State of Wisconsin

SENATE CHAIR
Alberta Darling

317 East, State Capitol
P.O. Box 7882
Madison, WI 53707-7882
Phone: (608) 266-5830

ASSEMBLY CHAIR
John Nygren

309 East, State Capitol
P.O. Box 8593
Madison, WI 53708-8953
Phone: (608) 266-2343

Joint Committee on Finance

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative John Nygren

Date: May 8, 2017

Re: 14-Day Passive Review Approval – ETF

Pursuant to s. 40.03(6)(L), Stats., attached is a 21-day passive review request from the Department of Employee Trust Funds, received on May 8, 2017.

Please review the material and notify **Senator Darling** or **Representative Nygren** no later than **Monday, June 5, 2017,** if you have any concerns about the request or if you would like the Committee to meet formally to consider it.

Also, please contact us if you need further information.

Attachments

AD:JN:jm

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
etf.wi.gov

May 8, 2017

The Honorable Alberta Darling, Co-Chair
Joint Committee on Finance
317 East, State Capitol
Madison, WI 53701

The Honorable John Nygren, Co-Chair
Joint Committee on Finance
309 East, State Capitol
Madison, WI 53701

MAY 08 2017
Jt. Finance

Dear Senator Darling and Representative Nygren:

We are pleased to notify the Joint Committee on Finance (Committee) that the Department of Employee Trust Funds (Department) has successfully negotiated three year self-insurance contracts with optional renewals to save the State of Wisconsin at least $60 million in General Purpose Revenue (GPR) over the 2017-2019 biennial budget.

The contracts presented do not change the benefits that the employees receive, rather they change the financing of those benefits. As a result of the Department's proposed shift to a self-insurance model, these contracts will realize the $60 million of savings included in the biennial budget. Under current law, an additional $32.5 million in Affordable Care Act (ACA) taxes will be avoided annually.

The Department is prepared to execute contracts with the following Third Party Administrators (TPAs):

Statewide/Nationwide Vendor

- Compcare Health Services Insurance Corporation (Anthem Blue Cross Blue Shield)

Eastern Regional Vendors

- Compcare Health Services Insurance Corporation (Anthem Blue Cross Blue Shield)
- Network Health Administrative Services, LLC

Northern Regional Vendor

- Security Administrative Services

Southern Regional Vendors

- Dean Health Plan Inc.
- SPWI TPA, Inc. (Quartz)

Western Regional Vendor

- HealthPartners Administrators, Inc.

The contracts provide self-insured group health plans on a regional and statewide basis to state employees, effective January 1, 2018. Consistent across the vendors, the contracts are for a three-year term, with options for three, two-year renewals. This letter and the attached contracts are being submitted as required under Wis. Stats. § 40.03 (6)(L).

To ensure financial performance, the contracts include discount guarantees, and shared-savings arrangements tied to quality-of-care performance measures to incent cost containment and improved quality. The contracts also include performance guarantees that will hold vendors financially accountable for performance pertaining to customer service, claims processing, enrollment, account management, and other measures.

We ask that the Committee recognize the unique nature of the statewide/ nationwide contract. This contract replaces the current self-insured health benefit program and Medicare Supplement program administered by Wisconsin Physicians Service (WPS). This is the only benefit offering that provides members with nationwide coverage options. The current contract with WPS expires December 31, 2017. If the Committee rejects this contract, it would leave the Department without an administrator for these programs for 2018, and without sufficient time to execute a procurement process. Special consideration for this contract is appreciated.

To ensure the Department has been responsive to Committee members' questions about the self-insurance and regionalization recommendations, the following is a discussion of the issues raised by Committee members during its meeting on March 28, 2017.

Why Self-Insure: Research & Analysis

The Group Insurance Board (Board) began investigating the merits of self-insuring the program in 2012. Like many large employers that were fully-insured at the time, the Board was concerned about exposure to a new tax on insurers included in the Affordable Care Act (ACA), which could be avoided by self-insuring. In researching the issue over the past several years, the Board and the Department learned the following:

- The National Conference on State Legislatures indicates that 46 states either completely or partially self-insure their health benefits.
- Almost all large employers self-insure their health benefits (94% of employers with more than 5000 employees).
- Self-insuring health care benefits ensures that employers have access to data about their plans' health care costs and utilization.
- Employers that self-insure save money by avoiding Wisconsin premium taxes, insurer risk charges, and the ACA insurer tax.

- The current fully-insured managed competition model has been successful at keeping annual rate increases low over time and yet costs remain high compared to other states, even when controlling for benefit design.
- Self-insurance can be implemented within a regional model to maintain competition among the health plans, maintain provider choice, maximize savings, and maintain benefits for members.

Self-insurance is a widely used strategy by both private and public sector employers. Self-insuring also lays the groundwork for additional Board initiatives to reduce costs and improve care by ensuring access to program data and by allowing the Board and the Department to establish long-term partnerships with a small corps of high-quality, competitive health plans.

Fundamentals of Self-Insurance

Risk Transfer

In a self-insured structure, the state will assume the risk for claims costs. In a fully-insured environment, the state pre-pays premiums for anticipated health care costs. If actual claims are lower than anticipated, the insurer profits. If claims are higher than anticipated, the insurer profits less, or potentially loses money in that year. However, the insurer will aim to make up for those losses by charging higher premiums the following year.

In a self-insured environment, the state pays medical claims as those claims occur, and therefore realizes the costs of those claims sooner. If claims are lower than anticipated, the state realizes the savings instead of the insurer. If claims are higher than anticipated, the state incurs the higher cost immediately, rather than experiencing higher premiums the following year. To mitigate against the risk of potential higher than anticipated costs, the state has established, and will continue to maintain, adequate reserves.

Establishing Reserves

Claim reserves must be set up to pay for services that are received, and can also temporarily protect an employer if revenue from premium payments are not sufficient to cover claims if risk is unusually high. However, if used for such purposes, an employer should take steps to restore reserves for the future through future higher premium payments.

Because a portion of the State Group Health Benefit Program is already self-insured, reserves already exist. As of December 31, 2016, those reserves are $165 million. The Board, based on the advice of its actuaries, has a policy that reserves should be set at 15-25% of annual claims. The current reserves are sufficient to comply with the Board reserves policy in a completely self-insured program restructure.

Elimination of the Risk Charge
The health risk of employees can be better or worse from year to year. In a fully-insured model, insurers anticipate this in their premium and build in a risk charge to compensate themselves for the uncertainty of whether they are going to have a good year (meaning state employees had fewer catastrophic costs) or a bad year (they had more catastrophic costs). In a good year, the insurer earns a profit. In a bad year, the insurer experiences a loss and tries to make up for that loss in the premium bid the following year. Regardless of whether an insurer has a good year or a bad year, the insurer includes that risk charge each year and it is currently estimated at 1-2% of premium across all the plans. The risk charge is completely eliminated in a self-insurance model.

Stop Loss Insurance
Stop loss insurance is often purchased by self-insured employers to protect themselves against exceptionally high cost claims. However, employer groups the size of the state program would not normally purchase stop loss insurance since experience should be relatively stable in a group of this size, and reserves should be sufficient to absorb such catastrophic claims. Segal Consulting (Segal), the Board's consulting actuary, has advised the Board that stop loss insurance is unnecessary and would create an additional, unnecessary expense.

If the Legislature is concerned about this low probability occurrence, the state could choose to initially purchase stop loss insurance to protect against claims fluctuation concerns and provide greater stability and predictability in the initial implementation. Stop loss insurance is typically purchased based on an attachment point, the point at which the insurance starts to pay on a specific claim. Segal has calculated that a stop loss policy with a $1 million attachment point would cost $4 million annually. Estimates are available based on a different attachment points; however, more precise estimates would require a formal bid process with stop loss insurance carriers.

Learning from Previous Experiences
The Board and the Department are taking steps to ensure experiences of the past are not repeated by including the following provisions in the health plan contracts:

- Including TPA discount guarantees which provide protection that provider prices will not increase beyond certain reasonable inflationary amounts;
- Requiring improvements in provider pricing over the course of the contract to ensure the health plans are seeking to improve their contracts with health care providers over time;
- Including gain sharing incentives tied to performance on quality benchmarks to reward those health plans that perform well on quality measures and achieve additional savings above and beyond those savings anticipated in their initial bids.

While these provisions cannot guarantee that the state will not have some high risk years, they will offer protections that were not in place previously and put the state in a

much better place to mitigate against the risk of cost and/or utilization increases in the future.

Impact on Members

Under our current structure, premiums can fluctuate from year to year and employees experience annual disruptions in available providers and health plans. The contracts negotiated by the Department will create more premium stability via the contract duration and the anticipated disruptions are not greater than in any other year.

Premiums

The Division of Personnel Management at the Department of Administration is responsible for establishing the employee share of premium for most state employees, but typically the employee share trend has followed the overall trend in premium. For 2018, it is expected that both the state and employee share of premiums will be relatively flat, assuming these contracts are executed.

Benefit Design

The Board is committed to maintaining benefits and not shifting additional costs to members for 2018. Uniform Benefits, the standard benefit package that all health plans administer, will continue to cover all benefits mandated under state law, as well as all Essential Health Benefits required under the federal Affordable Care Act.

Communicating changes about which health plans will be available will require a significant communication effort to plan members. Acknowledging this communication effort, the Board determined that additional benefit design changes would be undesirable for 2018.

Provider Disruption

Members will largely have access to the same doctors and hospitals available today in the new program structure. This includes the Group Health Cooperative – South Central, Gundersen, and Physicians Plus provider networks, which have partnered with the new Quartz offering.

Based on commitments made from the health plans, Segal has determined that 98% of the providers that are currently available in Wisconsin will continue to be available with the health plans that the Board has selected to contract with in 2018. Of the two percent of providers that may not be available in 2018, most are considered "ancillary" or other providers, as opposed to primary care providers. As stated above, annual provider disruption also occurs in the current fully insured model.

Health Plan Disruption

The number of health plans in the State Health Benefit Program will decrease from 18 to six under the restructuring approved by the Board. The plans were selected for their improved cost and their demonstrated success on quality and focus on customer service. These plans will be held to performance standards to ensure they maintain that level of service delivery.

Further, the regionalization of the new structure ensures that there will be more stability in terms of which plans are available in counties. Working with fewer plans will also improve the Department's ability to develop strategic partnerships with the plans and focus on strategies to improve health and quality of care.

Estimated Savings

Estimated Savings

As stated above, contract negotiations successfully position the program to achieve the $60 million GPR savings included in the biennial budget. To achieve similar savings under a fully insured model, 2018 premium increases would have to be limited to a low, single-digit percent increase. If the current Affordable Care Act fees remain in place for fully insured plans in 2018, participating health plans would essentially experience a net premium freeze for 2018.

The biennial budget correlates with savings estimates reported to the Board by Segal Consulting. Savings are primarily due to reduced administrative fees and discounted claims costs.

The administrative fee savings are due to the elimination of the insurer risk fee and other administrative efficiencies reflected in the vendors' bids. The claims savings are based on improved provider pricing available from the health plans selected through the RFP process. These savings are not strictly associated with the transition to a self-insured model, but rather the result of selecting the most cost efficient health plans.

In preparing these estimates, Segal had to make numerous assumptions about medical trend, loss ratios, and to which plans members would move. Segal ran several scenarios to develop a range of estimates. The estimate presented to the Board represents the mid-point, or most-likely scenario, for the restructuring option the Board selected.

Affordable Care Act Insurer Assessment Fees

The savings estimates do not include the savings associated with avoiding the insurer tax that would be paid in 2018 if the State Health Benefit Program stayed fully-insured and if the Affordable Care Act remains current law. The fees for this assessment are estimated to be $32.5 million annually (All Funds) for 2018 based on data reported by the health plans.

Previous Actuarial Estimates

The Department continues to respond to inquiries from legislators, media, and members of the public about differences between the actuarial estimates prepared by two different Board consultants over the last few years. Below is a summary of those actuarial estimates which highlight why the most recent estimates adopted by the Board are the most reliable.

The Board has been researching self-insurance since 2012. It asked its then actuary, Deloitte Consulting, to conduct an initial high level estimate of the impact of moving to

self-insurance. Deloitte initially estimated the impact to range between savings of $20 million annually to costing up to $100 million annually. This estimate assumed the state would save money through the avoidance of taxes and fees. However, the estimate also made numerous assumptions about plan design and vendor selection and lacked concrete data to inform the analysis. The primary conclusion was that the actuary needed to collect additional data to refine the estimates.

In 2013, the Department and Deloitte completed a Request for Information collecting information from 17 health plans and third-party administrators. Based on this report, Deloitte assessed some of the opportunities and challenges associated with self-insuring with one statewide carrier versus multiple regional carriers. Deloitte did not revise its earlier estimates, but rather indicated that self-insurance was worth pursuing and recommended the Board proceed with a comprehensive Request for Proposal (RFP) to further refine and assess information from potential bidders.

In 2014, Deloitte's contract with the Board expired and Segal Consulting was selected to replace Deloitte through a competitive RFP process.

In 2015, Segal completed two comprehensive reports to the Board on the State Group Health Benefit Program, including an analysis of self-insurance. Segal recommended pursuing self-insurance and estimated that the program could save $42.1 million, but this estimate was based purely on the avoidance of taxes and risk charges, and administrative savings. It did not take into account changes in provider discounts or benefit design or other program changes. Segal separately recommended combining a self-insurance model with other regional program changes.

Both actuaries recommended the Board pursue getting bids from potential vendors through an RFP process to accurately assess the impact of self-insurance. As a result, the Department released an RFP in 2016. The current cost savings estimates reflect actual bids guaranteed by vendors through that RFP process, providing the first fully-informed and contractually-bound cost projection.

Impact of Regionalization

The Board approved maintaining a competitive marketplace for state employees by selecting six different vendors. Employees will have multiple options in every region of the state.

Today, employees can choose from 18 different health plans. Performance by plan in terms of customer service and health care quality metrics varies widely. By using a competitive process to select health plans, and including unprecedented performance requirements, the new contracts ensure that the plans available in the program are the top choices in terms of cost, quality and value.

Not all current health plans chose to participate in the recent competitive bid process. For many of them, the state health plan is not a significant portion of their business. For

others, they determined the cost, quality, and performance requirements included in the RFP were prohibitively restrictive.

Some opponents to the restructure have argued that the state is subsidizing the larger insurance market and that private employers' costs will increase if the state self-insures. Others have made the exact opposite argument – that insurers currently give the state artificially low premium rates that are being subsidized by the private sector. Neither argument is backed by any concrete evidence.

The insurance market – in Wisconsin and elsewhere – is evolving in unprecedented fashion due to forces beyond the state employee program. Mergers and acquisitions preceded this change, and will continue into the foreseeable future.

Impact on Retirees

The savings achieved from self-insuring the health plans are passed through directly to our retirees since they pay 100% of premiums, so this population will benefit the most directly from the savings achieved under the new model. Pre-Medicare retirees will continue to have the same health plan options as active employees in the new program structure.

In 2018, Medicare-eligible retirees will continue to have the Medicare coverage options that are available today:

- IYC Medicare – administered by the regional and statewide/nationwide vendors
- IYC Medicare Plus – a Medicare supplement health plan to be administered by Anthem
- IYC Medicare Advantage – administered by Humana

The Board is considering expanding Medicare-eligible retiree options to include additional, more affordable Medicare offerings for 2019 and beyond. Department staff will bring recommendations to the Board at its May 24, 2017 meeting.

Impact on Local Government Employers

Participants in the Wisconsin Public Employer (WPE) Health Benefit Program will experience the same program structure changes as state employees in 2018, and will also benefit from the projected program cost savings.

