENT, all incentive payments issued to PARTICIPANTS for DEPARTMENT distribution to EMPLOYER payroll centers for tax reporting purposes. The CONTRACTOR must link all payment records to the primary SUBSCRIBER and avoid duplication for instances of a reissued incentive.

7) Provider obtained biometric screenings as required by the DEPARTMENT'S wellness program shall be provided by the CONTRACTOR at the PARTICIPANT'S request, for no cost to the PARTICIPANT, and at a minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings may be administered as non-fasting and shall be in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines.

220M PHARMACY BENEFIT PLAN Specifications

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

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

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

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

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

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

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

220N MEDICARE PART D/EGWP Coverage

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

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

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

225 Quality

1) The CONTRACTOR must demonstrate, upon request by the DEPARTMENT, their efforts in encouraging and/or requiring IN-NETWORK HOSPITALS, providers, large multi-specialty groups, small group practices and systems of care, and PARTICIPATING PHARMACIES to participate in quality standards and initiatives, including those as identified by the DEPARTMENT.

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

3) 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.

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

    b) The CONTRACTOR shall submit the results of its annual CAHPS survey to the DEPARTMENT as follows:

        i) Results must be based on responses from Medicare members in Wisconsin;

        ii) Survey must be conducted by a certified CAHPS survey vendor;

        iii) Results must utilize the current version of the CAHPS survey as specified by the NCQA guidelines at the time the survey is administered;

        iv) Results must be for each standard NCQA composite;

        v) Results must be submitted annually and in a file format as specified by the DEPARTMENT; and,

        vi) Separate results must be submitted for each region, if applicable.

4) 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.

5) The DEPARTMENT will monitor health care quality and/or customer satisfaction using quality measures available in the data warehouse and visual business intelligence tool, and will establish quality metrics, baseline results, and target levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage quality improvement. See Appendix 8 for the quality measures that will be evaluated as part of this CONTRACT.

Prior to the DEPARTMENT holding the CONTRACTOR accountable for any of these measures, either through financial means and/or through publishing the measure results, the DEPARTMENT will provide the CONTRACTOR with an opportunity to review and validate the DEPARTMENT'S results within a specific timeframe, as determined by the DEPARTMENT.

~~5)~~ 6) The CONTRACTOR shall collaborate with providers on quality initiatives to address current population health issues. The CONTRACTOR shall report to the DEPARTMENT semi-annually any initiatives and pilot programs offered by the CONTRACTOR or the CONTRACTOR'S IN-NETWORK providers, including information on patient engagement and outcomes.

230 Provider Contracts

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

Upon request by the DEPARTMENT, the CONTRACTOR shall agree to disclose the cost savings calculated with implementing any provider contract reimbursement methods as directed by the BOARD. This may include a detailed explanation of how providers, HOSPITALS, and PARTICIPATING PHARMACIES compensation is established, reviewed and changed. The intent is to secure information on how a CONTRACTOR reimburses its providers. The BOARD is not interested in specific fees or salary information.

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

The CONTRACTOR must submit provider data to the DEPARTMENT'S data warehouse as specified in Section 150. The DEPARTMENT will not amend its contract with the data warehouse vendor in a manner that directly or indirectly changes the terms of this section without prior notice to the CONTRACTOR. The DEPARTMENT'S notice to the CONTRACTOR will allow for comment by the CONTRACTOR, and when requested by the CONTRACTOR, discussion between the DEPARTMENT and the CONTRACTOR about the proposed changes.

Provider agreements for transplants are expected to specify that re-transplantation due to immediate rejection that occurs within the first thirty (30) DAYS of a transplant shall be covered and is not subject to the UNIFORM BENEFITS exclusion on retransplantation.

The CONTRACTOR shall use best efforts to incorporate into Wisconsin provider agreements:

1) Guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors.

2) HOSPITAL readmissions reduction program and the community-based care transitions program as described by Medicare.

Provider contracts must include a provision whereby the provider agrees to accept the CONTRACTOR'S payment as full payment for covered services, not including PARTICIPANT cost-sharing as outlined in UNIFORM BENEFITS. The CONTRACTOR must hold the PARITICPANT harmless from any efforts(s) by third parties to collect payments for covered services.

CONTRACTOR must provide a copy of the current provider administrative manual upon request by the DEPARTMENT.

230A Provider Access Standards

The CONTRACTOR must provide an annual provider submission to the DEPARTMENT containing any changes to their provider network for the upcoming benefit period. See Appendix 7. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150. If the CONTRACTOR is required to report a change in its provider network to CMS, it must also report such a change to the DEPARMENT within five (5) BUSINESS DAYS of reporting such a change to CMS.

Providers will be sorted by zip code based on where they are physically located within each country and major city in the region. Major cities are those that have over thirty-three percent (33%) of the county population. Those cities are Antigo, Appleton, Ashland, Eau Claire, Florence, Fond du Lac, Green Bay, Janesville, Kenosha, LaCrosse, Madison, Manitowoc, Menomonie, Merrill, Milwaukee, Monroe, Oshkosh, Prairie du Chien, Racine, Sheboygan, Stevens Point, Sturgeon Bay, and Superior. These providers must agree to accept new patients unless specifically indicated otherwise.

In addition to the access standards set forth in **Wis. Stat. § 609.22**, the CONTRACTOR must meet at least 90% geoaccess in the county for INPATIENT HOSPITALS, PCPs (includes Internal Medicine, Family Medicine and General Medicine), and chiropractors or the following minimum requirements for all counties and major cities in the county to be qualified:

1) There must be at least one (1) general HOSPITAL under contract and/or routinely utilized by IN-NETWORK providers per county or major city. If a HOSPITAL is not present in the county, CONTRACTORS must sufficiently describe how they provide access to providers.
2) The ratio of full time equivalent (FTE) PCPs accepting new patients to total PARTICIPANTS in a county or major city is at least one per two thousand (1.0/2,000) with a minimum of five (5) PCPs per county or major city. The PCPs counted for this requirement must be able to admit patients to an IN-NETWORK HOSPITAL in the county or major city.
3) A chiropractor must be available in each county or major city.

230B CONTRACTOR Provider Directory

The CONTRACTOR must make a provider directory available to PARTICIPANTS during the annual IT'S YOUR CHOICE OPEN ENROLLMENT period and throughout the benefit period.

Providers listed in these directories are subject to CMS MEDICARE ADVANTAGE access standards and requirements to accept new patients, unless otherwise noted. The CONTRACTOR is required to have a current provider directory easily accessible on their website at all times. The provider directory must include a revision date and all past versions within a benefit period and must be provided to the DEPARTMENT upon request for the purposes of resolving complaints.

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

230C Continuity of Care

The CONTRACTOR must comply with the continuity of care provisions under Wis. Stat. § 609.24 for providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and listed in the provider data submission required under Section 230A. 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 SUBSCRIBER shall be held harmless and indemnified. This does not apply in the 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.

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 must:

1) 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:

    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.

2) Update the provider directory on the CONTRACTOR'S website.

The CONTRACTOR shall keep a record of this notification mailing and shall provide documentation, by SUBSCRIBER and indicating the mailing address used, upon the DEPARTMENT'S request.

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

If the CONTRACTOR removes providers from its network for the next benefit period, the CONTRACTOR is prohibited from adding those providers back to the network until the subsequent benefit period unless approved by the DEPARTMENT. This provision does not apply to normal attrition.

230D Provider Contracts Shall Include Compliance Plans

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

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

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

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

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

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

5) Certify as to the accuracy, completeness and truthfulness of all data submitted to payers.

235 Pharmacy Network Administration

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

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

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

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

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

The CONTRACTOR must submit provider data to the DEPARTMENT’S data warehouse as specified in Section 150. The DEPARTMENT will not amend its contract with the data warehouse vendor in a manner that directly or indirectly changes the terms of this section without prior notice to the CONTRACTOR. The DEPARTMENT’S notice to the CONTRACTOR will allow for comment by the CONTRACTOR, and when requested by the CONTRACTOR, discussion between the DEPARTMENT and the CONTRACTOR about the proposed changes.

The CONTRACTOR must certify annually that their pharmacy contracts meet the requirements in Section 235. The DEPARTMENT reserves the right to review any contracts with PARTICIPATING PHARMACIES that are IN-NETWORK for the PHARMACY BENEFIT PLAN.

235A Pharmacy Network Access

The CONTRACTOR must provide an annual pharmacy network submission to the DEPARTMENT containing the network of PARTICIPATING PHARMACIES for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly data submission as detailed in Section 150C.

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

235B Pharmacy Network Directory

The CONTRACTOR is required to have a current pharmacy directory easily accessible on their website at all times. If the PARTICIPATING PHARAMACIES change during the benefit period, an updated pharmacy 225B directory must be provided by the CONTRACTOR and include a revision date. All past versions within a benefit period must be available and provided to the DEPARTMENT upon request for the purposes of resolving complaints.

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

235C Pharmacy Network Contracts Shall Include Compliance Plans

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

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

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

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

240 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 315B.

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

Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR shall provide the total dollar amount of claims paid by the HEALTH BENEFIT PROGRAM.

245 Data

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

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

The CONTRACTOR must provide a copy of any CMS Model Output Report (MOR) file and a copy of the Monthly Membership Report (MMR) file, including all fields as received from CMS, 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 30 days of request. The MMR file must be provided monthly by the end of the corresponding month.

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

The CONTRACTOR agrees to assign ID numbers according to the system established by the DEPARTMENT. Social security numbers shall be incorporated into the PARTICIPANT'S data file and may be used for identification purposes only and not disclosed and used for any other purpose. Any costs incurred by the DEPARMENT because of CONTRACTORS failure to comply with this requirement will be paid by the CONTRACTOR.

250 Grievances

250A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with external review in accordance with applicable federal or state law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections 160I, 245E, and 245F.

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

Grievances regarding non-covered services or services excluded from coverage by the 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.

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

The following provides an overview of the steps in the PARTICIPANT grievance process. Details are provided in Sections 250B – F.

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

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

5) External review (not all grievances eligible).

250B Claim Review

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

250C 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.

250D Investigation and Resolution Requirements

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

250E Notification of Department Administrative Review Rights

In the final grievance decision letters, the CONTRACTOR shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an 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.

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

The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). However, the DEPARTMENT will not issue a determination regarding denials of coverage by a CONTRACTOR 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.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. Participation means providing evidence and testimony necessary to explain the claim decisions made by the CONTRACTOR. The CONTRACTOR shall be responsible for any cost required for participation in the administrative hearings by the CONTRACTOR'S staff and any approved subcontractors, including but not limited to time spent at the hearing and travel time to and from the hearing. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

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

250F External Review

The PARTICIPANT shall have the option to request an external review subject to applicable federal or state law. In accordance with federal or state law, any decision by an Internal Review Organization (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.

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

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

250G Provision of Complaint Information

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

250H 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.

250I Notification of Legal Action

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

250J Penalty for Noncompliance

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.

255 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for Local ANNUITANTS), or by the DEPARTMENT for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see Section 265D.

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

260 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as 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.

The CONTRACTOR must support an Automated Clearinghouse (ACH) mechanism that allows for direct pay PREMIUM to be submitted 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 notice of cancellation from the SUBSCRIBER or

within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first. LOCAL ANNUITANTS are irrevocably cancelled, see Section 125E.

265 Continuation

265A Right to Continue Coverage

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

265B Subscriber Nonpayment of Premiums

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

1) When coverage is canceled,

2) PREMIUMS are not paid when due, or

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

The CONTRACTOR shall bill the CONTINUANT directly for required PREMIUMS.

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

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

265C Conversion

The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897

265D Surviving Dependents

As required by Wis. Adm. Code ETF 40.01, the surviving covered DEPENDENT of a covered EMPLOYEE or ANNUITANT shall have the right to continue coverage, either individual or family. A DEPENDENT that regains eligibility and was previously covered under a contract of a deceased EMPLOYEE or ANNUITANT, or a child of the EMPLOYEE or ANNUITANT who is in the process of being adopted by the deceased EMPLOYEE or ANNUITANT, or born within nine (9) months

after the death of the EMPLOYEE or ANNUITANT, will be eligible for coverage under the survivor's contract until such time that they are no longer eligible.

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

PREMIUMS shall be paid:

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

2) Directly to the CONTRACTOR.

270 Miscellaneous Program Requirements

270A Implementation

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

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

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

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

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT

Activity	Due Dates
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2019 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	September 1, 2018
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 16, 2018
Informational Meetings: The CONTRACTOR shall hold regional informational meetings to share educational information, approved by the DEPARTMENT, at locations approved by the DEPARMENT to retirees about the MEDICARE ADVANTAGE plan and available benefit designs.	August, September, and October, 2018
Customer Service: The CONTRACTOR'S toll-free customer service telephone number is operational and customer service staff are trained.	September 30, 2018
Web Content Launch: The web content dedicated to the PHARMACY BENEFIT PLAN and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2018
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	September 2018 (Date TBD)
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation according to pre-established timelines.	November 16, 2018
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2018
ID CARDS: The CONTRACTOR issues welcome packets that contain ID CARDS for SUBSCRIBERS with coverage effective January 1, 2019.	December 15, 2018
Claims Administrative Services: All claims administrative services for the HEALTH BENEFIT PLAN are fully operational.	January 1, 2019
Accumulator File Data: The medical and pharmacy data transfer processes for accumulating PARTICIPANT out-of-pocket costs for	January 1, 2019

Activity	Due Dates
deductibles and out-of-pocket limits is established, tested and working correctly according to pre-established timelines.	
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2019
Medical and Dental Data: The medical and dental data transfer process is established, tested, and working correctly.	January 15, 2019
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2019
Pharmacy Claims & Network Data: The pharmacy claims and network data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2019

270B Account Management and Staffing

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

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

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

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

5) Resolve general administrative problems identified by the DEPARTMENT.

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

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

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

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

The CONTRACTOR must also provide a central point of contact for PARTICIPANT enrollment and premium issues related to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must acknowledge receipt of an inquiry from the RETIREE HEALTH INSURANCE UNIT within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the RETIREE HEALTH INSURANCE UNIT.

The CONTRACTOR shall provide onsite staff attendance at the annual IYC EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the annual IT'S YOUR CHOICE OPEN ENROLLMENT period, and any annuitant group meetings, as appropriate. The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR'S operations and policies.

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

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

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

270C Customer Service

The CONTRACTOR shall operate a customer service department for the HEALTH BENEFIT PROGRAM between 7:30 a.m. and 6:00 p.m., CST/CDT Monday through Thursday and 7:30 a.m.

to 5:00 p.m. CST/CDT on Friday at a minimum, except for legal holidays. PARTICIPANTS must also be able to submit questions using e-mail and/or via a website. The call center must be equipped with Telephone Device for the Deaf (TDD) in order to serve the hearing-impaired population. Calls and correspondence to customer services representatives shall be tracked, recorded, and retrieved when necessary by name or the DEPARTMENT'S eight (8)-digit member ID.

The CONTRACTOR must have a dedicated toll free number for the 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.

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

The CONTRACTOR must monitor and report to the DEPARTMENT the performance standards for the 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 315C and are based on the dedicated toll free number for the HEALTH BENEFIT PROGRAM.

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. On a monthly basis, the CONTRACTOR must submit 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.

The system must track and log the following detail:

1) The PARTICIPANTS identifying information;

2) The date and time the inquiry was received;

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

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

5) The representative that handled the inquiry;

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

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

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

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

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five 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.

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.

270D Contractor Web Content and Web-Portal

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) General information about the HEALTH BENEFIT PROGRAM and other programs offered by the BOARD;

b) Directions on how to access the HEALTH BENEFIT PROGRAM provider directory and Summary of Benefits and Coverage (SBC);

c) Information about PARTICIPANT requirements, including prior authorizations and referrals;

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

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

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

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

The data center network shall include robust firewall, intrusion prevention and intrusion detection systems to prevent and detect unauthorized access. Any scheduled maintenance must occur between the hours of midnight and 5:00 a.m. CST/CDT or another time agreed to by the DEPARTMENT Program Manager, and must be scheduled in advance with a notification on the program website/portal. Unscheduled disruption to the availability of the website or web-portal must be communicated to the DEPARTMENT Program Manager within one (1) hour of realization that a problem occurred.

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

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

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

6) The CONTRACTOR must have web-portal content and functionality updated, tested and approved by the DEPARTMENT Program Manager or designee at least fourteen (14) calendar DAYS prior to the benefit period start date. The web-portal will securely authenticate the user. After the user is authenticated, all web-portal features must be available without the need for an additional login. Available features must include:

   a) User name and password creation and recovery;

   b) Enrollment confirmation;

   c) Secure upload functionality for submitting program required documentation;

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

   e) Incentive payment status, if applicable (e.g., pending, issued, etc.).

270E Patient Rights and Responsibilities

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

270F Errors

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

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.

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

Subscriber Errors

In the event 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 him/her in selecting an IN-NETWORK PCP. 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.

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 IT'S YOUR CHOICE 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 IT'S YOUR CHOICE OPEN ENROLLMENT period or other enrollment opportunity as specified in this AGREEMENT.

Contractor / Provider / Subcontractor Errors

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

270G Examination of Records

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. The information shall be furnished within ten (10) BUSINESS DAYS of the request or as directed by the DEPARTMENT. All such information is the sole property of the DEPARTMENT.

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

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

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

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

270H Record Retention

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

Any records that relate to: (1) litigation or settlement of claims arising out of the performance of this AGREEMENT; or (2) costs or expenses of this AGREEMENT with which exception is taken by litigation, claims, or exceptions, must be retained for seven (7) years after the conclusion of the litigation, regardless of the termination date of the contract.

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.

270I Disaster Recovery and Business Continuity

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

270I Other

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

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 pharmacy benefit manager..

270J 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.

270K Conflict of Interest
During the term of this AGREEMENT, the CONTRACTOR shall have no interest, direct or indirect, that would conflict in any manner or degree with the performance of services required under this AGREEMENT.

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

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

300 DELIVERABLES

305 Reporting Requirements

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

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

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

Report	Description	Frequency
1) Direct Pay Terminations Report	The CONTRACTOR provides 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 Sections 255 and 260B.)*	See description
2) Claims Data Transfer to Data Warehouse	The CONTRACTOR submits to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a. and 150B.)*	Monthly
3) Customer Service Inquiry Report	The CONTRACTOR must submit 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. *(See Section 265B.)*	Monthly
4) Provider Data Transfer to Data Warehouse	The CONTRACTOR submits to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Provider Data Specifications document, the specified data for all IN-NETWORK providers including subcontracted providers, and any OUT-OF-NETWORK providers for which the CONTRACTOR has processed or expects to process claims. *(See Section 150A, 5, b and 150B.)*	Monthly
5) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155E, 2.)*	Quarterly
6)	*Intentionally left blank.*	
7) OUT-OF-NETWORK Claims	The CONTRACTOR submits to the DEPARTMENT a report of all claims paid to OUT-OF-NETWORK providers that includes the billed amount and amount paid to the provider in the format specified by the DEPARTMENT. *(See Section 220C.)*	Quarterly

Report	Description	Frequency
8) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
9) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives. Initiatives are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM PARTICIPANTS. The current DEPARTMENT Initiatives are: Care Coordination, and Advance Care Planning. *(See Section 215B.)*	Semi-annually
10) Pilot Programs and Initiatives	The CONTRACTOR reports to the DEPARTMENT any initiatives and pilot programs offered by the CONTRACTOR or the CONTRACTOR'S IN-NETWORK providers, including information on patient engagement and outcomes. *(See Section 225, 5.)*	Semi-annually
11) Taxable Income Report for PARTICIPANT Incentive Payments	The CONTRACTOR reports, as directed by the DEPARTMENT, all incentive payments issued to PARTICIPANTS for DEPARTMENT distribution to EMPLOYER payroll centers for tax reporting purposes. *(See Section 220L, 6.)*	Semi-annually
12) Business Recovery Plan and Simulation Report	The CONTRACTOR submits to the DEPARTMENT a business recovery plan that is documented and tested annually, at a minimum. *(See Section 145, 5.)*	Annually
13) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. *(See Section 225, 3, b.)*	Annually
14) Coordination of Benefits (COB) Report	The CONTRACTOR collects from SUBSCRIBERS COB information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and reports this information to the DEPARTMENT at least annually. *(See Section 205F.)*	Annually
15) Disabled Adult Children Eligibility Verification Report	The CONTRACTOR reports to the DEPARTMENT 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 Section 205D.)*	Annually
16) Financial and Utilization Data Submission *(formerly Addendum 1)*	The CONTRACTOR submits to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information. *(See Section 115, 10 and 130B.)*	Annually
17) Financial Stability Documentation	The CONTRACTOR submits 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 155E.)*	Annually