Legal Authority to Self-Insurer for Local Employers

Recently, a Legislative Council memo raised questions about whether the Board has the authority to self-insure health benefits for local employers. The question was raised based on a 1987 Attorney General Opinion that found that self-insuring benefits for local employers could create a debt obligation for the state and would therefore be unconstitutional. Attorneys for the Department recently completed a review of that Attorney General's Opinion and performed its own analysis of the relevant statutes. In

short, the attorneys found that the Board does have the authority to self-insure health benefits for local employers for the following reasons:

- Self-insuring for health benefits for local employees does not create "an absolute obligation to pay monies or its equivalent," i.e. debt, for the state. Health benefits for local employees are currently separately funded; meaning reserves, premium rates, and financial risk for local employees are entirely separate from state employees.
- The Legislative Council memo indicates that if funding for local employee benefits is kept separate (as noted above), a self-insurance model would be constitutional.

In addition, the Board currently self-insures dental and pharmacy benefits for local government employers participating in the Wisconsin Public Employer (WPE) health benefit program.

Cost Containment & Quality Improvement Strategies

As stated above, self-insurance is only one strategy being pursued by the Board to reduce costs, and lays the groundwork for additional Board initiatives to reduce costs and improve care. The Board is in the early stages of several aligned initiatives to improve program costs or improve health, described below.

Wellness & Disease Management – The Board's short term strategic plan for wellness focused on centralized administration of the health assessment, biometric screenings, and wellness incentive to increase participation and employee engagement. This was achieved earlier this year with the implementation of the contract with StayWell. Also starting in 2017, the program is incorporating health and lifestyle coaching into the program. Over the next two years, the Board plans to improve participation in these programs through an improved incentive, and continue to develop targeted disease management programs to improve the overall health of the state employee population.

Data Warehouse & Analytics – The Board's long term strategic plan is focused on using data to inform plan design and targeted disease management programs. Earlier this year, the Board executed a contract with Truven Health Analytics to develop a data warehouse for the program data. The data warehouse is targeted to be fully functional for data analytics in early 2018.

In 2014, the Board prioritized gaining access to high quality medical and pharmacy claim data about the State Health Benefit Program in a central database to better manage the health of program participants and program costs. Contracting with a data warehouse vendor will give the Board the ability to move forward on a variety of strategic initiatives to control health care costs and improve service delivery. In February 2016, the Board approved moving forward with an RFP for a data warehouse and visual business intelligence vendor. In November 2016, the Board selected Truven Health Analytics, LLC to provide these services. The Department is currently working to

implement these tools and expects to have the data warehouse and reporting tools operational in early 2018.

Capturing medical and pharmacy claims data is critical for identifying cost drivers and managing health and costs in the health program whether it's a fully-insured or self-insured program. However, in a self-insured model, there is no question about whether the Department has the ability to collect health claims data. In a fully-insured model, health plans resist efforts to collect data, making it difficult to measure their results, identify gaps in care, disease prevalence and other cost drivers and therefore develop programs to target those cost drivers.

Note on Data Privacy: The Department understands the sensitive nature of member-level health information and has no business case or interest in having access to member-identifiable medical or pharmacy claims. Therefore, when building the data warehouse, Truven will mask, or de-identify, member level information so that neither the Department nor Segal will be able to identify the member on a claim. The contract with Truven and Non-Disclosure Agreements with the TPAs have extensive protections pertaining to member information, and are compliant with all pertinent federal regulations including HIPAA, GINA, and HITECH.

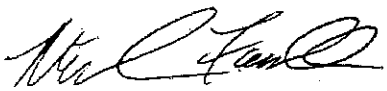
If the Department has a need to receive member-level information due to a grievance or customer inquiry, Department staff obtain an authorization from the member and work with the health plans to get this data, as they do today.

Benefit Design – For 2016, the Board adopted cost-sharing changes which encourage more consumerism among plan participants through the addition of a deductible, and more nuanced pharmacy benefit co-insurance design to encourage the most effective use of low-cost generic drugs. These changes shifted an estimated $84 million in health care costs to members in the 2015-17 biennium. In 2015, the Board introduced the High Deductible Health Plan and associated Health Savings Accounts, increasing the employer HSA contribution in 2016 to encourage enrollment in the plan. The Board also introduced co-insurance to the plan design in 2012, which reduced the value of the benefit package by 5%. In 2011, state employees' premium contribution doubled, requiring them to cover an additional 6% of premium costs.

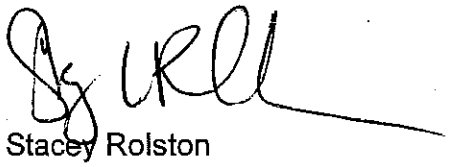
Vendor Council on Health Program Improvement – In 2017, the Department kicked-off a vendor council that convenes all program TPAs (medical, pharmacy, wellness, dental, data warehouse) to discuss Department initiatives, and share trend and population health strategies. The goal of the council is to improve member health through a coordinated, data-informed strategy amongst vendors.

We hope this information successfully addresses the concerns Committee members have about the Board's proposal. If we can be of any additional assistance, please let us know.

Sincerely,



Michael Farrell, Chair
Group Insurance Board



Stacey Rolston
Division of Personnel Management

State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R07/2016)
§ 51.01(5) Wis. Stats. § 111.32(13m) Wis. Stats.

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

Contract

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

Contract No./Request for Bid/Proposal No: ETG0003 (A)
Authorized Board: Group Insurance Board

Contract Period: June 1, 2017 through December 31, 2020 with the optional renewal of three (3) two (2) year periods

1. This Contract is entered into by the State of Wisconsin, Department of Employee Trust Funds (Department), the State of Wisconsin Group Insurance Board (Board) and between Anthem Blue Cross and Blue Shield hereinafter referred to as the "Contractor", whose address and principal officer appears on page 2. The Department is the sole point of contact for this Contract.

2. Whereby the Department of Employee Trust Funds agrees to direct the purchase and the Contractor agrees to supply the Contract requirements cited in accordance with the State of Wisconsin standard terms and conditions and in accordance with the Contractor's proposal dated September 16, 2016 hereby made a part of this Contract by reference.

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

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

5. Contractor agrees to the Discount Guarantees and Gain Sharing Agreement in Exhibit B for Anthem Priority.

6. For purposes of administering this Contract, the order of precedence is:
   a) This Contract with Anthem Blue Cross and Blue Shield;
   b) Exhibit A, Contract clarifications from ETF;
   c) Exhibit B, Discount Guarantees and Gain Sharing Agreement (Anthem Priority);
   d) RFP Exhibit 1 – State of Wisconsin Health Benefit Program Agreement, dated May 1, 2017;
   e) RFP Exhibit 4 – Department Terms and Conditions, dated April 26, 2017;
   f) Appendix 4a Claims Data Specifications – Medical, dated March 29, 2017;
   g) Appendix 5 Provider Data Specifications, dated March 29, 2017;
   h) Request for Proposal (RFP) ETG0003 dated July 22, 2016, including all appendices, attachments, and amendments thereto; and,
   i) Contractor's proposal dated September 16, 2016.

Contract Number & Service: ETG0003 (A) Administrative Services for the State of Wisconsin Health Benefit Program

State of Wisconsin Department of Employee Trust Funds	Contractor to Complete
By Authorized Board *(Name)* **Group Insurance Board**	Legal Company Name **Compare Health Services Insurance Corporation**
By *(Name)* **Michael Farrell**	Trade Name Anthem Blue Cross and Blue Shield
Signature	Taxpayer Identification Number **39-1462554**
Title **Chair** Group Insurance Board	Company Address *(City, State, Zip)* N17 W24340 Riverwood Drive Waukesha, WI 53188-1142
Phone 608.266.9854 (A. John Voelker, Deputy Secretary)	By *(print Name)* Paul Nobile
Date *(MM/DD/CCYY)*	Signature
	Title President & General Manager
	Phone 262.523.4825
	Date *(MM/DD/CCYY)* 05/02/2017

Exhibit A

Contract ETG0003 (A): Clarifications and changes agreed to by the parties to the July 22, 2016 Request for Proposal (RFP) ETG0003 Administrative Services for the State of Wisconsin Health Benefit Program to be provided by Anthem Blue Cross and Blue Shield to the State of Wisconsin Department of Employee Trust Funds for the Health Insurance Programs Offered by the State of Wisconsin Group Insurance Board.

The following are clarifications to Contract terms:

#	Document / Section	Section Description	Clarification
1	n/a	n/a	Any dispute, disagreement or question of interpretation of Exhibits 2, 3, or 4 (the Terms and Conditions) and the application of those Exhibits to the terms of this contract is subject to discussion and resolution under Exhibit 4, Section 13.0 (Contract Dispute Resolution) of the Department Terms and Conditions."
2	Exhibit 1 Section 130	Premiums	The language in this section is not intended to hold a Contractor liable for payment of actuarial services related to a review of claims experience, trends and other factors covered by the rate renewal reports submitted by a Contractor pursuant to this section.
3	Exhibit 1 Section 135B	Administrative Fee Adjustments	Language as shown was drafted with the intention to allow for administrative fee increases, as recommended by ETF's actuary. Should an administrative fee change be implemented for which the TPA disagrees, the process on contract dispute resolution is provided in Exhibit 4.0, Section 13.0.
4	Exhibit 1 Section 215A	Disease Management / Prior Authorizations / Utilization Review	The contract requires prior authorizations to include member out-of-pocket cost sharing information. The intent is to base the authorization on the provider status at time of the authorization review with disclosure about any anticipated provider status change for the length of the approval period and disclosure that the member's deductible, coinsurance and/or copayment applies. Member out-of-pocket costs do not need to be amount specific and instruction should be provided on how members can obtain specific cost-sharing information. The contract also states the Contractor is responsible for the cost of services not covered under the contract when the member has received a prior authorization. The intent is to hold the Contractor accountable if it errors by prior authorizing a service that is not covered under the contract.

#	Document / Section	Section Description	Clarification
5	Exhibit 1 Sections 230 and 230D	Provider Contracts Provider Contracts Shall Include Compliance Plans	Including the provider agreement requirements outlined in Section 230 and the compliance plans outlined in Section 230D in a policy, program or process for which the provider contract requires compliance, even though the provider contract does not specifically identify such items, is deemed to meet this contractual requirement.
6	Exhibit 4 Section 28.0 (i)(2)	Data Security and Privacy Agreement	1) The data should be destroyed; 2) unless Contractor can definitely prove to ETF that the data was de-identified; and 3) that Contractor confirms to ETF in writing that no crosswalk exists to re-identify the data.
7	n/a	n/a	Based on the contract negotiations that ETF has conducted over the last several weeks with each of the six contractors, ETF now believes it is appropriate to delete references in the RFP and Section 135B of RFP Exhibit 1 specifically stating that the contractors are fiduciaries. The duties that contractors will perform are delineated throughout the RFP and Exhibit 1. Case law confirms that whether or not a contract specifically states that a contractor is a fiduciary, courts have issued decisions finding that the duties and facts in a particular situation demonstrate that a contractor is a fiduciary.
8	Exhibit 4 Section 12.0	Liquidated Damages	It is the Department's intent that the Contractor will be able to utilize the process described in Exhibit 4, Section 13.0 (Contract Dispute Resolution) prior to the Department imposing any Liquidated Damages.

Wisconsin Department of Employee Trust Funds
Discount Guarantees for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Anthem Priority**
Region **Eastern**

Vendor will provide 2018 expected overall level of discount.
ETF and Vendor will mutually agree on final starting point.

2018 Discount Target*

* A supplemental worksheet allows vendors to calculate this discount with enrollment and regional assumptions. Upon open enrollment these will be re-based accordingly.

Annual improvement - Spread between Eligible Charge Increase and Vendor Allowed Increase. Expectations on Discount improvement decrease with higher baseline discounts. Improvement is calculated as Assumed Spread x (1-Discount).

Assumed Spread

		Annual Improvement
2019 overall level of discount is expected to improve over 2018	**2019 Discount Target**	
2020 overall level of discount is expected to improve over 2019	**2020 Discount Target**	

Fees at Risk will vary by percentage below target for each of the 3 years based on the following Scale:

% of Actual Discount below Target	% of Total Admin Fees at Risk
	0%
	5%
	10%

Notes:
Actual Performance against Target Discounts will be calculated 6 months after the end of the Calendar Year with runout data available in the data warehouse at that time.
Large claims over $100,000, and any out-of-network claims, will be removed from the calculation.
Discount Percent is calculated as Total Submitted Eligible Charge less Total Allowed (state & member) divided by Total Submitted Eligible Charge.
Discount Guarantee is null and void if Gain-Sharing Actual PMPM is less than Target PMPM.

ETG0003

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Exhibit B

Vendor **Anthem Priority**
Region **Eastern**

Annual Shared Savings will be calculated based on two factors:
(1) Performance of Actual versus Target PMPM
(2) Performance of Actual versus Target Clinical Performance Measures

Performance of Actual versus Target PMPM

Illustrative Calculation

Prior Calendar Year allowed claims for those members who select vendor during open enrollment will be used as a starting point to determine a base aggregate PMPM. The data will be normalized to the vendor's network pricing. It is anticipated that this will include 12 months of incurred allowed claims. (TBD)

A claims completion factor will be applied to the allowed claims. This will be updated with runout during the settlement process with claims paid through June of the following Calendar Year. (TBD)

Total Calendar Year Incurred Claims

Apply Industry and Market Specific Trend (TBD) - Trend assumptions will be uniform across all vendors

Calendar Year Allowed PMPM Target

Amount of savings to be shared with vendor will vary by percentage of actual PMPM below Target PMPM based on the following Scale:

	CY 2018	CY 2019	CY 2020
% of Actual PMPM below Target	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**
< 3.00%	0%	0%	0%
3.00% - 6.00%	5%	7.5%	10%
> 6.00%	10%	17.5%	25%

Notes on PMPM:
1) Target PMPM will be set by March 1st of the current CY based on prior CY incurred claims with current year enrollment, adjustment for network pricing, completion factors and trend.
2) Performance of Actual versus Target PMPM will be calculated at the end of the CY when 6 months of runout is available in the data warehouse. This results in 18 months of runout for the Target PMPM and 6 months of runout for the Actual PMPM. Note that the Actual PMPM will have a completion factor applied.

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Anthem Priority**
Region **Eastern**

Performance of Actual versus Target Clinical Performance Measures

In addition to the shared savings amounts based on Actual versus Target PMPM Calculations, payments will be reduced based on the percentage of clinical targets met by the vendor for the Calendar Year. If all clinical targets are met, payouts will be 100% of the PMPM calculations described above. If, for example, 75% of the clinical targets are met, payouts will be 75% of the PMPM calculations described above.

Clinical Targets for each year of the contract will be determined for each vendor individually by comparing actual baseline for each vendor to an ultimate target for each measure. The difference between the vendor's baseline and target will be the gap that should be closed over 3 years with equal improvement in each of the 3 years to reach the target. Examples are shown below:

	Baseline	Target	Gap	2018 Target	2019 Target	2020 Target
Vendor A	50%	90%	40%	63%	77%	90%
Vendor B	80%	90%	10%	83%	87%	90%
Vendor C	95%	90%	-5%	90%	90%	90%

ETG0003

Wisconsin Department of Employee Trust Funds
Discount Guarantee Development Worksheet

Exhibit B

Vendor **Anthem Priority**
Region **Eastern**

		Preliminary Discount Guarantee			Final Discount Guarantee		
Region	Total Members	Expected Enrollment	Expected Distribution	Discount Guarantee	Open Enrollment	Final Distribution	Discount Guarantee
Eastern	63,766						
Northern	8,151						
Southern	113,299						
Western	21,024						
In-State	206,240						
Out-of-State	3,379						
Total Membership	209,619						

After open enrollment, a final discount guarantee will be developed based on vendor's actual enrollment.
Discount guarantees by region may not be altered during this process.

ETG0003

RFP ETG0003

Exhibit 1: State of Wisconsin Health Benefit Program Agreement

Issued May 1, 2017

State of Wisconsin Health Benefit Program Agreement

Issued by the State of Wisconsin

Department of Employee Trust Funds

On behalf of the Group Insurance Board

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000 DEFINITIONS

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

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

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).

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).

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 attachments, supplements, endorsements riders and the CONTRACTOR'S PROPOSAL.

CONTRACTOR means the legal signatory to this AGREEMENT.

DAY means calendar DAY unless otherwise indicated.

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

DEPENDENT as defined in Uniform Benefits.

DOMESTIC PARTNER as defined in Uniform Benefits.

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

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

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.

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.

PBM means the Pharmacy Benefit Manager (PBM) which is a third party administrator that is contracted with the BOARD to administer the prescription drug benefits under this HEALTH BENEFIT PROGRAM. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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.

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

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

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.

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

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).

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETG0003 and in the PROPOSAL.

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 (forms 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).

110 Objectives

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

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

2) To provide excellent customer service to PARTICIPANTS.

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

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

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

6) 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.

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

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

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

9) 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 to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

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

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

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

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

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

8) 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.

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

   a) This includes a formal grievance procedure, which at a minimum complies with federal law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the 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.

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

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

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

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

14) Provide notification of all significant events:

a) 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 (15%) percent 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 (51%) percent) interest in the CONTRACTOR or any transfer of ten (10%) percent or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the 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."

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

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

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

18) 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.

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

20) 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, per Wis. Stat. § 40.02 (25) (b), eligible EMPLOYEES include:

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

2) Elected state officials.

3) Members or EMPLOYEES of the legislature.

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

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

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

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

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

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

c) Certain visiting faculty members in the UW System.

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

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

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

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

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

8) ANNUITANTS and CONTINUANTS:

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

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

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

d) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll 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.

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

f) Any retired public employee under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

125B Dependent Coverage Eligibility

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

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

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

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the 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.

125E Local Annuitants

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

125F Medicare Participants

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

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

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

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

130 Premiums

The BOARD determines the PREMIUM for its self-insured benefit plans as part of the HEALTH BENEFIT PROGRAM. This PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to:

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

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

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

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

5) Substantiation of any proposed increase in fixed costs, such as administrative costs, via a thorough analysis of activities and costs covered by those fees.

6) Explanations for any unusual trend results (high or low relative to the market).

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

SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255.

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

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 the Medicare HOSPTIAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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 coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. 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.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see Sections 125F and 220H.

135 Administrative Fee and Financial Administration

135A Invoicing and Banking

1) Claims Invoicing:

   a) The CONTRACTOR shall notify the DEPARTMENT every calendar week during the term of this AGREEMENT and inform the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. The amount due every week shall be the total amount of BENEFIT payments issued by the CONTRACTOR for the claims processed during the immediately prior calendar week (Saturday through Friday).

   b) The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT by the first Friday immediately following the DEPARTMENT'S receipt of the request for payment by the CONTRACTOR. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.

   c) The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within twenty (20) BUSINESS DAYS following month-end.

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

2) Administrative Fee Invoicing:

   a) The CONTRACTOR must submit to the DEPARTMENT on the twentieth (20th) DAY of each calendar month (or the first BUSINESS DAY following the twentieth (20th) DAY of the calendar month), an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The monthly invoice must show the total amount of administration

fees, other approved fees and expenses due for the immediately following calendar month. The DEPARTMENT shall deposit funds into the bank account designated by the CONTRACTOR on the first BUSINESS DAY of the calendar month following the DEPARTMENT'S receipt of the invoice from the CONTRACTOR.

b) The CONTRACTOR shall be paid the administrative fee per month per PARTICIPANT as detailed in the CONTRACT. All administrative plan arrangement-related fees are included in the CONTRACTOR's administrative fee.

   The statewide/nationwide CONTRACTOR shall be paid for underwriting services to evaluate risk and submit recommendations for LOCAL EMPLOYERS requesting participation in the local HEALTH BENEFIT PROGRAM. The LOCAL EMPLOYER shall send payments for underwriting services to the DEPARTMENT. The DEPARTMENT shall forward one check for the appropriate amount shown in the Cost Proposal to the CONTRACTOR for their services.

3) Direct Pay SUBSCRIBER Invoicing:

   The CONTRACTOR shall not process any PREMIUM transactions related to enrollment, except for those direct pay SUBSCRIBERS.

135B Administrative Fee Adjustments

Administrative fee adjustments, if any, required as recommended by the BOARD's consulting actuary for BENEFIT changes, mandated BENEFIT payments, and/or operational changes, will occur on January 1 after the next contract period begins unless otherwise approved by the BOARD. The CONTRACTOR shall supply an administrative monthly invoice that must be based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The CONTRACTOR shall be paid the following administrative charge per month per PARTICIPANT for the AGREEMENT periods stated as follows:

Medical administration fee per individual and family contract. The medical administration fee includes, but is not limited to, the following:

1) Claims administration (including adjudication, payment, reprocessing, coordination of BENEFITS (excluding vendor recoveries), and overpayment collection).

2) Utilization review fees.

3) Network access fees.

4) MHSA claims administration.

5) Medical management (including medical review).

6) Disease management.

7) Customer service (to meet all requirements of this AGREEMENT, including all key personnel).

8) PARTICIPANT materials (including explanations of BENEFITS, summary of BENEFITS and coverage, web tools, ID cards, printing and mailing costs).

9) All required reports (including federally required reports and tax related forms).

10) Claims data extracts.

11) Administration, collection of, and passing through to the DEPARTMENT, premiums for direct pay SUBSCRIBERS (including reporting non-payment terminations).

12) IT services (including hardware and software).

13) Telecom (other program resource links, reporting, special usage or access requirements).

14) Required reviews (including fraud and abuse, and HOSPITAL bill).

15) Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing).

16) Telehealth services.

17) Twenty-four (24)-hour nurse line services.

18) Underwriting services (applies to a CONTRACTOR providing statewide/nationwide services under this AGREEMENT only).

135C Prohibited Fees

1) The CONTRACTOR is prohibited from including in their administrative fee:

   a) The cost to handle any claims paid outside of Uniform Benefits or IYC Medicare Plus administered by the statewide/nationwide CONTRACTOR.

   b) The cost to administer any optional health and wellness benefit(s) beyond Uniform Benefits, IYC Medicare Plus that is administered by the statewide/nationwide CONTRACTOR or the Well Wisconsin program.

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

135D Recovery of Overpayments

1) Overpayments:
   If it is determined that any payment has been made under this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or

shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.

If any overpayments made to ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments. Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR'S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments. Any overpayment caused by the CONTRACTOR'S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.

The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures.

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

   The DEPARTMENT shall not hold the CONTRACTOR responsible for any overpayments caused by DEPARTMENT or EMPLOYER errors or fraud by a person other than an employee of the CONTRACTOR.

   The CONTRACTOR shall assist the DEPARTMENT in identifying overpayments caused by such error or fraud.

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

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

5) Disputes over Charges:

   Notwithstanding any other terms, conditions, and provisions of this AGREEMENT, the CONTRACTOR shall pay CHARGES as determined by the CONTRACTOR. Disputes as to CHARGES will be referred, on a timely basis, to the CONTRACTOR who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

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

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 administrative fees or other 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:

1) Providers to request and receive electronic funds transfer (EFT) of claims payments for BENEFITS.

2) SUBSCRIBERS to submit EFT of direct pay PREMIUM payments. The CONTRACTOR must support other mechanisms for payment of direct pay PREMIUMS.

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.

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.

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. 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. The next roll-out for the new system is currently scheduled for 2018.

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.

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 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.

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

b) 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, 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. 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 and integrate the data as required under Section 240. 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 provided by the DEPARTMENT with 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 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 RFP, 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. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file. 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 and are the direct result of the CONTRACTOR's failure to meet the

DEPARTMENT'S data submission requirements or timelines and which the DEPARTMENT will deduct from any payment owed the CONTRACTOR in the payment period.

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.

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 Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits. All amounts recovered under this program shall be paid forty-five (45%) percent to the CONTRACTOR and fifty-five (55%) percent to the BOARD.

155D 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.

155E 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) 16 and provide a copy of the CPA's report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.) The audit report must be submitted annually.

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.

155F 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. For information see Section 135D.

2) Contractor Provider 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; and,

n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. 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 personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

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

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

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

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

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

155H 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.

155I 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 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) In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.

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

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

155J Transition Plan

During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. In the event that the CONTRACTOR terminates the CONTRACT, an updated

transition plan must accompany the notice of termination. In the event the BOARD terminates the CONTRACT, the CONTRACTOR must send an updated transition plan to the DEPARTMENT within thirty (30) DAYS of the written notice of termination to the CONTRACTOR. The transition plan must be approved by the DEPARTMENT prior to the transition begin date and must include the CONTRACTOR'S cooperation and participation in planning calls or meetings with the succeeding vendor.

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

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

1) Participate in all DEPARTMENT requested meetings.

2) Provide all reports for program close out.

3) Report on performance standards specified in Section 315.

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

5) Transmit program data to the new vendor.

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

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

155K Health Underwriting for Statewide/Nationwide Contractor only

LOCAL EMPLOYERS with one or more employees requesting participation in the local HEALTH BENEFIT PROGRAM are subject to underwriting. The CONTRACTOR shall evaluate risk and submit a recommendation back to the DEPARTMENT for final approval by the BOARD'S actuary. The effective date shall be determined by the DEPARTMENT. The fees described in the Cost Proposal, or as agreed upon by the DEPARTMENT, shall be administered per Section 135A.

Employers with fifty-one (51) or more EMPLOYEES shall submit claims and enrollment experience including high cost claims data for the most recent available twenty-four (24) months along with the fees to the DEPARTMENT.

Employers with fifty (50) or less EMPLOYEES shall submit small employer information as required by the CONTRACTOR to the DEPARTMENT along with the fees.

The DEPARTMENT will submit information and appropriate fees to the 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.

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. 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) 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 Eligibility

The 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.

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

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 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 as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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. See Appendix 6, Guidance for DEPARTMENT Initiatives, for additional detail.

The current DEPARTMENT Initiatives 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) High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.

3) Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.

4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.

5) 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.

215C Quality Initiatives

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.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in Uniform Benefits to all PARTICIPANTS with the exception of the statewide/nationwide CONTRACTOR who must provide the BENEFITS and services listed in the IYC Medicare Plus certificate to all Medicare 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 high deductible health plan (HDHP) 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger 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 Preferred Provider Organization (PPO)

The BOARD may offer different copayment and deductible schedules for OUT-OF-NETWORK providers, except in the case of emergency, urgent care or when the services are not reasonably available IN-NETWORK.

If the PARTICIPANT resides in a CONTRACTOR'S service area, the PPO must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty IN-NETWORK provider when determining if that provider is reasonably available.

220G Medicare

The CONTRACTOR will provide BENEFITS and services as described in Uniform Benefits to PARTICIPANTS enrolled in Medicare with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS.

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

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 EMPLOYEE, 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. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payer after this thirty (30)-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty (30) -month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer. No reduction in PREMIUM is available for active EMPLOYEES under this section.

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, change from or to the IYC HDHP).

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:

1) If a PARTICIPANT changes benefit plans.

2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER (or combination of spouse-to-DOMESTIC PARTNER) transfer resulting in a change of SUBSCRIBER, but does not change benefit plans.

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.

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. For HDHPs, medical and pharmacy accumulations are combined.

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.

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 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 audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year, which includes 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 commercially insured adult 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.

c) The results of the survey shall be used for the measurement of PARTICIPANT satisfaction as specified in the performance standards in Section 315G.

4) The DEPARTMENT will monitor health care quality and/or customer satisfaction using performance measures available in the data warehouse and visual business intelligence tool, and will establish performance metrics, baseline results, and target performance levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage performance improvement.

   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.

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 and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how 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.

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.

The 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 their provider network for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150.

The DEPARTMENT will use this data to ensure provider access standards are met. 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 (33%) percent 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 the following minimum requirements:

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 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 the access standards above, including accepting 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. 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 Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in Uniform Benefits with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS. Targets for claims processing performance standards and associated penalties are specified in Section 315C.

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. The CONTRACTOR shall pay claims of providers according to a time standard mutually established by the CONTRACTOR and the DEPARTMENT.

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

In accordance with state statute, the CONTRACTOR must maintain individual documentation used for claim adjudication for a minimum of seven (7) years.

240 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 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.

245 Grievances

245A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with the HHS-administered federal external review in accordance with federal law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections 245E, 245F, and 265A.

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 245A – H.

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

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

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

245B 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.

245C 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.

245D 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.

245E Notification of Department Administrative Review Rights

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

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 HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

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

245F External Review

The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an 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.

245G 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.

245H 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.

245I 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.

245J 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.

250 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see Section 260D.

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.

255 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt. It is acceptable to credit the collected direct pay PREMIUM amount on the administrative monthly invoice provided that it contains itemized SUBSCRIBER level detail.

Direct pay PREMIUMS may be submitted to the CONTRACTOR via electronic funds transfer or 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.

260 Continuation

260A 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.

260B 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.

260C Conversion / Marketplace

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

260D 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.

265 Miscellaneous Program Requirements

265A 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.

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

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Nondiscrimination Testing Plan: The CONTRACTOR works with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.	Within thirty (30) DAYS of execution of this CONTRACT
Transition Plan: The transition plan is established in a mutually agreed upon format and submitted to the DEPARTMENT Program Manager or designee for review.	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2018 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	August 18, 2017
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 1, 2017
Employer Meeting: The CONTRACTOR attends the It's Your Choice EMPLOYER Kick-Off meeting.	Fall 2017 (Date TBD)
Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.	September 30, 2017
Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2017
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	September 2017 (Date TBD)
Employer Health Fairs: The CONTRACTOR shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area.	October – November 2017
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation.	November 16, 2017

Activity	Due Dates
Financial Administration: Financial administration requirements are operational, including but not limited to: • Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. • Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). • Direct pay invoicing process. • ACH mechanism for EFT of claims payments and direct pay PREMIUMS.	November 30, 2017
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2017
ID Cards: The CONTRACTOR issues welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018.	December 15, 2017
Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM are fully operational.	January 1, 2018
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2018
Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly.	January 15, 2018
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2018
Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2018
Claims Data: The claims data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	March 31, 2018

265B Account Management and Staffing

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

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

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

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

5) Resolve general administrative problems identified by the DEPARTMENT.

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

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

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

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

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

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

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

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the 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 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting HEALTH BENEFIT PROGRAM services.

265C Customer Service

The CONTRACTOR shall operate a dedicated 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 315D 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, EMPLOYER group);

5) The representative that handled the inquiry;

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

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

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

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

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each 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.

265D 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.).

265E 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.

265F 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR.

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.

265G 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 "personal information", as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;

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

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

265H 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.

265I Subrogation and Other Payers

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

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

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel or utilize in-house counsel to provide the BOARD with subrogation litigation services on the BOARD'S behalf at a contingency fee not to exceed thirty (30%) percent for outside legal counsel or twenty (20%) percent for in-house counsel of net dollars recovered by such counsel, with those attorneys' fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

For such subrogation matters, the BOARD shall not pay or provide any additional reimbursement for the outside legal counsel's or in-house counsel's legal fees, expenses, costs and disbursements incurred by such counsel while providing subrogation-related legal services and such legal fees, expenses, costs and disbursements are included in, and will be paid out of, the maximum thirty (30%) percent contingency fee that is paid to the outside legal counsel or twenty (20%) percent fee paid to in-house counsel as set forth in this subsection. The CONTRACTOR will not be paid or receive any portion of the contingency fee that is paid to the outside legal counsel if outside legal counsel is hired. The BOARD shall be solely responsible and liable for paying the contingency fee to outside legal counsel for its attorneys' fees, legal costs and disbursements incurred by the outside legal counsel representing the BOARD in subrogation cases, not the CONTRACTOR. The CONTRACTOR is not responsible or liable for paying the contingency fee or any outside counsel attorneys' fees, legal costs and disbursements.