Report	Description	Frequency
18) Grievance Summary Report	The CONTRACTOR retains records of grievances and submits an annual summary to the DEPARTMENT of the number, types of grievances received, and the resolution or outcome. *(See Section 115, 9, c.)*	Annually
19) Group Experience / Utilization Report	The CONTRACTOR reports annually to the BOARD its utilization and disease management capabilities and effectiveness in improving the health of PARTICIPANTS and encouraging healthy behaviors, demonstrating support for technology and automation in the format as determined by the DEPARTMENT. The CONTRACTOR also includes details on the HEALTH BENEFIT PROGRAM'S experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the CONTRACTOR believes will be useful to DEPARTMENT staff and the BOARD in understanding the source of cost and utilization trends in a format as determined by the DEPARTMENT. *(See Section 215A.)*	Annually
20) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results for the previous calendar year for its Medicare membership that includes HEALTH BENEFIT PROGRAM PARTICIPANTS. *(See Section 225, 3, a.) Add STAR Rating*	Annually
21) CMS Star Ratings	The CONTRACTOR submits CMS overall STAR ratings and star ratings for each domain and each measure within each domain.	Annually
22) MAR Certification	The CONTRACTOR submits a MAR Certification. *(See Section 155E.)*	Annually
23) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually
24) SOC 1, Type 2 Audit Report	The CONTRACTOR agrees to a SOC 1, Type 2 audit of internal controls conducted by an independent CPA firm at the CONTRACTOR'S expense that is in accordance with the SSAE 18 and provides a copy of the CPA's report to the DEPARTMENT. *(See Section 155E.)*	Annually

310 Deliverables

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

310A Deliverables to the Department

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

Deliverable	Description	Frequency
1) Implementation Plan	The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARMENT Program Manager or designee. See Section 270A.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT

Deliverable	Description	Frequency
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. See Sections 270A and 270B.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. See Section 155E and 270A.	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section 205B, 2.)*	Upon identification of issue
5) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff,. *(See Section 2A.)*	April August
7) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider and PARTICIPATING PHARMACY network for the upcoming benefit period. *(See Section 230A.)*	June
8) Annual Premium Rates	The CONTRACTOR must submit annual rates for the each following benefit year as directed by the DEPARTMENT. The CONTRACTOR's sealed rates are submitted in the format as specified by the DEPARTMENT. 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. *(See Section 130B.)*	June - July

Deliverable	Description	Frequency
9) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July
10) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
11) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
12) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September
13) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 12) above was issued. *(See Section 140B, 1.)*	October
14) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
15) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT

Deliverable	Description	Frequency
16) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 270DC, 1a and 1p.)*	As directed by the DEPARTMENT
17) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred eighty (180) DAYS prior to undertaking a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM. *(See Section 145, 8.)*	As needed
18) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 270B.)*	As needed
19) CMS Model Output Report and Monthly Membership Reports	The CONTRACTOR provides copies of CMS Model Output Reports or Monthly Membership Reports, including all fields as received from CMS *(Section 245)*.	As needed
20) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 250I.)*	As needed
21) Notification of Privacy Breach	The CONTRACTOR notifies 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 Section 155F.)*	As needed
22) Notification of Significant Events	The CONTRACTOR provides notification of all significant events as described in Section 115, 14.	As needed
23) External Review Determination	Within fourteen (14) calendar DAYS of the CONTRACTOR'S receipt of the notification of the external review's determination, the CONTRACTOR notifies the DEPARTMENT of the outcome. *(See Section 250F.)*	See description
24) Medicare Enrollment Denial	The CONTRACTOR notifies the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare. (*See Section 220G.)*	See description

Deliverable	Description	Frequency
25) Transition Plan	The CONTRACTOR provides 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 155I.)*	Upon DEPARTMENT request, and prior to CONTRACT termination
~~26)~~		

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • 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 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, HOSPITAL, or PARTICIPATING PHARMACY during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. *(See Section 230C.)*	See description
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides 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. *(See Section 250C.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an external review in accordance with applicable federal or state law, using the language approved by the DEPARTMENT. *(See Section 250E.)*	See description
7) SUBSCRIBER Notification Upon Termination	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897,. *(See Section 265C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed
10) 1095-C Reporting	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

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

The penalties assessed in Section 150B and Section 315 shall not exceed three percent (3%) of the CONTRACTOR'S total premium in any given quarter. Performance standards will be measured by the DEPARTMENT on a QUARTERLY basis. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

315A Account Management

Performance Standards	Penalties
1) **CONTRACTOR Services:** The CONTRACTOR shall achieve a ninety-five percent (95%) satisfaction or better (defined as “top two-box” satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(See Section 270B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
2) **Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS and potential PARTICIPANTS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 270D, 1.)*	Five thousand ($5,000) dollars per incident

315B Claims Processing

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards.

Performance Standards	Penalties
1) **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 240.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
2) **Claims Processing Time:** At least ninety-five percent (95%) of all claims received must be processed within thirty (30) DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 240.)*	

315C Customer Service

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards.

Performance Standards	Penalties
1) **Call Answer Timeliness**: At least eighty percent (80%) of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 270C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
2) **Call Abandonment Rate:** Less than three 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 270C.)*	
3) **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 270C.)*	
4) **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 270C.)*	

315D Data Management

The DEPARTMENT will specify the timetable and dates for which the claims and provider data transfers must be provided.

Performance Standards	Penalties
1) **Claims Data Transfer:** The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a and 150B.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) **Provider Data Transfer:** The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Provider Data Specifications document, the specified data for all IN-NETWORK providers including subcontracted providers, and any OUT-OF-NETWORK providers for which the CONTRACTOR has processed or expects to process claims. *(See Section 150A, 5, b and 150B.)*	

Performance Standards	Penalties
3) Data File Corrections: Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT. *(See Sections 150A, 5, a and b.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
4) Notification of Data Breach: The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the PHI and/or PII of one (1) or more PARTICIPANTS may have been breached, or has been breached. The CONTRACTOR is required to report using the form provided by the DEPARTMENT. *(See Section 155F.)*	
5) The CONTRACTOR must provide a copy of any CMS Model Output Report (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 30 days of request.	
6) The CONTRACTOR must provide a copy of the Monthly Membership Report (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 by the end of the corresponding month.	

315E Enrollment

The CONTRACTOR shall report QUARTERLY any DAY for which any of the following standards are not met.

Performance Standards	Penalties
1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 150A, 4, a and c.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Enrollment Discrepancies and Exceptions: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. The CONTRACTOR must correct the differences on the exception report within five (5) BUSINESS DAYS of notification by the DEPARTMENT. *(See Section 150A, 4, a. and b.)*	

Performance Standards	Penalties
3) MEDICARE Disenrollment: The CONTRACTOR shall ensure that all PARTICIPANTS are enrolled in both MEDICARE PARTS A and B by the PARTICIPANT's coverage EFFECTIVE DATE. If a PARTICIPANT disenrolls from MEDICARE PARTS A or B after the EFFECTIVE DATE, the CONTRACTOR shall notify the DEPARTMENT on the day the CONTRACTOR identifies the PARTICIPANT as having disenrolled from PARTS A or B and the effective date. *(See Section 125B)*	
4) ID Cards: The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
5) ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID cards by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1 calendar year, as submitted on enrollment files generated on the first DAY of the IT'S YOUR CHOICE OPEN ENROLLMENT period through December 10. *(See Section 205B, 2.)*	
6) Direct Pay Terminations: The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section 2605.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

315F Other

Performance Standards	Penalties
1) mplementation and Go-Live Dates: All services shall take effective/'go live' and be fully operational on the due date specified in the Implementation Plan. *(See Section 270A.)*	Two hundred thousand for the first DAY and $20,000 for each subsequent DAY the deadline that services are not fully operational.
2) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155D.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one	

Performance Standards	Penalties
hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	
4) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident
5) Mail Order Dispensing Accuracy: At least ninety-nine (99%) percent of the time, prescriptions are dispensed accurately with no errors.	Twenty-five hundred ($2,500) dollars for each percentage point below the Performance Standard listed, assessed on a monthly basis.
6) Mail Order Shipping Time: At least ninety (90%) percent of clean prescriptions are shipped within two (2) business days. At least ninety-nine (99%) percent of prescriptions requiring intervention are shipped within five (5) business days.	Twenty-five hundred ($2,500) dollars for each percentage point below the Performance Standard listed, assessed on a monthly basis.
7) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. **8)** *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

400 UNIFORM BENEFITS

NOTE: Uniform Benefits are reviewed and updated annually. These Uniform Benefits will be updated with any benefit changes approved by the Group Insurance Board for 2019.

These are the Uniform Benefits or "Summary Plan Description" offered under the Medicare Advantage Program.

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

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

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

These Uniform Benefits are provided to a SUBSCRIBER who is a retired public employee under Wis. Stat. § 40.02 (25) (b) 11, or any DEPENDENT of such an employee, and, if eligible, has acted under Wis. Stat. § 40.51 (10) to elect group health insurance coverage.

I. Schedule of Benefits

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

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the PRESCRIPTION DRUG BENEFIT as provided for under the terms and conditions of the UNIFORM BENEFITS for those who are COVERED under the State of Wisconsin Health Benefit Program.

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

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

The covered benefits are subject to the following:

State of Wisconsin and Wisconsin Public Employer Medicare Retirees:
DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefits	PO1, PO2/12, PO6/16 or PO7/17 Benefit Plan	ALTERNATIVE BENEFIT DESIGN
Annual Medical **DEDUCTIBLE**	None.	
Annual Medical **COINSURANCE**	BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	
Annual medical **OUT-OF-POCKET LIMIT (OOPL)**	None except as described below for DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]	
Annual **MAXIMUM OUT-OF-POCKET (MOOP)**	Not applicable.	
*Routine, **Preventive Services** as required by federal law	Covered 100%.	
Primary Care Office Visit COPAYMENT applies to: • Family Practice • General Practice • Internal Medicine • Gynecology/Obstetrics • Midwives (if BENEFIT PLAN offers) • Nurse Practitioners • Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy • Speech Therapy	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	No medical COPAYMENTS.	
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	

Benefits	PO1, PO2/12, PO6/16 or PO7/17 Benefit Plan	ALTERNATIVE BENEFIT DESIGN
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.	
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL per PARTICIPANT; no family limit).[2]	
Cochlear Implants for PARTICIPANTS **age 18 and older**	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL CHARGES. MEDICARE/BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL or MOOP).	
Cochlear Implants for PARTICIPANTS **under age 18**	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	
Hearing Aids for PARTICIPANTS **age 18 and older**. One aid per ear no more than once every 3 years.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL or MOOP). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	
Hearing Aids for PARTICIPANTS **under age 18**	As required by Wis. Stat. §632.895 (16), covered 100%.	
Temporo- mandibular Joint Disorders	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: MEDICARE/BENEFIT PLAN pays 100%. Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures	

Benefits	PO1, PO2/12, PO6/16 or PO7/17 Benefit Plan	ALTERNATIVE BENEFIT DESIGN
	and nonsurgical treatment per PARTICIPANT per calendar year.	
Dental Implants	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	
Prescription Drugs	See below.	