265J 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.

265K Other

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

265L 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.

265M Conflict of Interest

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

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

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

300 DELIVERABLES

305 Reporting Requirements

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

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

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the 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 Invoicing	The CONTRACTOR notifies the DEPARTMENT every calendar week during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. *(See Section 135A, 1, a.)*	Weekly
3) Administrative Fee Invoice	The CONTRACTOR submits to the DEPARTMENT an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. *(See Section 135A, 2, a.)*	Monthly
4) 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, 1.)*	Monthly
5) Bank Reconciliation Report	The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. *(See Section 135A, 1, c.)*	Monthly
6) Claims Invoice Reconciliation Report	The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. *(See Section 135A, 1, d.)*	Monthly

Report	Description	Frequency
7) 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 265C.)*	Monthly
8) 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, 2..)*	Monthly
9) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155F, 2.)*	Quarterly
10) Hospital Bill Audit	The CONTRACTOR performs a HOSPITAL bill audit process for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and provides results of material findings to the DEPARTMENT. *(See Section 155C.)*	Quarterly
11) 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
12) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
13) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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, High Tech Radiology, Low Back Surgery, Shared Decision Making, and Advance Care Planning. *(See Section 215B.)*	Semi-annually
14) 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 215C.)*	Semi-annually
15) 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.)*	Semi-annually

Report	Description	Frequency
16) 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
17) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. *(See Section 225, 3, b.)*	Annually
18) 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
19) 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
20) 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.)*	Annually
21) 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
22) 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
23) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year. *(See Section 225, 3, a.)*	Annually
24) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually

Report	Description	Frequency
25) Rate Renewal Reports	To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. *(See Section 130.)*	Annually
26) 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 16 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 DEPARTMENT Program Manager or designee. *(See Section 265A.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. *(See Sections 265A and 265B.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. *(See Section 155F, 2 and Section 265A.)*	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section 205B, 2.)*	Upon identification of issue
5) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section 265B.)*	April August

Deliverable	Description	Frequency
7) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. *(See Section 230A.)*	June
8) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July
9) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
10) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
11) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
12) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. *(See Section 140B, 1.)*	October
13) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
14) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
15) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 265D, 1a and 1p.)*	As directed by the DEPARTMENT
16) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred 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
17) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 265B.)*	As needed
18) Recovery of Overpayments	The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures. *(See Section 135F.)*	As needed
19) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 245K.)*	As needed

Deliverable	Description	Frequency
20) Notification of Legal Action Against PARTICIPANT in Dispute over Charges	If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit's status in a mutually agreeable format. *(See Section 135F.)*	As needed
21) Notification of 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 personal 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 155G.)*	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 245F.)*	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, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. *(See Section 155J.)*	During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • The HEALTH BENEFIT PROGRAM provider directory or directions on how to request a printed copy of the provider directory. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. *(See Section 230C.)*	See description
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. *(See Section 245B.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. *(See Section 245D.)*	See description
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment. *(See Section 260C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed
10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

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

The penalties assessed in Section 150B and Section 315 shall not exceed twenty-five (25%) percent of the CONTRACTOR'S total administrative fee in any given quarter. After implementation, all performance standards will be measured by the DEPARTMENT on a QUARTERLY basis and assessed based on PARTICIPANT counts as of the first calendar DAY of the quarter, as determined by DEPARTMENT enrollment records. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

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

315A Implementation

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

Performance Standards – three (3%) percent Penalty	Penalties
1) Program Information: All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards – three (3%) percent Penalty	Penalties
2) Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) Customer Service: The CONTRACTOR's dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained no later than September 30, 2017. (*See Section 265A.)*	
4) Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. *(See Section 265A.)*	
5) Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 265A.)*	
6) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. *(See Section 265A.)*	
7) Financial Administration: Financial administration requirements are operational no later than November 30, 2017. *(See Section 265A.)*	
8) Grievance Procedure: The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT'S review and approval. *(See Section 265A.)*	
9) ID Cards: No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018. *(See Section 265A.)*	
10) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018. *(See Section 265A.)*	

Performance Standards – three (3%) percent Penalty	Penalties
11) Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
12) Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly no later than January 31, 2018. *(See Section 265A.)*	
13) Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than February 28, 2018. *(See Section 265A.)*	
14) Claims Data Transfer: The claims data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than March 31, 2018. *(See Section 265A.)*	

315B Account Management

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

Performance Standards	Penalties
1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(*See *Section 265B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey

Performance Standards	Penalties
2) **Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 265D, 1.)*	Five thousand ($5,000) dollars per incident

315C Claims Processing

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

Performance Standards	Penalties
1) **Financial Accuracy:** At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid in the correct amount divided by the total claim dollars paid. *(See Section 235.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
2) **Processing Accuracy:** At least ninety-seven (97%) percent level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section 235.)*	
3) **Claims Processing Time:** At least ninety-five (95%) percent of all claims received must be processed within fifteen (15) BUSINESS DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 235.)*	

315D Customer Service

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

Performance Standards	Penalties
1) **Call Answer Timeliness**: At least eighty (80%) percent of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)

Performance Standards	Penalties
2) Call Abandonment Rate: Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
3) Open Call Resolution Turn-Around-Time: At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section 265C.)*	
4) Inquiry Resolution Tracking Document/Log: Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request. *(See Section 265C.)*	
5) Electronic Written Inquiry Response: At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section 265C.)*	

315E Data Management

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

Performance Standards	Penalties
1) Claims Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a and 150B, 1.)*	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, 2.)*	

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 155G.)*	

315F Enrollment

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

Performance Standards	Penalties
1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 150A, 4, a and c.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Enrollment Discrepancies: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. *(See Section 150A, 4, a.)*	
3) ID Cards: The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
4) ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID cards by December 15 (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.)*	

Performance Standards	Penalties
5) Direct Pay Terminations: The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section 255.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

315G Other

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

Performance Standards	Penalties
1) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155E.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Grievance Resolution: Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. *(See Section 245C.)*	
3) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	
4) PARTICIPANT Satisfaction Surveys: The CONTRACTOR shall achieve at or above a ninety (90%) percent satisfaction rating (defined as “top three-boxes” using a zero (0) to ten (10) rating scale with ten (10) being the highest ranking) on the health plan rating question on the CAHPS survey tool or other survey instrument as approved by the DEPARTMENT. *(See Section 225, 3, c.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
5) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident

Performance Standards	Penalties
6) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

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 2018.

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

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

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

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

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

I. Schedule of Benefits

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

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

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

The covered benefits are subject to the following:

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

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Annual medical DEDUCTIBLE	$250 individual/$500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	None.	$1,500 per individual plan / $3,000 per family plan The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the plan pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).
Annual medical COINSURANCE	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies OOPL except as described below.	BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL.
Annual medical OUT-OF-POCKET LIMIT (OOPL)	$1,250 PARTICIPANT / $2,500 aggregate family limit except as described below.[1]	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]	After DEDUCTIBLE: $2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN pays 100%.	Covered 100%.	BENEFIT PLAN pays 100%.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $75 COPAYMENT (counts towards to OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit).[2]	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. §632.895 (16), covered 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	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 and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). 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 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Prescription Drugs	See below.	See below.	After DEDUCTIBLE: subject to medical DEDUCTIBLE above. After DEDUCTIBLE, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

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

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

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

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

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical DEDUCTIBLE	None.	$250 individual / $500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	$500 individual / $1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). When an individual within a family plan meets the $500 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.	$1,500 per individual plan / $3,000 per family plan. The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the BENEFIT PLAN pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical COINSURANCE	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLEMEDICAL EQUIPMENT, cochlear implants and hearing aids.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visits, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.	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.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / 10% applies to medical services except for office visits, and as described below. COINSURANCE applies to OOPL except as described below.
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]	$1,250 individual / $2,500 aggregate family limit except as described below.[1]	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOPL.[1]	$2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
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	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15 per visit. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.	PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
Cochlear Implants for PARTICIPANTS age 18 and older	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLANS pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), BENEFIT PLANS pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
		treatment per PARTICIPANT per calendar year.		treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.
Prescription Drugs	See below.	See below.	See below.	After DEDUCTIBLE: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

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

b) Preventive Prescription Drugs:

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

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

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

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

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

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

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

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

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): no annual OOPL.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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

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

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

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $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:

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

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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

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

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

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

II. Definitions

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

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

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

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

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

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

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

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

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

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

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

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

2) the TPA's methodology guidelines,

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

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

5) other factors.

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

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

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

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

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

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

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

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

1) Spouse.[1]

2) DOMESTIC PARTNER, if elected.[2]

3) Child.[3, 4, 5]

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

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

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

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

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

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

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

[3] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, 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.

[4] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

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

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

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

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

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

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

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

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

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

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

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

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

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 TPA and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

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

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 TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the TPA and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the TPA and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

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

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

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

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

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

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

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the TPA.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

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

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

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses or DOMESTIC PARTNERS.

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

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The TPA agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the TPA in advance of the services being provided.

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

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the TPA after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

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

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

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

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

4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the TPA and/or PBM:

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

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

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

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

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

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

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

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this TPA.

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

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM’S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

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

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

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

4) Dietitian visit.

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

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

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

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

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

PHARMACY BENEFIT MANAGER (PBM): The PBM is a THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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 TPA before obtaining the services. Unless otherwise indicated by YOUR TPA, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the TPA and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

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

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-

language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

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

SELF-ADMINISTERED 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 TPA to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a TPA or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The TPA or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

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

SKILLED NURSING FACILITY: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a SKILLED NURSING FACILITY.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

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

THIRD PARTY ADMINISTRATOR (TPA): The THIRD PARTY ADMINISTRATOR who is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

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

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the TPA, when taking into consideration, among other factors determined by the TPA, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases the amount the TPA determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. TPA approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

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

III. Benefits and Services

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

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the TPA reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see item A, 1 and item A, 2 below).

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

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

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

A. Medical/Surgical Services

1) EMERGENCY Care

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

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

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

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

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

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

2) URGENT CARE

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

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

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

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

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

a) PREOPERATIVE and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

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

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

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

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

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

   i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit 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 TPA terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the TPA may request notification of the inpatient stay prior to the delivery or shortly thereafter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if

correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

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

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

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

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)

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

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

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

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

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

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

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the TPA if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the TPA. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the TPA.

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

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

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

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

14) Phase II Cardiac Rehabilitation

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

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

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

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

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

16) Oral Surgery

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

a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

e) Apicoectomy. (Excision of apex of tooth root.)

f) Excision of exostoses of the jaws and hard palate.

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

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

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

18) Transplants

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

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

i) Aplastic anemia

ii) Acute leukemia

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

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the TPA.

h) In addition to the above-listed diagnoses for covered transplants, the TPA may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the TPA determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants 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 TPA.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The TPA may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the TPA.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

   c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
   EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up

care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA.

   a) Outpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "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 TPA within 72 hours after the initial provision of service.

   d) Other
   Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section 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 TPA.

(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 TPA:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the TPA, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the TPA.

k) Other medical equipment and supplies as approved by the TPA. Rental or purchase of equipment/supplies is at the option of the TPA.

l) When PRIOR AUTHORIZED as determined by the TPA, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the TPA will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the TPA. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the TPA. Additional visits may be approved by the TPA. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any TPA under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and

dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for 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 TPA.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The TPA, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED 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 TPA or a contracted PROVIDER administers the injection. If the TPA or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.

d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED 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 TPAs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 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 TPA and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   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 TPA.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, 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 TPA.

c) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

d) All separately billed donor-related services, except for kidney transplants.

e) Non-human organ transplants or artificial organs.

7) Reproductive Services

a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c) Services for storage or processing of semen (sperm); donor sperm.

d) Harvesting of eggs and their cryopreservation.

e) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the TPA.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the TPA.

c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the TPA.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the TPA. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED 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 TPA and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) 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 TPA and/or PBM, or services received after the TPA and/or PBM coverage or eligibility terminates. Except when

a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under TPAs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding TPA will be the responsibility of the succeeding TPA unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding TPA's network. In this instance, the liability will remain with the previous TPA.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the TPA and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

   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 TPA.

v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the TPA. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the TPA.

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 TPA 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 TPA. The treatment of the complication must be a covered benefit of the TPA and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any TPA as part of this program.

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 TPA to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the TPA's and/or PBM's Control: If, due to circumstances not reasonably within the control of the TPA and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the TPA and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the TPA, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other

benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section 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 TPA has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the TPA any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the TPA may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The TPA will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the TPA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1) The persons it has paid or for whom it has paid,

2) Insurance companies, or

3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the TPA and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the TPA and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the TPA, provide any relevant and reasonably available information which the TPA believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the TPA and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the TPA's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The TPA, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the TPA, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The TPA may employ a professional staff to provide case management services. As part of this case management, the TPA or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the TPA agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the TPA's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the TPA. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

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

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the TPA or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The TPA and/or PBM might pay more than the TPA and/or PBM owes under the policy. If so, the TPA and/or PBM can recover the excess from YOU. The TPA and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the TPA and/or PBM.

Each PARTICIPANT agrees to reimburse the TPA and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the TPA and/or PBM. At the option of the TPA and/or PBM, benefits for future CHARGES may be reduced by the TPA and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

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

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a TPA or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the TPA provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The TPA'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

1) The third party or any liability or other insurance covering the third party.

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the TPA or DEPARTMENT to such extent.

The TPA'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the TPA'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the TPA'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the TPA or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the TPA or DEPARTMENT such additional information as is reasonably requested by the TPA or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the TPA'S or DEPARTMENT'S rights against a third party. The TPA or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the TPA or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the TPA or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the TPA or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the TPA or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the TPA or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the TPA or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in

making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the TPA or DEPARTMENT for all amounts theretofore or thereafter paid by the TPA or DEPARTMENT which would have otherwise been recoverable under such acts and the TPA or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the TPA or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the TPA and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the TPA, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the TPA and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the TPA and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating TPAs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the TPA and/or PBM. Contact the TPA and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the TPA and/or PBM. The TPA and/or PBM will advise YOU of YOUR

right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the TPA and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the TPA and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the TPA's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the TPA and/or PBM breached its contract with the Group Insurance Board.

EXHIBIT 2

Standard Terms And Conditions (Request For Bids / Proposals)

1.0 SPECIFICATIONS: The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid/proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 DEVIATIONS AND EXCEPTIONS: Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 QUALITY: Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 QUANTITIES: The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 DELIVERY: Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 PRICING AND DISCOUNT: The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the contractor which are demonstrated to be industrywide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 UNFAIR SALES ACT: Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 ACCEPTANCE-REJECTION: The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 METHOD OF AWARD: Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 ORDERING: Purchase orders or releases via purchasing cards shall be placed directly to the contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements

are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW AND COMPLIANCE: This contract shall be governed under the laws of the State of Wisconsin. The contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel this contract if the contractor fails to follow the requirements of s. 77.66, Wis. Stats., and related statutes regarding certification for collection of sales and use tax. The State of Wisconsin also reserves the right to cancel this contract with any federally debarred contractor or a contractor that is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

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

17.0 ASSIGNMENT: No right or duty in whole or in part of the contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION / AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan by the contractor. An exemption occurs from this requirement if the contractor has a workforce of less than fifty (50) employees. Within fifteen (15) working days after the contract is awarded, the contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

19.2 The contractor agrees to post in conspicuous places, available for employees and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the contractor's becoming declared an "ineligible" contractor, termination of the contract, or withholding of payment.

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

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

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

23.0 INSURANCE RESPONSIBILITY: The contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employees engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin public records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot be copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin public records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employees and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

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

32.0 HOLD HARMLESS: The contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the contractor, or of any of its contractors, in prosecuting work under this agreement.

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

34.0 WORK CENTER PROGRAM: The successful bidder/proposer shall agree to implement processes that allow the State agencies, including the University of Wisconsin System, to satisfy the State's obligation to purchase goods and services produced by work centers certified under the State Use Law, s.16.752, Wis. Stat. This shall result in requiring the successful bidder/proposer to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses.

35.0 FORCE MAJEURE: Neither party shall be in default by reason of any failure in performance of this Agreement in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the party.

State of Wisconsin
Department of Administration
DOA-3681 (01/2001)
ss. 16, 19 and 51, Wis. Stats.

Division of Agency Services
Bureau of Procurement

EXHIBIT 3

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor; and

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential contractor shall certify in writing to the procuring agency that no relationship exists between the potential contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employee or who is retained as a contractor full-time by a State of Wisconsin agency from being retained as a contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.0831 Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

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

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the contractor. The contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

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

EXHIBIT 4

Department Terms and Conditions

1.0 ENTIRE AGREEMENT: This Contract, its exhibits, subsequent amendments and the documents incorporated by order of precedence contain the entire understanding between the parties on the subject matter hereof, and no representations, inducements, promises, or agreements, oral or otherwise, not embodied herein shall be of any force or effect. This Contract supersedes any other oral or written agreement entered into between the parties on the subject matter hereof.

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

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

In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state.

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

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

Contractor will comply with the provisions of Wis. Stat. § 134.98**.**

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

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

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

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

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

None of the Services to be provided by the Contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without prior written notification to, and approval of, the Department.

After execution of the Contract, ETF will provide a designated contact person and commit to a timely approval process for notification of a change in subcontractor(s) and/or delegated services.

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

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

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

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

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

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

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

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

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

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

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

Authorized personnel shall have access to interview any Contractor's or subcontractor's employee or authorized agent involved with this Contract in conjunction with any audit, review, or investigation deemed necessary by the State of Wisconsin.

7.0 **CRIMINAL BACKGROUND VERIFICATION:** The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://oser.state.wi.us/docview.asp?docid=6658). The Contractor is expected to perform background checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

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

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

to the Department's local computer network.

9.0 SECURITY OF PREMISES, EQUIPMENT, DATA AND PERSONNEL: The State of Wisconsin shall have the right, acting by itself or through its authorized representatives, to enter the premises of the Contractor at mutually agreeable times to inspect and copy the records of the Contractor and the Contractor's compliance with this section. In the course of performing Services under this Contract, the Contractor may have access to the personnel, premises, equipment, and other property, including data files, information, or materials (collectively referred to as "data") belonging to the State.

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

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

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

12.0 LIQUIDATED DAMAGES: The Contractor and Department acknowledge that it can be difficult to ascertain actual damages when a Contractor fails to carry out the responsibilities of this Contract. Because of that, the Contractor and Department will negotiate liquidated damages, as required by the State of Wisconsin, for this Contract. The Contractor agrees that the Department shall have the right to liquidate such damages, through deduction from the Contractor's invoices, in the amount equal to the damages incurred, or by direct billing to the Contractor.

The Department shall notify the Contractor in writing of any claim for liquidated damages pursuant to this section within thirty (30) Calendar Days after the Contractor's failure to perform in accordance with the terms and conditions of this Contract.

Notwithstanding the foregoing language, when necessary the Department will identify in the RFP specific financial penalties for failure of the Contractor to meet performance standards and guarantees that may be set forth in the RFP.

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

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

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

Level	Contractor	The Department	Allotted Time
First Second	Level 1 entity	Deputy Office Director Office	10 Business Days
	Level 2 entity	Director	20 Business Days
Third	Level 3 entity	Secretary	30 Business Days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is days from the date that the Invoking Party's notice was originally received by the other party. If the Third Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's

original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the section below. The time periods herein are in addition to those periods for a party to cure provided elsewhere in this Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

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

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

16.0 **TERMINATION OF THIS CONTRACT:** The Department may terminate this Contract at any time at its sole discretion by delivering one-hundred eighty (180) Calendar Days written notice to the Contractor.

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

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

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

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

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

The State of Wisconsin reserves the right to cancel this Contract in whole or in part without penalty in one (1) or more of the following occurrences:

- **(a)** If the Contractor intentionally furnished any statement, representation, warranty, or certification in connection with its Proposal which is materially false, incorrect, or incomplete;
- **(b)** If applicable, fails to follow the sales and use tax certification requirements of Wis. Stat. § 77.66;
- **(c)** Incurs a delinquent Wisconsin tax liability;
- **(d)** Fails to submit a non-discrimination or affirmative action plan per the requirements of Wis. Stat. § 16.765 and Wisconsin's Fair Employment Law, subch. II, Chapter 111 of the Wisconsin Statutes as required herein;
- **(e)** Is presently identified on the list of parties excluded from State of Wisconsin procurement and non-procurement Contracts;
- **(f)** Becomes a state or federal debarred Contractor, or becomes excluded from state Contracts, or;
- **(g)** Fails to maintain and keep in force all required insurance, permits and licenses as required per this Contract;
- **(h)** Fails to maintain the confidentiality of the State of Wisconsin's information that is considered to be Confidential Information or Protected Health Information;
- **(i)** Files a petition in bankruptcy, become insolvent, or otherwise takes action to dissolve as a legal entity; or,
- **(j)** If at any time the Contractor's performance threatens the health or safety of a State of Wisconsin employee, citizen, or customer.
- **(k)** Violation of any requirements in Section 22 regarding Confidential Information.

In the event of a termination for cause by the State of Wisconsin, the State of Wisconsin shall be liable for payments for

any work accepted by the State of Wisconsin prior to the date of termination.

18.0 **REMEDIES OF THE STATE:** The State of Wisconsin shall be free to invoke any and all remedies permitted under Wisconsin law. In particular, if the Contractor fails to perform as specified in this Contract, the State of Wisconsin may issue a written notice of default providing for at least a seven (7) Business Day period in which the Contractor shall have an opportunity to cure, provided that cure is possible, feasible, and approved in writing by the State of Wisconsin. Time allowed for cure of a default shall not diminish or eliminate the Contractor's liability. If the default remains, after opportunity to cure, then the State of Wisconsin may: (1) exercise any remedy provided in law or in equity or (2) terminate Contractor's Services.

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

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

19.0 **TRANSITIONAL SERVICES:** Upon cancellation, termination, or expiration of this Contract for any reason, the Contractor shall provide reasonable cooperation, assistance and Services, and shall assist the State of Wisconsin to facilitate the orderly transition of the work hereunder to the State of Wisconsin and or to an alternative Contractor selected for the transition upon written notice to the Contractor at least thirty (30) business days prior to termination or cancellation, and subject to the terms and conditions set forth herein.

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

21.0 **OWNERSHIP OF MATERIALS:** Except as otherwise provided in subsection (t) of Section 22, all information, data, reports and other materials as are existing and available from the Department and which the Department determines to be necessary to carry out the scope of Services under this Contract shall be furnished to the Contractor and shall be returned to the Department upon completion of this Contract. The Contractor shall not use it for any purpose other than carrying out the work described in this Contract.

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

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

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

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

22.0 **CONFIDENTIAL INFORMATION AND HIPAA BUSINESS ASSOCIATE AGREEMENT:** This Section is intended to cover handling of Confidential Information under state and federal law, and specifically to comply with the requirements of HIPAA, HITECH, and the Genetic Information Nondiscrimination Act (GINA) and the federal implementing regulations for those statutes requiring a written agreement with business associates.

(a) DEFINITIONS: As used in this Section, unless the context otherwise requires:

(1) Business Associate. "Business Associate" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Contractor (insert name of Contractor).

(2) Confidential Information has the meaning ascribed to it in Section 1.5 of the RFP.

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

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

(5) Individual Personal Information "Individual Personal Information" has the meaning ascribed to it at Wis. Admin. Code ETF § 10.70 (1).

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

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

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

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

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

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

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

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

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

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

(f) MANDATORY REPORTING: Contractor shall report to ETF in the manner set forth in Subsection (l) any use or disclosure or suspected use or disclosure of Confidential Information not provided for by this Contract, of which it becomes aware, including breaches or suspected breaches of unsecured Protected Health Information as required at 45 CFR 164.410.

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

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

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

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

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

(l) CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** A list of any affected members (if available);
- **b.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **c.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **d.** The date of the discovery by Contractor;
- **e.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **f.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than one (1) business day before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

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

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

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

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

(o) NOTICE OF LEGAL PROCEEDINGS: If Contractor or any of its employees, agents, or subcontractors is legally required in any administrative, regulatory or judicial proceeding to disclose any Confidential Information, contractor shall give the Department prompt notice (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

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

reasonable corrective action plan, as directed by the Department.

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

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

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

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

1. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to ETF or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;
4. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;
5. Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and
6. If required by ETF, transmit the Confidential Information to another contractor of ETF.

23.0 INDEMNIFICATION:

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

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

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

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

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

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

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

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

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

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

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

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

The State of Wisconsin reserves the right to approve all individuals assigned to this project. The Contractor agrees to use its best effort to minimize personnel changes during the Contract term.

At the time of contract negotiations, the Contractor shall furnish the Department with names of all key personnel assigned to perform work under this Contract and furnish the Department with criminal background checks.

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

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

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

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

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

An unauthorized change by the Contractor of any Contracted Personnel designed as key personnel will result in the imposition of liquidated damages, as defined in this Contract.

28.0 DATA SECURITY AND PRIVACY AGREEMENT

(a) PURPOSE AND SCOPE OF APPLICATION: This Data Security and Privacy Agreement (Agreement) is designed to protect the Department of Employee Trust Fund's (ETF) Confidential Information and ETF Information Resources (defined below). This Agreement describes the data security and privacy obligations of Contractor and its sub-contractors that connect to ETF Information Resources and/or gain access to Confidential Information.

(b) DEFINED TERMS:

(1) **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) Individual Personal 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); or (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 by Contractor on FORM D –Designation of Confidential and Proprietary Information (DOA-3027). Pricing information cannot be held confidential.

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

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

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

(e) PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor agrees to hold ETF's Confidential Information, and any information derived from such information, in strictest confidence. Contractor will not access, use or disclose Confidential Information other than to carry out the purposes for which ETF disclosed the Confidential Information to Contractor, except as permitted or required by applicable law, or as otherwise authorized in writing by ETF. For avoidance of doubt, this provision prohibits Contractor from using for its own benefit Confidential Information or any information derived from such information. If required by a court of competent jurisdiction or an administrative body to disclose Confidential Information, Contractor will notify ETF in writing immediately upon receiving notice of such requirement and prior to any such disclosure, to give ETF an opportunity to oppose or otherwise respond to such disclosure (unless prohibited by law from doing so).

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

(g) SAFEGUARD STANDARD: Contractor agrees to protect the privacy and security of Confidential Information according to all applicable laws and regulations, including HIPAA, by commercially-acceptable frameworks or standards such as the ISO/IEC 27000-series, NIST, 800-53, RFC 2196, IEC 62443, and SANS CIS Top 20. ISO 270001, etc. Security Controls, and no less rigorously than it protects its own confidential information, but in no case less than reasonable care. Contractor will implement, maintain and use appropriate administrative, technical and physical security measures to preserve the confidentiality, integrity and availability of the Confidential Information. All Confidential Information stored on portable devices or media must be encrypted in accordance with the Federal Information Processing Standards (FIPS) Publication 140-2. Contractor will ensure that all security measures are regularly reviewed including ongoing monitoring, an annual penetration and vulnerability test, and an annual security incident response test, and revised, no less than annually, to address evolving threats and vulnerabilities while Contractor has responsibility for the Confidential Information under the terms of this Agreement. Prior to agreeing to the terms of this Agreement, and periodically thereafter (no more frequently than annually) at ETF's request, Contractor will provide assurance, in the form of a third-party audit report or other documentation acceptable to ETF, such as SOC2 Type II, demonstrating that appropriate information security safeguards and controls are in place.

(h) INFORMATION SECURITY PLAN:

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

(2) Contractor will establish, maintain and comply with an information security plan (Information Security Plan), which will contain, at a minimum, such elements as those set forth in this Agreement.

(3) Contractor's Information Security Plan will be designed to:

- **a.** Ensure the privacy, security, integrity, availability, and confidentiality of Confidential Information;
- **b.** Protect against any anticipated threats or hazards to the security or integrity of such information;
- **c.** Protect against unauthorized access to or use of such information that could result in harm or inconvenience to the person that is the subject of such information;
- **d.** Reduce risks associated with Contractor having access to ETF Information Resources; and
- **e.** Comply with all applicable legal and regulatory requirements for data protection.

(4) On at least an annual basis, Contractor will review its Information Security Plan, update and revise it as needed, and submit it to ETF upon request. At ETF's request, Contractor will make modifications to its Information Security Plan or to the procedures and practices thereunder to conform to ETF's security requirements as they exist from time to time. If there are any significant

modifications to Contractor's Information Security Plan, Contractor will notify ETF within a reasonable period of time, not to exceed two weeks. Any significant modification must include the same or a higher framework or information security standard maturity level than what currently exists in the Plan.

(i) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION:

Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

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

(2) Where feasible, return to ETF, or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;

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

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

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

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

(j) NOTIFICATION OF CORRESPONDENCE CONCERNING CONFIDENTIAL INFORMATION: Contractor agrees to notify ETF immediately, both orally and in writing, but in no event more than twenty-four (24) hours after Contractor receives correspondence or a complaint regarding Confidential Information, including but not limited to, correspondence or a complaint that originates from a regulatory agency or an individual.

(k) BREACHES OF CONFIDENTIAL INFORMATION:

CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure of ETF's Confidential Information, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** The nature of the unauthorized access, use or disclosure;
- **b.** A list of any affected members (if available);
- **c.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **d.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **e.** The date of the discovery by Contractor;
- **f.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **g.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than twenty-four (24) hours before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons

potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

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

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

COORDINATION OF BREACH RESPONSE ACTIVITIES:

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

- **a.** Immediately preserving any potential forensic evidence relating to the breach, and remedying the breach as quickly as circumstances permit
- **b.** Within forty-eight (48) hours designating a contact person to whom ETF will direct inquiries, and who will communicate Contractor responses to ETF inquiries; Contractor will designate a Privacy Officer and Security Officer to serve as contacts for ETF.
- **c.** As rapidly as circumstances permit, applying appropriate resources to remedy the breach condition, investigate, document, restore ETF service(s) as directed by ETF, and undertake appropriate response activities such as working with ETF, its representative, and law enforcement to identify the breach, identify the perpetrator(s), and take appropriate actions to remediate the security vulnerability;
- **d.** Providing status reports at least every two (2) hours until the root cause of the breach is identified and a plan is devised to fully remediate the breach;
- **e.** Once the root cause of the breach is identified and a plan is devised to fully remediate the breach, providing status reports daily or at mutually agreed upon timeframes, to ETF on breach response activities, findings, analyses, and conclusions;
- **f.** Coordinating all media, law enforcement, or other breach notifications with ETF in advance of such notification(s), unless expressly prohibited by law; and
- **g.** Ensuring that knowledgeable Contractor staff is available on short notice, if needed, to participate in ETF-initiated meetings and/or conference calls regarding the breach.

ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS:

(5) Contractor will make itself and any employees, subcontractors, or agents assisting Contractor in the performance of its obligations available to ETF at no cost to ETF to testify as witnesses, or otherwise, in the event of a breach or other unauthorized disclosure of Confidential Information caused by Contractor that results in litigation, governmental investigations, or administrative proceedings against ETF, its directors, officers, agents or employees based upon a claimed violation of laws relating to security and privacy or arising out of this Agreement or the Contract.

(l) RETENTION OF LOGS:

(1) HIPAA logs (logs of any systems that have information relating to HIPAA) must be kept for six (6) years.

(2) Firewall logs must be kept for twelve (12) months.

(m) ADDITIONAL INSURANCE: In addition to the insurance required under the Agreement, Contractor at its sole cost and expense will obtain, keep in force, and maintain an insurance policy (or policies) that provides coverage for privacy and data security breaches. This specific type of insurance is typically referred to as Privacy, Technology and Data Security Liability, Cyber Liability, or Technology Professional Liability. In some cases, Professional Liability policies may include some coverage for privacy and/or data breaches. Regardless of the type of policy in place, it needs to include coverage for reasonable costs in investigating and responding to privacy and/or data breaches with the following minimum limits unless ETF specifies otherwise: $1,000,000 Each Occurrence and $5,000,000 Aggregate.

(n) INFORMATION SECURITY PLAN REQUIREMENTS:

(1) Contractor will develop, implement, and maintain a comprehensive Information Security Plan that is written in one or more readily accessible parts and contains administrative, technical, and physical safeguards. The safeguards contained in such program must be consistent with the safeguards for protection of Confidential Information and information of a similar character set forth in any state or federal regulations by which the person who owns or licenses such information may be regulated.

(2) Without limiting the generality of the foregoing, every comprehensive Information Security Plan will include, but not be limited to:

a. Designating one or more employees to maintain the comprehensive Information Security Plan;

b. Identifying and assessing internal and external risks to the security, confidentiality, and/or integrity of any electronic, paper or other records containing Confidential Information and of ETF Information Resources, and evaluating and improving, where necessary, the effectiveness of the current safeguards for limiting such risks, including but not limited to:

c. Ongoing employee (including temporary and contract employee) training;

d. Employee compliance with policies and procedures; and

e. Means, including Contractor staff, processes, and technology, for detecting information system intrusions, data breaches, and anomalous system behavior or activity, and for preventing security breaches, intrusions, or unauthorized access to information systems or networks.

f. Developing security policies for employees relating to the storage, access and transportation of records containing Confidential Information outside of business premises.

g. Imposing disciplinary measures for violations of the comprehensive Information Security Plan rules.

h. Preventing terminated employees from accessing records containing Confidential Information and/or ETF Information Resources.

i. Overseeing service providers, by:

--Taking reasonable steps to select and retain third-party service providers that are capable of maintaining appropriate security measures to protect such Confidential Information and ETF Information Resources consistent with all applicable laws and regulations; and

-- Requiring such third-party service providers by contract to implement and maintain such appropriate security measures for Confidential Information.

j. Placing reasonable restrictions upon physical access to records containing Confidential Information and ETF Information Resources and requiring storage of such records and data in locked facilities, storage areas or containers.

k. Restrict physical access to any network or data centers that may have access to Confidential Information or ETF Information Resources.

l. Requiring regular monitoring to ensure that the comprehensive Information Security Plan is operating in a manner reasonably calculated to prevent unauthorized access to or

unauthorized use of Confidential Information and ETF Information Resources; and upgrading information safeguards as necessary to limit risks.

m. Reviewing the scope of the security measures at least annually or whenever there is a material change in business practices that may reasonably implicate the security or integrity of records containing Confidential Information and of ETF Information Resources.

n. Documenting responsive actions taken in connection with any incident involving a breach, and mandating post-incident review of events and actions taken, if any, to make changes in business practices relating to protection of Confidential Information and ETF Information Resources.

(o) COMPUTER SYSTEM SECURITY REQUIREMENTS: To the extent that Contractor electronically stores or transmits Confidential Information or has access to any ETF Information Resources, it will include in its written, comprehensive Information Security Plan the establishment and maintenance of a security system covering its computers, including any wireless system, that, at a minimum, and to the extent technically feasible, will have the following elements:

(1) Secure user authentication protocols including:

a. Control of user IDs and other identifiers;
b. A secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;
c. Multi-Factor Authentication (MFA);
c. Control of data security passwords to ensure that such passwords are kept in a location and/or format that does not compromise the security of the data they protect;
d. Multi-factor authentication for system administrators and others with 'super-user' access rights;
e. Restricting access to active users and active user accounts only;
f. Blocking access to user identification after multiple unsuccessful attempts to gain access or the limitation placed on access for the particular system; and
g. Periodic review of user access, access rights and audit of user accounts.

(2) Secure access control measures that:

a. Restrict access to records and files containing Confidential Information and systems that may have access to ETF Information Resources to those who need such information to perform their job duties; and
b. Assign unique identifications plus passwords, which are not vendor supplied default passwords, to each person with computer access, which are reasonably designed to maintain the integrity of the security of the access controls.

(3) Encryption of all transmitted records and files containing Confidential Information.

(4) Adequate security of all networks that connect to ETF Information Resources or access Confidential Information, including wireless networks.

(5) Reasonable monitoring of systems, for unauthorized use of or access to Confidential Information and ETF Information Resources.

(6) Encryption of all Confidential Information stored on Contractor devices, including laptops or other portable storage devices.

(7) For files containing Confidential Information on a system that is connected to the Internet or that may have access to ETF Information Resources, reasonably up-to-date firewall, router and switch protection and operating system security patches, reasonably designed to maintain the integrity of the Confidential Information.

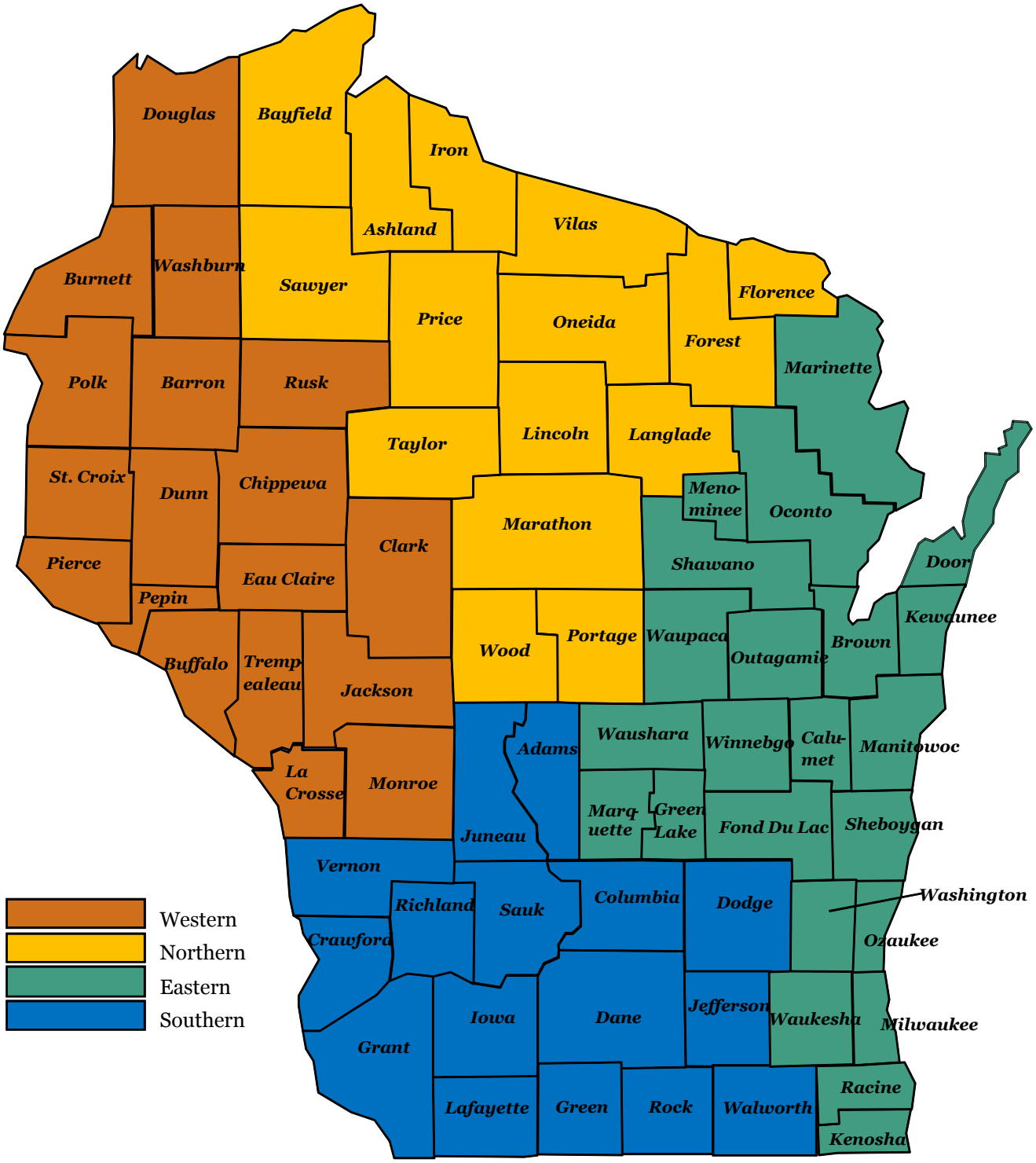
(8) Reasonably up-to-date versions of system security agent software, including intrusion detection systems, which must include malware protection and reasonably up-to-date patches and virus definitions, or a version of such software that can still be supported with up-to-date patches and virus definitions, and is set to receive the most current security updates on a regular basis.

(9) Education and training of employees on the proper use of the computer security system and the importance of Confidential Information and network security.

With reasonable notice to Contractor, ETF may require additional security measures which may be identified in additional guidance, contracts, communications or requirements.

State of Wisconsin
Department of Employee Trust Funds
Regional Map

RFP ETG0003
Exhibit 5: Map
Issued July 22, 2016



State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R07/2016)
§ 51.01(5) Wis. Stats. § 111.32(13m) Wis. Stats.

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

Contract

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

Contract No./Request for Bid/Proposal No: ETG0003 (A)
Authorized Board: Group Insurance Board

Contract Period: June 1, 2017 through December 31, 2020 with the optional renewal of three (3) two (2) year periods

1. This Contract is entered into by the State of Wisconsin, Department of Employee Trust Funds (Department), the State of Wisconsin Group Insurance Board (Board) and between Anthem Blue Cross and Blue Shield hereinafter referred to as the "Contractor", whose address and principal officer appears on page 2. The Department is the sole point of contact for this Contract.

2. Whereby the Department of Employee Trust Funds agrees to direct the purchase and the Contractor agrees to supply the Contract requirements cited in accordance with the State of Wisconsin standard terms and conditions and in accordance with the Contractor's proposal dated September 16, 2016 hereby made a part of this Contract by reference.

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

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

5. Contractor agrees to the Discount Guarantees and Gain Sharing Agreement in Exhibit B for Anthem Preferred.

6. Contractor agrees to administer the Medicare Plus Benefits (new section 500 in Exhibit 1, State of Wisconsin Health Benefit Program Agreement) program from January 1, 2018 through December 31, 2018 with the optional renewal of four (4) one (1) year periods.

7. For purposes of administering this Contract, the order of precedence is:
   a) This Contract with Anthem Blue Cross and Blue Shield;
   b) Exhibit A, Contract clarifications from ETF;
   c) Exhibit B, Discount Guarantees and Gain Sharing Agreement (Anthem Preferred);
   d) RFP Exhibit 1 – State of Wisconsin Health Benefit Program Agreement, dated May 1, 2017;
   e) RFP Exhibit 4 – Department Terms and Conditions, dated April 26, 2017;
   f) Appendix 4a Claims Data Specifications – Medical, dated March 29, 2017;
   g) Appendix 5 Provider Data Specifications, dated March 29, 2017;
   h) Request for Proposal (RFP) ETG0003 dated July 22, 2016, including all appendices, attachments, and amendments thereto; and,
   i) Contractor's proposal dated September 16, 2016.

Contract Number & Service: ETG0003 (A) Administrative Services for the State of Wisconsin Health Benefit Program

State of Wisconsin **Department of Employee Trust Funds**	**Contractor to Complete**
By Authorized Board *(Name)* **Group Insurance Board**	Legal Company Name **Compare Health Services Insurance Corporation**
By *(Name)* **Michael Farrell**	Trade Name Anthem Blue Cross and Blue Shield
Signature	Taxpayer Identification Number **39-1462554**
Title **Chair** Group Insurance Board	Company Address *(City, State, Zip)* N17 W24340 Riverwood Drive Waukesha, WI 53188-1142
Phone 608.266.9854 (A. John Voelker, Deputy Secretary)	By *(print Name)* Paul Nobile
Date *(MM/DD/CCYY)*	Signature
	Title President & General Manager
	Phone 262.523.4825
	Date *(MM/DD/CCYY)* 05/02/2017

Exhibit A

Contract ETG0003 (A): Clarifications and changes agreed to by the parties to the July 22, 2016 Request for Proposal (RFP) ETG0003 Administrative Services for the State of Wisconsin Health Benefit Program to be provided by Anthem Blue Cross and Blue Shield to the State of Wisconsin Department of Employee Trust Funds for the Health Insurance Programs Offered by the State of Wisconsin Group Insurance Board.

The following are clarifications to Contract terms:

#	Document / Section	Section Description	Clarification
1	n/a	n/a	Any dispute, disagreement or question of interpretation of Exhibits 2, 3, or 4 (the Terms and Conditions) and the application of those Exhibits to the terms of this contract is subject to discussion and resolution under Exhibit 4, Section 13.0 (Contract Dispute Resolution) of the Department Terms and Conditions."
2	Exhibit 1 Section 130	Premiums	The language in this section is not intended to hold a Contractor liable for payment of actuarial services related to a review of claims experience, trends and other factors covered by the rate renewal reports submitted by a Contractor pursuant to this section.
3	Exhibit 1 Section 135B	Administrative Fee Adjustments	Language as shown was drafted with the intention to allow for administrative fee increases, as recommended by ETF's actuary. Should an administrative fee change be implemented for which the TPA disagrees, the process on contract dispute resolution is provided in Exhibit 4.0, Section 13.0.
4	Exhibit 1 Section 215A	Disease Management / Prior Authorizations / Utilization Review	The contract requires prior authorizations to include member out-of-pocket cost sharing information. The intent is to base the authorization on the provider status at time of the authorization review with disclosure about any anticipated provider status change for the length of the approval period and disclosure that the member's deductible, coinsurance and/or copayment applies. Member out-of-pocket costs do not need to be amount specific and instruction should be provided on how members can obtain specific cost-sharing information. The contract also states the Contractor is responsible for the cost of services not covered under the contract when the member has received a prior authorization. The intent is to hold the Contractor accountable if it errors by prior authorizing a service that is not covered under the contract.