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

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

Local / Wisconsin Public Employers (WPE) Medicare Retirees Only:
DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefits	**PO4/14 Benefit Plan**
Annual Medical **DEDUCTIBLE**	$500 individual / $1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). The family DEDUCTIBLE is EMBEDDED. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.
Annual Medical **COINSURANCE**	After DEDUCTIBLE: BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.
Annual Medical **OUT-OF-POCKET LIMIT (OOPL)**	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOPL.[1]
Annual **MAXIMUM OUT OF POCKET (MOOP)**	$6,850 PARTICIPANT / $13,700 family limit. The MOOP is EMBEDDED
*Routine, **Preventive Services** as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.
Primary Care Office Visit COPAYMENT applies to: • Family Practice • General Practice • Internal Medicine • Gynecology/ Obstetrics • Midwives (if BENEFIT PLAN offers) • Nurse Practitioners • Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy • Speech Therapy	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.

Benefits	**PO4/14 Benefit Plan**
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT. After COPAYMENT: DEDUCTIBLE applies.
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no family limit.[2]
Cochlear Implants for PARTICIPANTS **age 18 and older**	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES. BENEFIT PLAN/ MEDICARE pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL or MOOP).
Cochlear Implants for PARTICIPANTS **under age 18**	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.
Hearing Aids for PARTICIPANTS **age 18 and older.** One aid per ear no more than once every 3 years.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL or MOOP). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.
Hearing Aids for PARTICIPANTS **under age 18**	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.
Temporomandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN/ MEDICARE pays 100%. Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.
Dental Implants	After DEDUCTIBLE: BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.

Benefits	**PO4/14 Benefit Plan**
Prescription Drugs	See below.

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

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

[3]

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

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

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

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

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

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

7) Home Care Benefits Maximum: MEDICALLY NECESSARY visits when authorized by the HEALTH PLAN.

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

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

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

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

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

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

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

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

The PRESCRIPTION DRUG BENEFIT is subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

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

b) Preventive Prescription Drugs:

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

ii) The PBM will publish a list of prescriptions drugs on its website affected by these provisions.

Copayments/Coinsurance			
	Uniform Benefits	**Alternative Benefit Design**	
Level 1	$5 Copayment		Preferred GENERIC DRUGS and certain lower-cost preferred BRAND NAME DRUGS.
Level 2	20% Coinsurance ($50 max)		Preferred BRAND NAME DRUGS and certain higher-cost preferred GENERIC DRUGS.
Level 3	40% Coinsurance ($150 max)		Non-covered, non-preferred drugs for which alternative/equivalent preferred GENERIC DRUGS and BRAND NAME DRUGS are covered.
Level 4 (Preferred)	$50 Copayment		Includes only Preferred SPECIALTY MEDICATIONS filled at a PREFERRED SPECIALTY PHARMACY.
Level 4 (Non-Preferred)	40% Coinsurance ($200 max)		Non-Preferred SPECIALTY MEDICATIONS filled at a PREFERRED SPECIALTY PHARMACY **and** all SPECIALTY MEDICATIONS filled at a pharmacy **other than** a PREFERRED SPECIALTY PHARMACY.
Out-of-Pocket Limits			
	Uniform Benefits	**Alternative Benefit Design**	
Level 1 & 2	$600 individual / $1,200 family		

Level 3	$6,850 individual / $13,700 family	
Level 4 (Preferred)	$1,200 individual / $2,400 family	
Level 4 (Non-Preferred)	No Out-of-Pocket Limit	

Level 1/Level 2 Annual OOPL:

Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows: $600 per individual or $1,200 per family for all PARTICIPANTS. When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

Level 3 Annual OOPL:
Level 3 out-of-pocket costs accumulate toward OOPLs as follows: no annual OOPL. When the OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $6,850 individual / $13,700 family.

The maximum annual amount YOU pay for YOUR Level 4 Preferred SPECIALTY MEDICATIONS.

Level 4 Preferred SPECIALTY MEDICATIONS out-of-pocket costs accumulate toward OOPLs as follows: $1,200 per individual or $2,400 per family. When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

2) **Certain medications as defined by the PBM:** Certain medications as defined by the PBM are available to YOU at a discount but are not covered by the BENEFIT PLAN. These medications may include drugs for weight loss, infertility, and erectile dysfunction. YOU will pay 100% of the cost of these medications.

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

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

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits description in Section 400, are defined and limited to that meaning only:

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

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

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

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

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

ALLOWED AMOUNT: Means the maximum amount on which payment is based for covered health care services. Generally this is composed of the PROVIDER's CHARGE, less any discount negotiated by the HEALTH PLAN.

ALTERNATIVE BENEFIT DESIGN: Means an alternative benefit plan design option available to PARTICIPANTS under the HEALTH BENEFIT PROGRAM and defined in the SCHEDULE OF BENEFITS.

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

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

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

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

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

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

2) the HEALTH PLAN'S methodology guidelines,

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

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

5) other factors.

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

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

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

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

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it

can reasonably be expected, in the opinion of the IN-NETWORK PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the State of Wisconsin Department of Employee Trust Funds.

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

1) Spouse.[1]

2) Child.[2, 3, 4]

3) Legal ward who becomes a permanent legal ward of the SUBSCRIBER or SUBSCRIBER'S spouse prior to age 19. [2, 3, 4]

4) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.[2, 3, 4]

5) Stepchild.[1, 2, 3, 4]

6) Grandchild if the parent is a DEPENDENT child.[2, 3, 4, 5]

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

[2] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except when:

a) An unmarried DEPENDENT child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is DEPENDENT on the SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER should decease, the disabled adult DEPENDENT must still meet the remaining disabled criteria and be incapable of self-support. The CONTRACTOR will monitor eligibility annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The CONTRACTOR will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the CONTRACTOR determination.

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

[3] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

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

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

DURABLE MEDICAL EQUIPMENT: See MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT.

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

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

EMBEDDED: Means the individual portion of PARTICIPANT financial responsibility (DEDUCTIBLE, OOPL, MOOP) within the family's total financial responsibility. For example, when a PARTICIPANT within a family plan meets the individual DEDUCTIBLE, that PARTICIPANT is no longer responsible for any further DEDUCTIBLE. The remaining family DEDUCTIBLE will still apply to other family PARTICIPANTS.

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

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

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

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

Examples of EMERGENCIES are listed in Section III, A, 1, d. EMERGENCY 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 services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the HEALTH PLAN and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the HEALTH PLAN and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

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

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

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

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

HABILITATION SERVICES: Means 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 that is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the HEALTH PLAN.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

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

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

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses.

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

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The HEALTH PLAN agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the HEALTH PLAN in advance of the services being provided.

LEVEL “M” DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M

DRUGS are required to be on the MEDICARE PRESCRIPTION DRUG PLAN’S MEDICARE Part D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the HEALTH PLAN.

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the HEALTH PLAN after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

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

1) Used primarily to treat an ILLNESS or INJURY, and
2) generally not useful to a person in the absence of an ILLNESS or INJURY, and
3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and
4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the HEALTH PLAN and/or PBM:

1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and
2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and
3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and
4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

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

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for

MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

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

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this HEALTH PLAN.

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

NON-EMBEDDED: Means that families must meet the full family amount before benefits are paid.

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM'S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

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

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

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

4) Dietitian visit.

MAXIMUM OUT-OF-POCKET LIMIT (MOOP): Means the most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health care that YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

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 YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the ALLOWED AMOUNT. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit. The most YOU pay during a policy period (usually a calendar year) for benefits considered essential health benefits under federal law. This limit never includes YOUR premium, balance-billed charges, charges for health care YOUR BENEFIT PLAN does not cover, or services that are not considered essential health benefits.

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 under the PRESCRIPTION DRUG BENEFIT. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PHARMACY BENEFIT MANAGER (PBM): Depending on the plan you selected, the PBM maybe the HEALTH PLAN you selected, or a separate THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the PRESCRIPTION DRUG BENEFIT. 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.

PERSCRIPTION DRUG BENEFIT means coverage for prescriptions drugs subject to certain COPAYMENTS, DEDUCTIBLES, or COINSURANCE requirements, limitations and exclusions as described in UNIFORM BENEFITS.

POSTOPERATIVE CARE: Means the medical observation and care of a PARTICIPANT necessary for recovery from a covered surgical procedure.

PREFERRED DRUG: Means a drug the PBM has determined offers more value and/or cost-effective treatment options compared to a NON-PREFERRED DRUG. This would include Preferred GENERIC DRUGS, Preferred BRAND NAME DRUGS and Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program.

PREFERRED SPECIALTY PHARMACY: Means a PARTICIPATING PHARMACY which meets criteria established by the PBM to specifically administer SPECIALTY MEDICATION services, with

which the PBM has executed a written contract to provide services to PARTICIPANTS, which are administered by the PBM and covered under the policy. The PBM may execute written contracts with more than one PARTICIPATING PHARMACY as a PREFERRED SPECIALTY PHARMACY.

PREOPERATIVE CARE: Means the medical evaluation of a PARTICIPANT prior to a covered surgical procedure. It is the immediate preoperative visit in the HOSPITAL, or elsewhere, necessary for the physical examination of the PARTICIPANT, the review of the PARTICIPANT'S medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

PRIMARY CARE PROVIDER (PCP): Means an IN-NETWORK PROVIDER who is named as a PARTICIPANT'S primary health care contact. He/She provides entry into the health care system. He/She also (a) evaluates the PARTICIPANT'S total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other PROVIDER health services and refers the PARTICIPANT to other PROVIDERS.

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

PRIOR AUTHORIZATION: Means obtaining approval from YOUR HEALTH PLAN before obtaining the services. Unless otherwise indicated by YOUR HEALTH PLAN, PRIOR AUTHORIZATION is required for care from any 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 and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

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

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the HEALTH PLAN PRIOR AUTHORIZATION form and approved by the HEALTH PLAN in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each HEALTH PLAN and are described in the It's Your Choice materials. The authorization from the HEALTH PLAN will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED visits and the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the HEALTH PLAN before services are rendered.

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

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

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

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 Health Benefit 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.

SUBSCRIBER: An ANNUITANT or CONTINUANT who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits under the Group Health Insurance Program or Wisconsin Public Employer Program.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the 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 these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. HEALTH PLAN approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the 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.

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

III. Benefits and Services

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

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

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

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

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

A. Medical/Surgical Services

1) EMERGENCY Care

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

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

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

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

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

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

2) URGENT CARE

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

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

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

c) Some examples of URGENT CARE cases are:

   i) Most broken bones,

   ii) Minor cuts,

   iii) Sprains,

   iv) Most drug reactions,

   v) Non-severe bleeding, and

   vi) Minor burns.

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

   a) PREOPERATIVE and POSTOPERATIVE CARE, and

   b) Needed services of assistants and consultants.

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

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

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

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

   i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit in Section III, D.

   ii) IUDs and diaphragms, as described under the DURABLE MEDICAL EQUIPMENT provision in item C, 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if

correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

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

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

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

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy.

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

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

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

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

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

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

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the HEALTH PLAN. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the HEALTH PLAN.

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

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

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

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

14) Phase II Cardiac Rehabilitation

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

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

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

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

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

a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

e) Apicoectomy. (Excision of apex of tooth root.)

f) Excision of exostoses of the jaws and hard palate.

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

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

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

18) Transplants
The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the HEALTH PLAN in order to be a covered transplant.

Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

Limited to one transplant per organ (which applies to items b., e., f., and g. as listed below) per PARTICIPANT per HEALTH PLAN during the lifetime of the policy, except as required for treatment of kidney disease.

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

   i) Aplastic anemia

   ii) Acute leukemia

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

   iv) Wiskott-Aldrich syndrome

   v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

   vi) Hodgkins and non-Hodgkins lymphoma

   vii) Combined immunodeficiency

   viii) Chronic myelogenous leukemia

   ix) Pediatric tumors based upon individual consideration

   x) Neuroblastoma

   xi) Myelodysplastic syndrome

   xii) Homozygous Beta-Thalassemia

   xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

   xiv) Multiple Myeloma, Stage II or Stage III

   xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

      (3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the HEALTH PLAN.

h) In addition to the above-listed diagnoses for covered transplants, the HEALTH PLAN may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the HEALTH PLAN determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants in Section III, A, 18), donor-related services, and related physician CHARGES.

20) Chiropractic Services
When performed by an IN-NETWORK PROVIDER. Benefits are not available for MAINTENANCE CARE.

21) Women's Health and Cancer Act of 1998
Under the Women's Health and Cancer Act of 1998, coverage for medical and surgical benefits with respect to mastectomies includes:

a) Reconstruction of the breast on which a mastectomy was performed,

b) Surgery and reconstruction of the other breast to produce a symmetrical appearance,

c) Prostheses (see DURABLE MEDICAL EQUIPMENT in Section III, C, 3) and physical complications of all stages of mastectomy, including lymphedemas,

d) Breast implants.

22) Smoking Cessation
Coverage includes pharmacological products that by law require a written prescription and are described under the prescription drug benefits in Section III, D, 1, e. Coverage also includes 1 office visit for counseling and to obtain the prescription and four telephonic counseling sessions per calendar year. Additional counseling and/or limited extension of pharmacological products require PRIOR AUTHORIZATION by the HEALTH PLAN.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The HEALTH PLAN may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the HEALTH PLAN.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

   c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the HEALTH PLAN prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the HEALTH PLAN.

   a) Outpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "Outpatient services" means non-residential services by PROVIDERS as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37 and the federal Mental Health Parity and Addiction Equity Act (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.

   b) Transitional Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. Transitional care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by MHPAEA.

   c) Inpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS and as required by Wis. Stat. §632.89, Wis. Adm. Code § INS 3.37 and MHPAEA. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by an OUT-OF-NETWORK PROVIDER, if provided as required by an EMERGENCY detention or on an EMERGENCY basis and the PROVIDER notifies the HEALTH PLAN within 72 hours after the initial provision of service.

   d) Other
   Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section III, D, 1.

2) Durable Diabetic Equipment and Related Supplies
When prescribed by an IN-NETWORK PROVIDER for treatment of diabetes and purchased from an IN-NETWORK PROVIDER, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered **subject**

to cost sharing as outlined in the SCHEDULE OF BENEFITS. The PARTICIPANT'S COINSURANCE will be applied to the annual OOPL. Durable diabetic equipment includes:

a) Automated injection devices.

b) Continuing glucose monitoring devices.

c) Insulin infusion pumps, limited to one pump in a calendar year and YOU must use the pump for 30 days before purchase.

All DURABLE MEDICAL EQUIPMENT purchases or monthly rentals must be PRIOR AUTHORIZED as determined by the HEALTH PLAN.

(Glucometers are available through the PBM. Refer to Section III, D, 2 for benefit information.)

3) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT
When prescribed by an IN-NETWORK PROVIDER for treatment of a diagnosed ILLNESS or INJURY and purchased from an IN-NETWORK PROVIDER, MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered **subject to cost sharing as outlined in the SCHEDULE OF BENEFITS**.

The following MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered only when PRIOR AUTHORIZED as determined by the HEALTH PLAN:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the HEALTH PLAN, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the HEALTH PLAN.

k) Other medical equipment and supplies as approved by the HEALTH PLAN. Rental or purchase of equipment/supplies is at the option of the HEALTH PLAN.

l) When PRIOR AUTHORIZED as determined by the HEALTH PLAN, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the HEALTH PLAN will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

   a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

   b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the HEALTH PLAN. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the HEALTH PLAN. Additional visits may be approved by the HEALTH PLAN. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any HEALTH PLAN under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes

orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. These minimum coverage monetary amounts shall be adjusted annually beginning in 2011 as determined by the Office of Commissioner of Insurance. The therapy limit does not apply to this benefit.

D. Prescription Drugs and Other Benefits Administered by the PHARMACY BENEFIT MANAGER (PBM)

YOU must obtain pharmacy benefits at a PBM PARTICIPATING PHARMACY except when not reasonably possible because of EMERGENCY or URGENT CARE. In these circumstances, YOU may need to file a claim as described in the paragraph below.

If YOU do not show YOUR PBM identification card at the pharmacy at the time YOU are obtaining benefits, YOU may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, YOU may be responsible for more than the COPAYMENT amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the DEPARTMENT. Contact the PBM if YOU have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by the HEALTH PLAN.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 PREFERRED DRUGS will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 PREFERRED DRUGS.

The HEALTH PLAN, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED INJECTABLE).

MEDICARE eligible PARTICIPANTS will be covered by a MEDICARE Part D prescription drug plan (PDP) provided by the PBM. PARTICIPANTS who choose to be enrolled in another MEDICARE Part D PDP other than this PDP will not have benefits duplicated.

Where a MEDICARE PRESCRIPTION DRUG PLAN is the primary payor, the PARTICIPANT is responsible for the COPAYMENT plus any charges in excess of the PBM ALLOWED AMOUNT. The ALLOWED AMOUNT is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

In most instances, claims for MEDICARE Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for PARTICIPANTS with MEDICARE Part D coverage, will be submitted to the PBM for adjudication even when the HEALTH PLAN or a contracted PROVIDER administers the injection. If the HEALTH PLAN or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

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

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

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 PREFERRED DRUGS determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED INJECTABLES and narcotics are among those for which a 90-day supply is not available.

i) Tablet splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 PREFERRED DRUGS that the PARTICIPANT can split the tablet of a higher strength dosage at home. Under this program, the PARTICIPANT gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. PARTICIPANTS who use tablet splitting will pay half the normal COPAYMENT amount.

j) The PBM reserves the right to designate certain over-the-counter drugs on the FORMULARY.

k) SPECIALTY MEDICATIONS and SELF-ADMINISTERED INJECTABLES when obtained by prescription and which can safely be administered by the PARTICIPANT, must be obtained from a PBM PARTICIPATING PHARMACY OR PREFERRED SPECIALTY PHARMACY. In some cases, the PBM may need to limit availability to specific pharmacies.

This coverage includes investigational drugs for the treatment of HIV, as required by [Wis. Stat. § 632.895 (9)].

2) Insulin, Disposable Diabetic Supplies, Glucometers
The PBM will list approved products on the FORMULARY. PRIOR AUTHORIZATION is required for anything not listed on the FORMULARY.

a) Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30-consecutive-day supply for one prescription drug COPAYMENT, as described on the SCHEDULE OF BENEFITS.

b) Disposable Diabetic Supplies and Glucometers will be covered after a 20% COINSURANCE as outlined in the SCHEDULE OF BENEFITS when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The PARTICIPANT'S COINSURANCE will be applied to the annual OOPL for prescription drugs.

3) Other Devices and Supplies
Other devices and supplies administered by the PBM that are subject to a 20% COINSURANCE and applied to the annual OOPL for prescription drugs are as follows:

a) Diaphragms

b) Syringes/Needles

c) Spacers/Peak Flow Meters

IV. Exclusions and Limitations

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under Uniform Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by HEALTH PLANs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 10 applies only to the pharmacy benefit administered by the PBM. Some of the listed exclusions may be MEDICALLY NECESSARY, but still are not covered under this program, while others may be examples of services which are not MEDICALLY NECESSARY or not medical in nature, as determined by the HEALTH PLAN and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   c) Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment.

2) Medical Services

   a) Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits and Services Section.

   b) Expenses for medical reports, including preparation and presentation.

   c) Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; or (c) treatment of flexible flat feet. This exclusion does not apply when services are performed by an IN-NETWORK PROVIDER to treat a metabolic or peripheral disease or a skin or tissue infection.

   d) Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include NUTRITIONAL COUNSELING as provided in the Benefits and Services Section.

   e) Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).

f) Services of a blood donor. MEDICALLY NECESSARY autologous blood donations are not considered to be services of a blood donor.

g) Genetic testing and/or genetic counseling services, unless MEDICALLY NECESSARY to diagnose or treat an existing ILLNESS.

3) Ambulance Services

a) Ambulance service, except as outlined in the Benefits and Services Section, unless authorized by the HEALTH PLAN.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, and mandated benefits for autism spectrum disorders under Wis. Stat. § 632.895 (12m) therapies.

c) Physical fitness or exercise programs.

d) Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

e) Massage therapy.

5) Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental INJURY

a) All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the Benefits and Services Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits and Services Section. (Note: Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may limit this exclusion.)

b) All periodontic procedures, except gingivectomy surgery as listed in the Benefits and Services Section.

c) All oral surgical procedures not specifically listed in the Benefits and Services Section.

6) Transplants

   a) Transplants and all related services, except those listed as covered procedures.

   b) Services in connection with covered transplants unless PRIOR AUTHORIZED by the HEALTH PLAN.

   c) Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.

   d) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

   e) All separately billed donor-related services, except for kidney transplants.

   f) Non-human organ transplants or artificial organs.