#	Document / Section	Section Description	Clarification
5	Exhibit 1 Sections 230 and 230D	Provider Contracts Provider Contracts Shall Include Compliance Plans	Including the provider agreement requirements outlined in Section 230 and the compliance plans outlined in Section 230D in a policy, program or process for which the provider contract requires compliance, even though the provider contract does not specifically identify such items, is deemed to meet this contractual requirement.
6	Exhibit 4 Section 28.0 (i)(2)	Data Security and Privacy Agreement	1) The data should be destroyed; 2) unless Contractor can definitely prove to ETF that the data was de-identified; and 3) that Contractor confirms to ETF in writing that no crosswalk exists to re-identify the data.
7	n/a	n/a	Based on the contract negotiations that ETF has conducted over the last several weeks with each of the six contractors, ETF now believes it is appropriate to delete references in the RFP and Section 135B of RFP Exhibit 1 specifically stating that the contractors are fiduciaries. The duties that contractors will perform are delineated throughout the RFP and Exhibit 1. Case law confirms that whether or not a contract specifically states that a contractor is a fiduciary, courts have issued decisions finding that the duties and facts in a particular situation demonstrate that a contractor is a fiduciary.
8	Exhibit 4 Section 12.0	Liquidated Damages	It is the Department's intent that the Contractor will be able to utilize the process described in Exhibit 4, Section 13.0 (Contract Dispute Resolution) prior to the Department imposing any Liquidated Damages.

Wisconsin Department of Employee Trust Funds
Discount Guarantees for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Anthem Preferred**
Region **Statewide/Nationwide**

Vendor will provide 2018 expected overall level of discount.
ETF and Vendor will mutually agree on final starting point.

2018 Discount Target*

* A supplemental worksheet allows vendors to calculate this discount with enrollment and regional assumptions. Upon open enrollment these will be re-based accordingly.

Annual improvement - Spread between Eligible Charge Increase and Vendor Allowed Increase. Expectations on Discount improvement decrease with higher baseline discounts. Improvement is calculated as Assumed Spread x (1-Discount).

Assumed Spread

		Annual Improvement
2019 overall level of discount is expected to improve over 2018	**2019 Discount Target**	
2020 overall level of discount is expected to improve over 2019	**2020 Discount Target**	

Fees at Risk will vary by percentage below target for each of the 3 years based on the following Scale:

% of Actual Discount below Target	% of Total Admin Fees at Risk
	0%
	5%
	10%

Notes:
Actual Performance against Target Discounts will be calculated 6 months after the end of the Calendar Year with runout data available in the data warehouse at that time.
Large claims over $100,000, and any out-of-network claims, will be removed from the calculation.
Discount Percent is calculated as Total Submitted Eligible Charge less Total Allowed (state & member) divided by Total Submitted Eligible Charge.
Discount Guarantee is null and void if Gain-Sharing Actual PMPM is less than Target PMPM.

ETG0003

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Exhibit B

Vendor **Anthem Preferred**
Region **Statewide/Nationwide**

Annual Shared Savings will be calculated based on two factors:
(1) Performance of Actual versus Target PMPM
(2) Performance of Actual versus Target Clinical Performance Measures

Performance of Actual versus Target PMPM **Illustrative Calculation**

Prior Calendar Year allowed claims for those members who select vendor during open enrollment will be used as a starting point to determine a base aggregate PMPM. The data will be normalized to the vendor's network pricing. It is anticipated that this will include 12 months of incurred allowed claims. (TBD)

A claims completion factor will be applied to the allowed claims. This will be updated with runout during the settlement process with claims paid through June of the following Calendar Year. (TBD)

Total Calendar Year Incurred Claims

Apply Industry and Market Specific Trend (TBD) - Trend assumptions will be uniform across all vendors

Calendar Year Allowed PMPM Target

Amount of savings to be shared with vendor will vary by percentage of actual PMPM below Target PMPM based on the following Scale:

	CY 2018	CY 2019	CY 2020
% of Actual PMPM below Target	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**
< 3.00%	0%	0%	0%
3.00% - 6.00%	5%	7.5%	10%
> 6.00%	10%	17.5%	25%

Notes on PMPM:
1) Target PMPM will be set by March 1st of the current CY based on prior CY incurred claims with current year enrollment, adjustment for network pricing, completion factors and trend.
2) Performance of Actual versus Target PMPM will be calculated at the end of the CY when 6 months of runout is available in the data warehouse. This results in 18 months of runout for the Target PMPM and 6 months of runout for the Actual PMPM. Note that the Actual PMPM will have a completion factor applied.

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Anthem Preferred**
Region **Statewide/Nationwide**

Performance of Actual versus Target Clinical Performance Measures

In addition to the shared savings amounts based on Actual versus Target PMPM Calculations, payments will be reduced based on the percentage of clinical targets met by the vendor for the Calendar Year. If all clinical targets are met, payouts will be 100% of the PMPM calculations described above. If, for example, 75% of the clinical targets are met, payouts will be 75% of the PMPM calculations described above.

Clinical Targets for each year of the contract will be determined for each vendor individually by comparing actual baseline for each vendor to an ultimate target for each measure. The difference between the vendor's baseline and target will be the gap that should be closed over 3 years with equal improvement in each of the 3 years to reach the target. Examples are shown below:

	Baseline	Target	Gap	2018 Target	2019 Target	2020 Target
Vendor A	50%	90%	40%	63%	77%	90%
Vendor B	80%	90%	10%	83%	87%	90%
Vendor C	95%	90%	-5%	90%	90%	90%

ETG0003

Wisconsin Department of Employee Trust Funds
Discount Guarantee Development Worksheet

Exhibit B

Vendor **Anthem Preferred**
Region **Statewide/Nationwide**

		Preliminary Discount Guarantee			Final Discount Guarantee		
Region	Total Members	Expected Enrollment	Expected Distribution	Discount Guarantee	Open Enrollment	Final Distribution	Discount Guarantee
Eastern	63,766						
Northern	8,151						
Southern	113,299						
Western	21,024						
In-State	206,240						
Out-of-State	3,379						
Total Membership	209,619						

After open enrollment, a final discount guarantee will be developed based on vendor's actual enrollment.
Discount guarantees by region may not be altered during this process.

ETG0003

RFP ETG0003
Exhibit 1: State of Wisconsin Health Benefit Program Agreement
Issued May 1, 2017

State of Wisconsin Health Benefit Program Agreement

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

Release Date: May 1, 2017

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000 DEFINITIONS

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

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

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).

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).

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 attachments, supplements, endorsements riders and the CONTRACTOR'S PROPOSAL.

CONTRACTOR means the legal signatory to this AGREEMENT.

DAY means calendar DAY unless otherwise indicated.

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

DEPENDENT as defined in Uniform Benefits.

DOMESTIC PARTNER as defined in Uniform Benefits.

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

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

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.

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.

PBM means the Pharmacy Benefit Manager (PBM) which is a third party administrator that is contracted with the BOARD to administer the prescription drug benefits under this HEALTH BENEFIT PROGRAM. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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.

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

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

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.

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

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).

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETG0003 and in the PROPOSAL.

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 (forms 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).

110 Objectives

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

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

2) To provide excellent customer service to PARTICIPANTS.

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

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

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

6) 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.

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

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

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

9) 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 to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

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

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

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

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

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

8) 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.

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

   a) This includes a formal grievance procedure, which at a minimum complies with federal law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the 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.

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

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

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

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

14) Provide notification of all significant events:

a) 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 (15%) percent 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 (51%) percent) interest in the CONTRACTOR or any transfer of ten (10%) percent or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the 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."

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

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

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

18) 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.

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

20) 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, per Wis. Stat. § 40.02 (25) (b), eligible EMPLOYEES include:

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

2) Elected state officials.

3) Members or EMPLOYEES of the legislature.

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

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

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

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

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

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

c) Certain visiting faculty members in the UW System.

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

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

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

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

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

8) ANNUITANTS and CONTINUANTS:

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

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

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

d) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll 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.

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

f) Any retired public employee under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

125B Dependent Coverage Eligibility

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

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

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

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the 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.

125E Local Annuitants

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

125F Medicare Participants

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

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

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

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

130 Premiums

The BOARD determines the PREMIUM for its self-insured benefit plans as part of the HEALTH BENEFIT PROGRAM. This PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to:

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

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

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

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

5) Substantiation of any proposed increase in fixed costs, such as administrative costs, via a thorough analysis of activities and costs covered by those fees.

6) Explanations for any unusual trend results (high or low relative to the market).

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

SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255.

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

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 the Medicare HOSPTIAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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 coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. 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.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see Sections 125F and 220H.

135 Administrative Fee and Financial Administration

135A Invoicing and Banking

1) Claims Invoicing:

   a) The CONTRACTOR shall notify the DEPARTMENT every calendar week during the term of this AGREEMENT and inform the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. The amount due every week shall be the total amount of BENEFIT payments issued by the CONTRACTOR for the claims processed during the immediately prior calendar week (Saturday through Friday).

   b) The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT by the first Friday immediately following the DEPARTMENT'S receipt of the request for payment by the CONTRACTOR. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.

   c) The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within twenty (20) BUSINESS DAYS following month-end.

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

2) Administrative Fee Invoicing:

   a) The CONTRACTOR must submit to the DEPARTMENT on the twentieth (20th) DAY of each calendar month (or the first BUSINESS DAY following the twentieth (20th) DAY of the calendar month), an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The monthly invoice must show the total amount of administration

fees, other approved fees and expenses due for the immediately following calendar month. The DEPARTMENT shall deposit funds into the bank account designated by the CONTRACTOR on the first BUSINESS DAY of the calendar month following the DEPARTMENT'S receipt of the invoice from the CONTRACTOR.

b) The CONTRACTOR shall be paid the administrative fee per month per PARTICIPANT as detailed in the CONTRACT. All administrative plan arrangement-related fees are included in the CONTRACTOR's administrative fee.

   The statewide/nationwide CONTRACTOR shall be paid for underwriting services to evaluate risk and submit recommendations for LOCAL EMPLOYERS requesting participation in the local HEALTH BENEFIT PROGRAM. The LOCAL EMPLOYER shall send payments for underwriting services to the DEPARTMENT. The DEPARTMENT shall forward one check for the appropriate amount shown in the Cost Proposal to the CONTRACTOR for their services.

3) Direct Pay SUBSCRIBER Invoicing:

   The CONTRACTOR shall not process any PREMIUM transactions related to enrollment, except for those direct pay SUBSCRIBERS.

135B Administrative Fee Adjustments

Administrative fee adjustments, if any, required as recommended by the BOARD's consulting actuary for BENEFIT changes, mandated BENEFIT payments, and/or operational changes, will occur on January 1 after the next contract period begins unless otherwise approved by the BOARD. The CONTRACTOR shall supply an administrative monthly invoice that must be based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The CONTRACTOR shall be paid the following administrative charge per month per PARTICIPANT for the AGREEMENT periods stated as follows:

Medical administration fee per individual and family contract. The medical administration fee includes, but is not limited to, the following:

1) Claims administration (including adjudication, payment, reprocessing, coordination of BENEFITS (excluding vendor recoveries), and overpayment collection).

2) Utilization review fees.

3) Network access fees.

4) MHSA claims administration.

5) Medical management (including medical review).

6) Disease management.

7) Customer service (to meet all requirements of this AGREEMENT, including all key personnel).

8) PARTICIPANT materials (including explanations of BENEFITS, summary of BENEFITS and coverage, web tools, ID cards, printing and mailing costs).

9) All required reports (including federally required reports and tax related forms).

10) Claims data extracts.

11) Administration, collection of, and passing through to the DEPARTMENT, premiums for direct pay SUBSCRIBERS (including reporting non-payment terminations).

12) IT services (including hardware and software).

13) Telecom (other program resource links, reporting, special usage or access requirements).

14) Required reviews (including fraud and abuse, and HOSPITAL bill).

15) Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing).

16) Telehealth services.

17) Twenty-four (24)-hour nurse line services.

18) Underwriting services (applies to a CONTRACTOR providing statewide/nationwide services under this AGREEMENT only).

135C Prohibited Fees

1) The CONTRACTOR is prohibited from including in their administrative fee:

   a) The cost to handle any claims paid outside of Uniform Benefits or IYC Medicare Plus administered by the statewide/nationwide CONTRACTOR.

   b) The cost to administer any optional health and wellness benefit(s) beyond Uniform Benefits, IYC Medicare Plus that is administered by the statewide/nationwide CONTRACTOR or the Well Wisconsin program.

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

135D Recovery of Overpayments

1) Overpayments:
   If it is determined that any payment has been made under this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or

shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.

If any overpayments made to ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments. Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR'S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments. Any overpayment caused by the CONTRACTOR'S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.

The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures.

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

   The DEPARTMENT shall not hold the CONTRACTOR responsible for any overpayments caused by DEPARTMENT or EMPLOYER errors or fraud by a person other than an employee of the CONTRACTOR.

   The CONTRACTOR shall assist the DEPARTMENT in identifying overpayments caused by such error or fraud.

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

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

5) Disputes over Charges:

   Notwithstanding any other terms, conditions, and provisions of this AGREEMENT, the CONTRACTOR shall pay CHARGES as determined by the CONTRACTOR. Disputes as to CHARGES will be referred, on a timely basis, to the CONTRACTOR who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

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

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 administrative fees or other 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:

1) Providers to request and receive electronic funds transfer (EFT) of claims payments for BENEFITS.

2) SUBSCRIBERS to submit EFT of direct pay PREMIUM payments. The CONTRACTOR must support other mechanisms for payment of direct pay PREMIUMS.

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.

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.

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. 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. The next roll-out for the new system is currently scheduled for 2018.

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.

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 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.

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

b) 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, 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. 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 and integrate the data as required under Section 240. 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 provided by the DEPARTMENT with 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 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 RFP, 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. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file. 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 and are the direct result of the CONTRACTOR's failure to meet the

DEPARTMENT'S data submission requirements or timelines and which the DEPARTMENT will deduct from any payment owed the CONTRACTOR in the payment period.

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.

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 Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits. All amounts recovered under this program shall be paid forty-five (45%) percent to the CONTRACTOR and fifty-five (55%) percent to the BOARD.

155D 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.

155E 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) 16 and provide a copy of the CPA's report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.) The audit report must be submitted annually.

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.

155F 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. For information see Section 135D.

2) Contractor Provider 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; and,

n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. 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 personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

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

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

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

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

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

155H 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.

155I 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 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) In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.

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

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

155J Transition Plan

During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. In the event that the CONTRACTOR terminates the CONTRACT, an updated

transition plan must accompany the notice of termination. In the event the BOARD terminates the CONTRACT, the CONTRACTOR must send an updated transition plan to the DEPARTMENT within thirty (30) DAYS of the written notice of termination to the CONTRACTOR. The transition plan must be approved by the DEPARTMENT prior to the transition begin date and must include the CONTRACTOR'S cooperation and participation in planning calls or meetings with the succeeding vendor.

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

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

1) Participate in all DEPARTMENT requested meetings.

2) Provide all reports for program close out.

3) Report on performance standards specified in Section 315.

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

5) Transmit program data to the new vendor.

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

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

155K Health Underwriting for Statewide/Nationwide Contractor only

LOCAL EMPLOYERS with one or more employees requesting participation in the local HEALTH BENEFIT PROGRAM are subject to underwriting. The CONTRACTOR shall evaluate risk and submit a recommendation back to the DEPARTMENT for final approval by the BOARD'S actuary. The effective date shall be determined by the DEPARTMENT. The fees described in the Cost Proposal, or as agreed upon by the DEPARTMENT, shall be administered per Section 135A.

Employers with fifty-one (51) or more EMPLOYEES shall submit claims and enrollment experience including high cost claims data for the most recent available twenty-four (24) months along with the fees to the DEPARTMENT.

Employers with fifty (50) or less EMPLOYEES shall submit small employer information as required by the CONTRACTOR to the DEPARTMENT along with the fees.

The DEPARTMENT will submit information and appropriate fees to the 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.

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. 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) 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 Eligibility

The 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.

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

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 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 as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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. See Appendix 6, Guidance for DEPARTMENT Initiatives, for additional detail.

The current DEPARTMENT Initiatives 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) High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.

3) Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.

4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.

5) 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.