7) Reproductive Services

   a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

   b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

   c) Services for storage or processing of semen (sperm); donor sperm.

   d) Harvesting of eggs and their cryopreservation.

   e) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

   f) Surrogate mother services.

   g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

   h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

   i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the HEALTH PLAN.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the HEALTH PLAN.

c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the HEALTH PLAN.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the HEALTH PLAN. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED INJECTABLE medications.

j) Charges for supplies and medicines purchased from a NON-PARTICIPATING PHARMACY, except when EMERGENCY or URGENT CARE is required.

k) Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM'S Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

l) Infertility and fertility medications.

m) Charges for medications obtained through a discount program or over the Internet, unless PRIOR AUTHORIZED by the PBM.

n) Charges to replace expired, spilled, stolen or lost prescription drugs.

11) General

a) Any additional exclusion as described in the SCHEDULE OF BENEFITS.

b) Services to the extent the PARTICIPANT is eligible for all MEDICARE benefits, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if the PARTICIPANT enrolled in MEDICARE coordinated coverage does not enroll in MEDICARE Part B when it is first available as the primary payor or who subsequently cancels MEDICARE coverage or is not enrolled in a MEDICARE Part D Plan.

c) Treatment, services and supplies for which the PARTICIPANT: (a) has no obligation to pay or which would be furnished to a PARTICIPANT without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

d) INJURY or ILLNESS caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.

e) Treatment, services and supplies for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.

f) Treatment, services and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services and supplies for which under the policy the HEALTH PLAN and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) MAINTENANCE CARE.

k) Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).

l) Personal comfort or convenience items or services such as in-HOSPITAL television, telephone, private room, housekeeping, shopping, homemaker services, and meal preparation services as part of home health care.

m) Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the BENEFIT PLAN.

n) Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

o) Expenses incurred prior to the 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. Except when a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under HEALTH PLANS during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding HEALTH PLAN will be the responsibility of the succeeding HEALTH PLAN unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding HEALTH PLAN'S network. In this instance, the liability will remain with the previous HEALTH PLAN.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the HEALTH PLAN and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the HEALTH PLAN.

   ii. EMERGENCIES in the SERVICE AREA when the PRIMARY CARE PROVIDER or another IN-NETWORK PROVIDER cannot be reached.

   iii. EMERGENCY or URGENT CARE services outside the SERVICE AREA. Non-urgent follow-up care requires PRIOR AUTHORIZATION from the HEALTH PLAN.

v) 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. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the HEALTH PLAN.

w) Coma stimulation programs.

x) Orthoptics (Eye exercise training) except for two sessions as MEDICALLY NECESSARY per lifetime. The first session for training, the second for follow-up.

y) Any diet control program, treatment, or supply for weight reduction.

z) Food or food supplements except when provided during a covered outpatient or inpatient CONFINEMENT.

aa) Services to the extent a PARTICIPANT receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation Act, employer's liability insurance plan or similar law or act. Entitled means YOU are actually insured under Worker's Compensation.

ab) Services related to an INJURY that was self-inflicted for the purpose of receiving HEALTH PLAN and/or PBM Benefits.

ac) Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires MEDICALLY NECESSARY treatment that is performed by 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. Non-covered services do not include any treatment or service that was covered and paid for under any HEALTH PLAN as part of this program.

ad) 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.

ae) Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services Section.

af) Any charges for, or in connection with, travel. This includes but is not limited to meals, lodging and transportation. An exception is EMERGENCY ambulance transportation.

ag) Sexual counseling services related to infertility.

ah) Services that a child's school is legally obligated to provide, whether or not the school actually provides the services and whether or not YOU choose to use those services.

ai) Hypnotherapy.

aj) Marriage/couples/family counseling.

ak) Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act.

al) Biofeedback.

B. Limitations

1) COPAYMENTS or COINSURANCE are required for:

   a) State of Wisconsin program PARTICIPANTS, except for retirees for whom MEDICARE is the primary payor, for all services unless otherwise required under federal and state law.

   b) State of Wisconsin PARTICIPANTS for whom MEDICARE is the primary payor, and for all PARTICIPANTS of the Wisconsin Public Employers program, and/or limitations apply to, the following services: DURABLE MEDICAL EQUIPMENT, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.

2) Benefits are limited for the following services: Replacement of NATURAL TEETH because of accidental INJURY, Oral Surgery, HOSPITAL Inpatient, licensed SKILLED NURSING FACILITY, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.

3) Use of OUT-OF-NETWORK PROVIDERS and HOSPITALS requires prior written approval by the PARTICIPANT'S PRIMARY CARE PROVIDER and the HEALTH PLAN to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the HEALTH PLAN'S and/or PBM'S Control: If, due to circumstances not reasonably within the control of the HEALTH PLAN and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the HEALTH PLAN and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the HEALTH PLAN, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

8) Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section V, the following words are defined as follows:

ALLOWABLE EXPENSE: means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more PLANS covering the person for whom the claim is made. The difference between the cost of a private HOSPITAL room and the cost of a semi-private HOSPITAL room is not considered an ALLOWABLE EXPENSE unless the patient's stay in a private HOSPITAL room is MEDICALLY NECESSARY either in terms of generally accepted medical practice or as specifically defined by the PLAN. When a PLAN provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an ALLOWABLE EXPENSE and a benefit paid.

However, notwithstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the SECONDARY PLAN will also be responsible for paying up to the maximum benefit allowed for its PLAN. This will not duplicate benefits paid by the PRIMARY PLAN.

CLAIM DETERMINATION PERIOD: means a calendar year. However, it does not include any part of a year during which a person has no coverage under THIS PLAN or any part of a year before the date this COB provision or a similar provision takes effect.

PLAN: means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:

1) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under MEDICAID (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does

not include any PLAN whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under a. or b. is a separate PLAN. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate PLAN.

PRIMARY PLAN / SECONDARY PLAN: The order of benefit determination rules state whether THIS PLAN is a PRIMARY PLAN or SECONDARY PLAN as to another PLAN covering the person.

When THIS PLAN is a SECONDARY PLAN, its benefits are determined after those of the other PLAN and may be reduced because of the other PLAN'S benefits.

When THIS PLAN is a PRIMARY PLAN, its benefits are determined before those of the other PLAN and without considering the other PLAN'S benefits.

When there are more than two PLANS covering the person, THIS PLAN may be a PRIMARY PLAN as to one or more other PLANS and may be a SECONDARY PLAN as to a different PLAN or PLANS.

THIS PLAN: means the part of YOUR Summary Plan Description (group contract) that provides benefits for health care and pharmaceutical expenses.

C. Order of Benefit Determination Rules

1) General
   When there is a basis for a claim under THIS PLAN and another PLAN, THIS PLAN is a SECONDARY PLAN that has its benefits determined after those of the other PLAN, unless:

   a) The other PLAN has rules coordinating its benefits with those of THIS PLAN, and

   b) Both those rules and THIS PLAN'S rules described in subparagraph 2 require that THIS PLAN'S benefits be determined before those of the other PLAN.

2) Rules
THIS PLAN determines its order of benefits using the first of the following rules which applies:

   a) Non-Dependent/DEPENDENT
      The benefits of the PLAN which covers the person as an employee or PARTICIPANT are determined before those of the PLAN which covers the person as a DEPENDENT of an employee or PARTICIPANT.

   b) DEPENDENT Child/Parents Not Separated or Divorced
      Except as stated in subparagraph 2, c below, when THIS PLAN and another PLAN cover the same child as a DEPENDENT of different persons, called "parents":

      i) The benefits of the PLAN of the parent whose birthday falls earlier in the calendar year are determined before those of the PLAN of the parent whose birthday falls later in that calendar year, but

ii) If both parents have the same birthday, the benefits of the PLAN which covered the parent longer are determined before those of the PLAN which covered the other parent for a shorter period of time.

However, if the other PLAN does not have the rule described in 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 C, 2, b.

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

d) Active/Inactive Employee
The benefits of a PLAN which covers a person as an employee who is neither laid off nor retired or as that employee's DEPENDENT are determined before those of a PLAN which covers that person as a laid off or retired employee or as that employee's DEPENDENT. If the other PLAN does not have this rule and if, as a result, the PLANS do not agree on the order of benefits, this paragraph d is ignored.

e) Continuation Coverage

i) If a person has continuation coverage under federal or state law and is also covered under another PLAN, the following shall determine the order of benefits:

(1) First, the benefits of a PLAN covering the person as an employee, member, or SUBSCRIBER or as a DEPENDENT of an employee, member, or SUBSCRIBER.

(2) Second, the benefits under the continuation coverage.

ii) If the other PLAN does not have the rule described in subparagraph 1, and if, as a result, the PLANS do not agree on the order of benefits, this paragraph e is ignored.

f) Longer/Shorter Length of Coverage
If none of the above rules determines the order of benefits, the benefits of the PLAN which covered an employee, member or SUBSCRIBER longer are determined before those of the PLAN which covered that person for the shorter time.

D. Effect on the Benefits of THIS PLAN

1) When This Section Applies
This section applies when, in accordance with Section C, Order of Benefit Determination Rules, THIS PLAN is a SECONDARY PLAN as to one or more other PLANS. In that event, the benefits of THIS PLAN may be reduced under this section. Such other PLAN or PLANS are referred to as "the other PLANS" in subparagraph 2 below.

2) Reduction in THIS PLAN'S Benefits
The benefits of THIS PLAN will be reduced when the sum of the following exceeds the ALLOWABLE EXPENSES in a CLAIM DETERMINATION PERIOD:

a) The benefits that would be payable for the ALLOWABLE EXPENSES under THIS PLAN in the absence of this COB provision, and

b) The benefits that would be payable for the ALLOWABLE EXPENSES under the other PLANS, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of THIS PLAN will be reduced so that they and the benefits payable under the other PLANS do not total more than those ALLOWABLE EXPENSES.

When the benefits of THIS PLAN are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of THIS PLAN.

E. Right to Receive and Release Needed Information

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

F. Facility of Payment

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

G. Right of Recovery

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

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

2) Insurance companies, or

3) Other organizations.

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

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the HEALTH PLAN and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the HEALTH PLAN and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the HEALTH PLAN, provide any relevant and reasonably available information which the HEALTH PLAN believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the HEALTH PLAN and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the HEALTH PLAN'S/PBM'S claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The HEALTH PLAN, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the HEALTH PLAN, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The HEALTH PLAN may employ a professional staff to provide case management services. As part of this case management, the HEALTH PLAN or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the HEALTH PLAN agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the HEALTH PLAN'S recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the HEALTH PLAN. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

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

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the HEALTH PLAN or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

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

Each PARTICIPANT agrees to reimburse the HEALTH PLAN and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the HEALTH PLAN and/or PBM. At the option of the HEALTH PLAN and/or PBM, benefits for future CHARGES may be reduced by the HEALTH PLAN and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

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

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a HEALTH PLAN or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the 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 DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

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

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the HEALTH PLAN or DEPARTMENT to such extent.

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

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the HEALTH PLAN or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the HEALTH PLAN or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the HEALTH

PLAN or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the HEALTH PLAN or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the HEALTH PLAN or DEPARTMENT for all amounts theretofore or thereafter paid by the HEALTH PLAN or DEPARTMENT which would have otherwise been recoverable under such acts and the HEALTH PLAN or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the HEALTH PLAN or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the HEALTH PLAN and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the 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 YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the HEALTH PLAN and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the HEALTH PLAN and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating HEALTH PLANs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the HEALTH PLAN'S and/or PBM'S administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the HEALTH PLAN and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the HEALTH PLAN and/or PBM. Contact the HEALTH PLAN and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the HEALTH PLAN'S and/or PBM'S GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the HEALTH PLAN and/or PBM. The HEALTH PLAN and/or PBM will advise YOU of YOUR right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the HEALTH PLAN and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through an external review process under applicable federal or state law. YOU may request an external review. In this event, YOU must notify the TPA and/or PBM of YOUR request. Any decision rendered through an external review is final and binding in accordance with applicable federal or state law. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the HEALTH PLAN'S or PBM'S GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an external review decision that is final and binding has been rendered in accordance with applicable federal or state law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the 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 Group Insurance Board.

State/Country	Subscribers	Dependents	Total
AK	5	1	6
AL	19	7	26
AR	22	9	31
AZ	245	109	354
CA	185	80	265
CO	102	45	147
CT	10	4	14
DC	6	2	8
DE	3	1	4
FL	485	223	708
GA	40	21	61
HI	16	5	21
IA	52	20	72
ID	12	3	15
IL	147	61	208
IN	25	6	31
KS	14	5	19
KY	10	3	13
LA	4	2	6
MA	31	14	45
MD	25	9	34
ME	11	7	18
MI	94	46	140
MN	300	116	416
MO	36	14	50
MS	11	4	15
MT	19	6	25
NC	68	39	107
ND	5	2	7
NE	11	3	14
NH	4	1	5
NJ	9	5	14
NM	35	12	47
NV	32	12	44
NY	37	14	51
OH	32	13	45
OK	15	5	20
OR	53	21	74
PA	21	6	27
RI	3	0	3
SC	36	17	53
SD	13	8	21
TN	37	12	49
TX	109	43	152
UT	25	12	37
VA	42	15	57

VI	1	1	2
VT	10	4	14
WA	89	34	123
WV	4	2	6
WY	8	2	10
Total US	**2628**	**1106**	**3734**
CANADA	2	2	4
FRANCE	1	2	3
GERMANY	3	0	3
INDIA	1	1	2
ISRAEL	2	1	3
LATVIA	1	0	1
NEW ZEALAND	1	0	1
PHILIPPINES	1	0	1
SINGAPORE	2	0	2
SWEDEN	1	0	1
THAILAND	1	0	1
TURKEY	1	1	2
UNITED KINGDO	1	1	2
Total	**2646**	**1114**	**3760**

High Deductible Health Plan Preventive Drug List

Updated July 2015

Your employer is making an effort to reduce your health care costs by giving you tools to help you stay healthy and productive. Below are the medications your employer has chosen to be included in the High Deductible Health Plan Preventive Drug list described in detail in your benefit plan. These medications help protect against or manage some high risk medical conditions. Taking these medications as directed by your prescriber can help avoid serious health problems. That may mean fewer doctor visits and hospitalizations, reducing your total health care costs.

In the drug list below, generic drugs are shown in lowercase type. Brand name drugs are shown in uppercase type.

ANTIANGINAL AGENTS

DILATRATE SR CAP
isosorbide dinitrate ER tab
isosorbide dinitrate SL tab
isosorbide dinitrate tab
ISOSORBIDE DINITRATE TAB 30MG, 40MG
isosorbide mononitrate ER tab
isosorbide mononitrate tab
NITRO-BID OINT
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR
nitroglycerin lingual spray
nitroglycerin patch
nitroglycerin SR cap
NITROMIST AEROSOL
NITROSTAT SL TAB
RANEXA TAB

ANTIARRHYTHMICS

amiodarone tab
disopyramide cap
disopyramide ER cap
flecainide tab
mexiletine cap
MULTAQ TAB
NORPACE CR CAP
propafenone ER cap
propafenone tab
quinidine gluconate CR tab
QUINIDINE SULFATE ER TAB
quinidine sulfate tab
QUINIDINE SULFATE TAB 200MG
TIKOSYN CAP

ANTIDIABETICS

acarbose tab
ACTOPLUS MET XR TAB
AVANDAMET TAB
AVANDARYL TAB
AVANDIA TAB
B-D INSULIN SYRINGE
B-D PEN NEEDLE
BYDUREON INJ

- Note: The list is subject to change and not all drugs listed may be covered on your formulary. Please refer to your Navitus formulary for a complete list of covered products.

BYDUREON PEN INJ
BYETTA INJ
CHLORPROPAMIDE TAB
CYCLOSET TAB
DIABETA TAB
FARXIGA TAB
FREESTYLE INSULIN SYRINGE
glimepiride tab
glipizide ER tab
glipizide tab
glipizide/metformin tab
GLUCAGEN HYPOKIT INJ
GLUCAGON INJ KIT
glyburide micronized tab
glyburide tab
glyburide/metformin tab
GLYSET TAB
HUMULIN R INJ U-500
INVOKAMET TAB
INVOKANA TAB
JANUMET TAB
JANUMET XR TAB
JANUVIA TAB
JARDIANCE TAB
JENTADUETO TAB
JUVISYNC TAB
KAZANO TAB
KOMBIGLYZE XR TAB
KORLYM TAB
LANTUS INJ
LANTUS SOLOSTAR INJ
LEVEMIR FLEXPEN INJ
LEVEMIR INJ
metformin ER tab
metformin tab
nateglinide tab
NESINA TAB
NOVOFINE PEN NEEDLE
NOVOLIN INJ VIAL
NOVOLOG FLEXPEN INJ
NOVOLOG INJ
NOVOLOG MIX 70/30 FLEXPEN INJ
NOVOLOG MIX INJ 70/30
NOVOLOG PENFILL INJ
NOVOTWIST PEN NEEDLE
NOVOTWIST/NOVOFINE PEN NEEDLE
ONGLYZA TAB
OSENI TAB
pioglitazone tab
pioglitazone/glimepiride tab
pioglitazone/metformin tab
PRANDIMET TAB
PRECISION INSULIN SYRINGE
PROGLYCEM SUSP
repaglinide tab
RIOMET SOLN
tolazamide tab
TOLBUTAMIDE TAB
TOUJEO SOLOSTAR INJ
TRADJENTA TAB
TRULICITY INJ
VICTOZA INJ
XIGDUO XR TAB
XIGDUO XR TAB 5-1000MG

ANTIHYPERLIPIDEMICS

ADVICOR TAB
ALTOPREV TAB
ANTARA CAP
atorvastatin tab
cholestyramine lite powder

- Note: The list is subject to change. Please always refer to your Navitus formulary for a complete list of covered products.

cholestyramine lite powder pack
cholestyramine powder
cholestyramine powder pack
colestipol granule
colestipol powder packet
colestipol tab
CRESTOR TAB
CRESTOR TAB 20MG
fenofibrate cap
fenofibrate micronized cap 130mg
fenofibrate micronized cap 43mg
fenofibrate tab
FENOGLIDE TAB
FIBRICOR TAB
fluvastatin cap
gemfibrozil tab
LESCOL XL TAB
LIPTRUZET TAB
LIVALO TAB
LOFIBRA CAP
LOFIBRA TAB
lovastatin tab
NIACOR TAB
omega-3-acid ethyl esters cap
pravastatin tab
SIMCOR TAB
simvastatin tab
simvastatin tab 80mg
VYTORIN TAB
VYTORIN TAB 10-80MG
WELCHOL PAK
WELCHOL TAB
ZETIA TAB

ANTIHYPERTENSIVES

ALTACE TAB
amlodipine/benazepril cap
amlodipine/valsartan tab
amlodipine/valsartan/hydrochlorothiazide tab
AMTURNIDE TAB
atenolol/chlorthalidone tab
AZOR TAB
benazepril tab
benazepril/hydrochlorothiazide tab
bisoprolol/hydrochlorothiazide tab
candesartan tab
candesartan/hydrochlorothiazide tab
captopril tab
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB
captopril/hydrochlorothiazide tab
clonidine patch
clonidine tab
DIBENZYLINE CAP
doxazosin tab
DUTOPROL TAB
EDARBI TAB
EDARBYCLOR TAB
enalapril tab
enalapril/hydrochlorothiazide tab
eplerenone tab
eprosartan mesylate tab
fosinopril tab
fosinopril/hydrochlorothiazide tab
GUANABENZ TAB
guanfacine IR tab
hydralazine tab
irbesartan tab
irbesartan/hydrochlorothiazide tab

- Note: The list is subject to change. Please always refer to your Navitus formulary for a complete list of covered products.

lisinopril tab
lisinopril/hydrochlorothiazide tab
losartan tab
losartan/hydrochlorothiazide tab
methyldopa tab
methyldopa/hydrochlorothiazide tab
metoprolol/hydrochlorothiazide tab
minoxidil tab
moexipril tab
moexipril/hydrochlorothiazide tab
NEXICLON XR SUSP
NEXICLON XR TAB
perindopril tab
prazosin cap
propranolol/hydrochlorothiazide tab
quinapril tab
quinapril/hydrochlorothiazide tab
ramipril cap
RESERPINE TAB
TEKAMLO TAB
TEKTURNA HCT TAB
TEKTURNA TAB
telmisartan tab
telmisartan/amlodipine tab
terazosin cap
TEVETEN HCT TAB
TEVETEN TAB 400MG
trandolapril tab
trandolapril/ verapamil ER tab
TRIBENZOR TAB
valsartan tab
valsartan/hydrochlorothiazide tab
VALTURNA TAB

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

anastrozole tab
bicalutamide tab
EMCYT CAP
exemestane tab
FARESTON TAB
flutamide cap
letrozole tab
LYSODREN TAB
megestrol susp
megestrol tab
NILANDRON TAB
tamoxifen tab
XTANDI CAP
ZYTIGA TAB

BETA BLOCKERS

acebutolol cap
atenolol tab
betaxolol tab
bisoprolol tab
BYSTOLIC TAB
carvedilol tab
COREG CR CAP
labetalol tab
LEVATOL TAB
metoprolol ER tab
metoprolol tab
nadolol tab
pindolol tab
propranolol ER cap
PROPRANOLOL SOLN
PROPRANOLOL SOLN
propranolol tab
sotalol AF tab
sotalol tab
timolol maleate tab

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CALCIUM CHANNEL BLOCKERS

amlodipine tab
CARDENE SR CAP
CARDIZEM LA TAB
COVERA-HS TAB
diltiazem ER cap
diltiazem tab
DYNACIRC CR TAB
felodipine ER tab
isradipine cap
matzim LA tab
nicardipine cap
nifedipine cap
nifedipine ER tab
nimodipine cap
nisoldipine ER tab
NISOLDIPINE ER TAB 25.5MG
verapamil SR cap
verapamil SR tab
verapamil tab
VERAPAMIL TAB 40MG

CARDIAC GLYCOSIDES

digoxin soln
digoxin tab

CARDIOVASCULAR AGENTS - MISC.

amlodipine/atorvastatin tab

CONTRACEPTIVES

amethyst tab
apri tab
aranelle tab
aviane tab
balziva tab
BEYAZ TAB
CERVICAL CAP
cesia tab
CONTRACEPTIVE FILM
CONTRACEPTIVE FOAM
CONTRACEPTIVE GEL
CONTRACEPTIVE SUPPOSITORIES
cryselle tab
DEPO-PROVERA SC INJ 104MG
DIAPHRAGM
ELLA TAB
enpresse tab
FEMALE CONDOMS
FEMCON FE CHEW TAB
IMPLANON IMPLANT
jolessa tab/ amethia tab
junel FE tab
junel tab
kariva tab
kelnor tab
levonorgestrel tab
LEVONORGESTREL TAB 0.75MG
LO LOESTRIN TAB
LO MINASTRIN 24 FE CHEW TAB
LOESTRIN 24 FE TAB
medroxyprogesterone inj
MINASTRIN CHEW TAB
MIRENA IUD
mononessa tab
NATAZIA TAB
necon tab
necon tab 1/50
nora-be tab
NORINYL TAB 1/50
NUVARING
OGESTREL TAB
ORTHO TRI-CYCLEN LO TAB

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OVCON 50 TAB
PARAGARD IUD
TODAY SPONGE
tri lo-sprintec tab
tri-legest tab
trinessa tab
xulane patch
YASMIN TAB
zeosa chew tab

DIAGNOSTIC PRODUCTS

ACCU-CHEK AVIVA PLUS METER
ACCU-CHEK AVIVA PLUS TEST STRIP
ACCU-CHEK AVIVA PLUS TEST STRIPS
ACCU-CHEK CALIBRATION LIQUID
ACCU-CHEK NANO METER
ACCU-CHEK SMARTVIEW TEST STRIP
ACCU-CHEK TEST STRIP
CLINISTIX
FREESTYLE CALIBRATION LIQUID
FREESTYLE FREEDOM LITE METER
FREESTYLE INSULINX METER
FREESTYLE INSULINX TEST STRIP
FREESTYLE LITE METER
FREESTYLE TEST STRIP
KETO-DIASTIX
KETOSTIX
LANCET DEVICE
LANCETS
PRECISION CALIBRATION LIQUID
PRECISION XTRA METER
PRECISION XTRA TEST STRIP
V-GO INJ KIT

DIURETICS

acetazolamide ER cap
acetazolamide tab
ACETAZOLAMIDE TAB 125MG
amiloride tab
amiloride/hydrochlorothiazide tab
bumetanide tab
chlorothiazide tab
CHLOROTHIAZIDE TAB 250MG
CHLORTHALIDONE TAB
DIURIL SOLN
DYRENIUM CAP
EDECRIN TAB
FUROSEMIDE SOLN
furosemide soln
furosemide tab
hydrochlorothiazide cap
hydrochlorothiazide tab
indapamide tab
methazolamide tab
METHYLCLOTHIAZIDE TAB
metolazone tab
spironolactone tab
spironolactone/hydrochlorothiazide tab
torsemide tab
triamterene/hydrochlorothiazide cap
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg
triamterene/hydrochlorothiazide tab

ENDOCRINE AND METABOLIC AGENTS - MISC.

alendronate tab
ALENDRONATE TAB 40MG
calcitonin nasal spray
etidronate disodium tab 200mg
ETIDRONATE DISODIUM TAB 400MG
FORTEO INJ
FORTICAL NASAL SPRAY
FOSAMAX SOLN

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FOSAMAX+D TAB
ibandronate tab 150mg
MIACALCIN INJ
risedronate DR tab
SKELID TAB

HEMATOLOGICAL AGENTS - MISC.

AGGRENOX CAP
anagrelide cap
BRILINTA TAB
cilostazol tab
clopidogrel tab 75mg
dipyridamole tab
EFFIENT TAB
pentoxifylline ER tab
ticlopidine tab

LAXATIVES

KRISTALOSE PACKET
lactulose soln
MOVIPREP SOLN
peg 3350/electrolytes soln
trilyte soln

MINERALS & ELECTROLYTES

FLUORABON SOLN
FLUOR-A-DAY CHEW TAB
GALZIN CAP
KLOR-CON M15 TAB
KLOR-CON POWDER 25MEQ
K-PHOS TAB
phospha 250 neutral tab
potassium bicarbonate effer tab
potassium chloride effer tab
potassium chloride ER cap
POTASSIUM CHLORIDE ER TAB
potassium chloride ER tab
potassium chloride liquid
potassium chloride micro tab
potassium chloride powder packet
sodium fluoride chew tab
sodium fluoride soln
SODIUM FLUORIDE TAB
SSKI SOLN
zinc sulfate cap

MOUTH/THROAT/DENTAL AGENTS

chlorhexidine gluconate soln
sodium fluoride cream
sodium fluoride gel
sodium fluoride paste
sodium fluoride rinse
sodium fluoride-potassium nitrate paste
triamcinolone in orabase paste

SMOKING CESSATION

bupropion tab
CHANTIX PAK
CHANTIX TAB
nicotine gum
NICOTINE KIT
nicotine lozenge
nicotine patch
NICOTROL INHALER
NICOTROL NASAL SPRAY

VACCINES

ADACEL INJ
BEXSERO INJ
BOOSTRIX INJ
CERVARIX INJ
ENGERIX B INJ
EZ FLU SHOT KIT
FLUBLOK INJ
FLUCELVAX INJ
FLULAVAL QUADRIVALENT INJ
FLUMIST NASAL
FLUVIRIN INJ

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FLUVIRIN PF INJ
FLUZONE HIGH DOSE PF INJ
FLUZONE INJ
FLUZONE INTRADERMAL
FLUZONE QUAD INJ
FLUZONE SPLIT QUAD INJ
GARDASIL 9 INJ
GARDASIL INJ
HAVRIX INJ
MENACTRA INJ
MENHIBRIX INJ
MENOMUNE INJ
MENVEO INJ
MMR INJ
PNEUMOVAX INJ
PREVNAR 13 INJ
RECOMBIVAX HB INJ
TETANUS/DIPHTHERIA INJ
TRUMENBA INJ
TWINRIX INJ
VAQTA INJ
VARIVAX INJ
VIVOTIF CAP
ZOSTAVAX INJ

VITAMINS

PRENATAL VITAMINS (NON-PREFERRED)
PRENATAL VITAMINS (PRENATAL PLUS/ PREPLUS/ PRENAPLUS)

- Note: The list is subject to change. Please always refer to your Navitus formulary for a complete list of covered products.

Share a Clear View

Health Care Reform
Preventive Drug Coverage Guidelines

Updated September 2015

The Affordable Care Act (ACA) requires that eligible people get certain preventive services at no cost. The following four categories and related drugs are clinical recommendations in the ACA. They are included in the ACA as preventive services. The ACA was passed in 2010.

Breast Cancer Prevention

Prescribe for women who are at increased risk of breast cancer (5-year risk of three percent or greater) and at a low risk for adverse drug effects. This applies to women without symptoms age 35 years or older. Also, they should not have a prior diagnosis of breast cancer, ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS). These drugs should not be used in women who have a history of thromboembolic events (deep venous thrombosis, pulmonary embolus, stroke, or transient ischemic attack).

Medications	Coverage Guideline	Age Guideline
tamoxifen	20 mg daily for up to 5 years	Women, age 35 and older
raloxifen (Evista equivalent)	60 mg daily for up to 5 years	Postmenopausal women

Colorectal Cancer Screening

Medications	Coverage Guideline	Age Guideline
Bowel Prep: Peg 3350/electrolytes solution and trilyte	Limited to 2 fills/calendar year	Covered for screening for colorectal cancer in adults between the ages of 50 and 75.

Heart Attack Prevention

Medications	Coverage Guideline	Age Guideline
Aspirin	Prescribe when potential benefit (due to reduced heart attacks) outweighs the potential harm (due to an increase in GI hemorrhage) in men ages 45-79 years and women ages 55-79 years.	Aspirin is covered for pregnant women who are at high risk for preeclampsia and for men between the ages of 45 and 79.

Smoking Cessation		
Medications	**Coverage Guideline**	**Age Guideline**
buproprion (Zyban equivalent) **Nicotrol Nasal Spray** **Nicotrol Inhaler** **Nicotine Kits** **nicotine patch** (Nicoderm equivalent) **nicotine gum** (Nicorette equivalent) **nicotine lozenge** (Commit equivalent) **Chantix**	Provide tobacco cessation intervention to those adults that use tobacco products. Includes FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications)	18 years and older

Vitamins and Minerals		
Medications	**Coverage Guideline**	**Age Guideline**
Fluoride	Prescribe to preschool children older than 6 months of age whose primary water source is deficient in fluoride.	Fluoride needs to be covered for children of both sexes: ages 0 months to five years.
Folic Acid	Prescribe to women planning or capable of pregnancy as a daily supplement containing 0.4 to 0.8 mg (400 to 800 ug) of folic acid.	No age guidelines.
Iron	Prescribe to children aged 6 to 12 months who are at increased risk of iron deficiency anemia.	Iron needs to be covered for children of both sexes: ages 0 months to 1 year.
Vitamin D 400unit & 1000unit	Covered for men and women 65 years or older.	Prevention of falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.