215C Quality Initiatives

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.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in Uniform Benefits to all PARTICIPANTS with the exception of the statewide/nationwide CONTRACTOR who must provide the BENEFITS and services listed in the IYC Medicare Plus certificate to all Medicare 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 high deductible health plan (HDHP) 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger 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 Preferred Provider Organization (PPO)

The BOARD may offer different copayment and deductible schedules for OUT-OF-NETWORK providers, except in the case of emergency, urgent care or when the services are not reasonably available IN-NETWORK.

If the PARTICIPANT resides in a CONTRACTOR'S service area, the PPO must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty IN-NETWORK provider when determining if that provider is reasonably available.

220G Medicare

The CONTRACTOR will provide BENEFITS and services as described in Uniform Benefits to PARTICIPANTS enrolled in Medicare with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS.

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

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 EMPLOYEE, 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. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payer after this thirty (30)-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty (30) -month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer. No reduction in PREMIUM is available for active EMPLOYEES under this section.

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, change from or to the IYC HDHP).

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:

1) If a PARTICIPANT changes benefit plans.

2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER (or combination of spouse-to-DOMESTIC PARTNER) transfer resulting in a change of SUBSCRIBER, but does not change benefit plans.

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.

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. For HDHPs, medical and pharmacy accumulations are combined.

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.

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 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 audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year, which includes 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 commercially insured adult 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.

c) The results of the survey shall be used for the measurement of PARTICIPANT satisfaction as specified in the performance standards in Section 315G.

4) The DEPARTMENT will monitor health care quality and/or customer satisfaction using performance measures available in the data warehouse and visual business intelligence tool, and will establish performance metrics, baseline results, and target performance levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage performance improvement.

   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.

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 and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how 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.

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.

The 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 their provider network for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150.

The DEPARTMENT will use this data to ensure provider access standards are met. 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 (33%) percent 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 the following minimum requirements:

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 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 the access standards above, including accepting 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. 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 Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in Uniform Benefits with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS. Targets for claims processing performance standards and associated penalties are specified in Section 315C.

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. The CONTRACTOR shall pay claims of providers according to a time standard mutually established by the CONTRACTOR and the DEPARTMENT.

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

In accordance with state statute, the CONTRACTOR must maintain individual documentation used for claim adjudication for a minimum of seven (7) years.

240 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 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.

245 Grievances

245A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with the HHS-administered federal external review in accordance with federal law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections 245E, 245F, and 265A.

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 245A – H.

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

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

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

245B 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.

245C 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.

245D 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.

245E Notification of Department Administrative Review Rights

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

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 HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

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

245F External Review

The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an 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.

245G 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.

245H 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.

245I 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.

245J 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.

250 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see Section 260D.

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.

255 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt. It is acceptable to credit the collected direct pay PREMIUM amount on the administrative monthly invoice provided that it contains itemized SUBSCRIBER level detail.

Direct pay PREMIUMS may be submitted to the CONTRACTOR via electronic funds transfer or 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.

260 Continuation

260A 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.

260B 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.

260C Conversion / Marketplace

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

260D 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.

265 Miscellaneous Program Requirements

265A 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.

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

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Nondiscrimination Testing Plan: The CONTRACTOR works with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.	Within thirty (30) DAYS of execution of this CONTRACT
Transition Plan: The transition plan is established in a mutually agreed upon format and submitted to the DEPARTMENT Program Manager or designee for review.	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2018 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	August 18, 2017
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 1, 2017
Employer Meeting: The CONTRACTOR attends the It's Your Choice EMPLOYER Kick-Off meeting.	Fall 2017 (Date TBD)
Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.	September 30, 2017
Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2017
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	September 2017 (Date TBD)
Employer Health Fairs: The CONTRACTOR shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area.	October – November 2017
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation.	November 16, 2017

Activity	Due Dates
Financial Administration: Financial administration requirements are operational, including but not limited to: • Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. • Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). • Direct pay invoicing process. • ACH mechanism for EFT of claims payments and direct pay PREMIUMS.	November 30, 2017
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2017
ID Cards: The CONTRACTOR issues welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018.	December 15, 2017
Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM are fully operational.	January 1, 2018
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2018
Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly.	January 15, 2018
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2018
Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2018
Claims Data: The claims data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	March 31, 2018

265B Account Management and Staffing

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

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

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

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

5) Resolve general administrative problems identified by the DEPARTMENT.

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

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

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

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

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

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

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

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the 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 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting HEALTH BENEFIT PROGRAM services.

265C Customer Service

The CONTRACTOR shall operate a dedicated 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 315D 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, EMPLOYER group);

5) The representative that handled the inquiry;

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

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

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

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

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each 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.

265D 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.).

265E 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.

265F 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR.

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.

265G 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 "personal information", as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;

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

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

265H 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.

265I Subrogation and Other Payers

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

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

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel or utilize in-house counsel to provide the BOARD with subrogation litigation services on the BOARD'S behalf at a contingency fee not to exceed thirty (30%) percent for outside legal counsel or twenty (20%) percent for in-house counsel of net dollars recovered by such counsel, with those attorneys' fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

For such subrogation matters, the BOARD shall not pay or provide any additional reimbursement for the outside legal counsel's or in-house counsel's legal fees, expenses, costs and disbursements incurred by such counsel while providing subrogation-related legal services and such legal fees, expenses, costs and disbursements are included in, and will be paid out of, the maximum thirty (30%) percent contingency fee that is paid to the outside legal counsel or twenty (20%) percent fee paid to in-house counsel as set forth in this subsection. The CONTRACTOR will not be paid or receive any portion of the contingency fee that is paid to the outside legal counsel if outside legal counsel is hired. The BOARD shall be solely responsible and liable for paying the contingency fee to outside legal counsel for its attorneys' fees, legal costs and disbursements incurred by the outside legal counsel representing the BOARD in subrogation cases, not the CONTRACTOR. The CONTRACTOR is not responsible or liable for paying the contingency fee or any outside counsel attorneys' fees, legal costs and disbursements.

265J 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.

265K Other

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

265L 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.

265M Conflict of Interest

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

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

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

300 DELIVERABLES

305 Reporting Requirements

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

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

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the 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 Invoicing	The CONTRACTOR notifies the DEPARTMENT every calendar week during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. *(See Section 135A, 1, a.)*	Weekly
3) Administrative Fee Invoice	The CONTRACTOR submits to the DEPARTMENT an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. *(See Section 135A, 2, a.)*	Monthly
4) 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, 1.)*	Monthly
5) Bank Reconciliation Report	The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. *(See Section 135A, 1, c.)*	Monthly
6) Claims Invoice Reconciliation Report	The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. *(See Section 135A, 1, d.)*	Monthly

Report	Description	Frequency
7) 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 265C.)*	Monthly
8) 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, 2..)*	Monthly
9) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155F, 2.)*	Quarterly
10) Hospital Bill Audit	The CONTRACTOR performs a HOSPITAL bill audit process for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and provides results of material findings to the DEPARTMENT. *(See Section 155C.)*	Quarterly
11) 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
12) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
13) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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, High Tech Radiology, Low Back Surgery, Shared Decision Making, and Advance Care Planning. *(See Section 215B.)*	Semi-annually
14) 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 215C.)*	Semi-annually
15) 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.)*	Semi-annually

Report	Description	Frequency
16) 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
17) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. *(See Section 225, 3, b.)*	Annually
18) 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
19) 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
20) 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.)*	Annually
21) 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
22) 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
23) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year. *(See Section 225, 3, a.)*	Annually
24) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually

Report	Description	Frequency
25) Rate Renewal Reports	To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. *(See Section 130.)*	Annually
26) 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 16 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 DEPARTMENT Program Manager or designee. *(See Section 265A.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. *(See Sections 265A and 265B.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. *(See Section 155F, 2 and Section 265A.)*	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section 205B, 2.)*	Upon identification of issue
5) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section 265B.)*	April August

Deliverable	Description	Frequency
7) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. *(See Section 230A.)*	June
8) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July
9) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
10) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
11) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
12) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. *(See Section 140B, 1.)*	October
13) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
14) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
15) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 265D, 1a and 1p.)*	As directed by the DEPARTMENT
16) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred 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
17) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 265B.)*	As needed
18) Recovery of Overpayments	The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures. *(See Section 135F.)*	As needed
19) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 245K.)*	As needed

Deliverable	Description	Frequency
20) Notification of Legal Action Against PARTICIPANT in Dispute over Charges	If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit's status in a mutually agreeable format. *(See Section 135F.)*	As needed
21) Notification of 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 personal 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 155G.)*	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 245F.)*	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, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. *(See Section 155J.)*	During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • The HEALTH BENEFIT PROGRAM provider directory or directions on how to request a printed copy of the provider directory. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. *(See Section 230C.)*	See description
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. *(See Section 245B.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. *(See Section 245D.)*	See description
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment. *(See Section 260C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed
10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

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

The penalties assessed in Section 150B and Section 315 shall not exceed twenty-five (25%) percent of the CONTRACTOR'S total administrative fee in any given quarter. After implementation, all performance standards will be measured by the DEPARTMENT on a QUARTERLY basis and assessed based on PARTICIPANT counts as of the first calendar DAY of the quarter, as determined by DEPARTMENT enrollment records. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

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

315A Implementation

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

Performance Standards – three (3%) percent Penalty	Penalties
1) **Program Information:** All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards – three (3%) percent Penalty	Penalties
2) Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) Customer Service: The CONTRACTOR's dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained no later than September 30, 2017. (*See Section 265A.)*	
4) Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. *(See Section 265A.)*	
5) Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 265A.)*	
6) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. *(See Section 265A.)*	
7) Financial Administration: Financial administration requirements are operational no later than November 30, 2017. *(See Section 265A.)*	
8) Grievance Procedure: The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT'S review and approval. *(See Section 265A.)*	
9) ID Cards: No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018. *(See Section 265A.)*	
10) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018. *(See Section 265A.)*	

Performance Standards – three (3%) percent Penalty	Penalties
11) Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
12) Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly no later than January 31, 2018. *(See Section 265A.)*	
13) Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than February 28, 2018. *(See Section 265A.)*	
14) Claims Data Transfer: The claims data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than March 31, 2018. *(See Section 265A.)*	

315B Account Management

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

Performance Standards	Penalties
1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(See Section 265B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey

Performance Standards	Penalties
2) **Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 265D, 1.)*	Five thousand ($5,000) dollars per incident

315C Claims Processing

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

Performance Standards	Penalties
1) **Financial Accuracy:** At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid in the correct amount divided by the total claim dollars paid. *(See Section 235.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
2) **Processing Accuracy:** At least ninety-seven (97%) percent level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section 235.)*	
3) **Claims Processing Time:** At least ninety-five (95%) percent of all claims received must be processed within fifteen (15) BUSINESS DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 235.)*	

315D Customer Service

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

Performance Standards	Penalties
1) **Call Answer Timeliness**: At least eighty (80%) percent of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)

Performance Standards	Penalties
2) **Call Abandonment Rate:** Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
3) **Open Call Resolution Turn-Around-Time:** At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section 265C.)*	
4) **Inquiry Resolution Tracking Document/Log:** Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request. *(See Section 265C.)*	
5) **Electronic Written Inquiry Response:** At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section 265C.)*	

315E Data Management

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

Performance Standards	Penalties
1) **Claims Data Transfer:** The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a and 150B, 1.)*	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, 2.)*	

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 155G.)*	

315F Enrollment

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

Performance Standards	Penalties
1) **Enrollment File:** The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 150A, 4, a and c.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) **Enrollment Discrepancies:** The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. *(See Section 150A, 4, a.)*	
3) **ID Cards:** The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
4) **ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period:** The CONTRACTOR shall issue ID cards by December 15 (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.)*	

Performance Standards	Penalties
5) **Direct Pay Terminations:** The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section 255.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

315G Other

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

Performance Standards	Penalties
1) **Audit:** The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155E.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) **Grievance Resolution:** Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. *(See Section 245C.)*	
3) **Major System Changes and Conversions:** The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	
4) **PARTICIPANT Satisfaction Surveys:** The CONTRACTOR shall achieve at or above a ninety (90%) percent satisfaction rating (defined as “top three-boxes” using a zero (0) to ten (10) rating scale with ten (10) being the highest ranking) on the health plan rating question on the CAHPS survey tool or other survey instrument as approved by the DEPARTMENT. *(See Section 225, 3, c.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
5) **Non-Disclosure:** The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident

Performance Standards	Penalties
6) **Reporting and Deliverables Requirements:** The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

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 2018.

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

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

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

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

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

I. Schedule of Benefits

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

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

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

The covered benefits are subject to the following:

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

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Annual medical DEDUCTIBLE	$250 individual/$500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	None.	$1,500 per individual plan / $3,000 per family plan The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the plan pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).
Annual medical COINSURANCE	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies OOPL except as described below.	BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL.
Annual medical OUT-OF-POCKET LIMIT (OOPL)	$1,250 PARTICIPANT / $2,500 aggregate family limit except as described below.[1]	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]	After DEDUCTIBLE: $2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN pays 100%.	Covered 100%.	BENEFIT PLAN pays 100%.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $75 COPAYMENT (counts towards to OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit).[2]	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. §632.895 (16), covered 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	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 and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). 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 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Prescription Drugs	See below.	See below.	After DEDUCTIBLE: subject to medical DEDUCTIBLE above. After DEDUCTIBLE, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

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

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

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

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

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical DEDUCTIBLE	None.	$250 individual / $500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	$500 individual / $1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). When an individual within a family plan meets the $500 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.	$1,500 per individual plan / $3,000 per family plan. The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the BENEFIT PLAN pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical COINSURANCE	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLEMEDICAL EQUIPMENT, cochlear implants and hearing aids.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visits, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.	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.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / 10% applies to medical services except for office visits, and as described below. COINSURANCE applies to OOPL except as described below.
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]	$1,250 individual / $2,500 aggregate family limit except as described below.[1]	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOPL.[1]	$2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
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	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15 per visit. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.	PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
Cochlear Implants for PARTICIPANTS age 18 and older	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLANS pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), BENEFIT PLANS pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
		treatment per PARTICIPANT per calendar year.		treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.
Prescription Drugs	See below.	See below.	See below.	After DEDUCTIBLE: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

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

b) Preventive Prescription Drugs:

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

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

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

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

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

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

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

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

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): no annual OOPL.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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

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

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

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $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:

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

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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

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

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

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

II. Definitions

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

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

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

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

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

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

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

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

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

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

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

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

2) the TPA's methodology guidelines,

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

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

5) other factors.

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

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

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

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

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

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

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

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

1) Spouse.[1]

2) DOMESTIC PARTNER, if elected.[2]

3) Child.[3, 4, 5]

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

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

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

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

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

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

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

[3] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, 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.

[4] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

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

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

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

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

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

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

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

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

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

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

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

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

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 TPA and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

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

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 TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the TPA and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the TPA and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

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

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

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

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

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

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

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the TPA.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

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

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

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses or DOMESTIC PARTNERS.

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

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The TPA agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the TPA in advance of the services being provided.

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

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the TPA after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

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

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

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

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

4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the TPA and/or PBM:

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

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

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

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

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

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

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

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this TPA.

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

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM'S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

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

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

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

4) Dietitian visit.

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

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

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

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

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

PHARMACY BENEFIT MANAGER (PBM): The PBM is a THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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 TPA before obtaining the services. Unless otherwise indicated by YOUR TPA, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the TPA and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

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

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-

language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

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

SELF-ADMINISTERED 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 TPA to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a TPA or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The TPA or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

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

SKILLED NURSING FACILITY: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a SKILLED NURSING FACILITY.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

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

THIRD PARTY ADMINISTRATOR (TPA): The THIRD PARTY ADMINISTRATOR who is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

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

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the TPA, when taking into consideration, among other factors determined by the TPA, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases the amount the TPA determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. TPA approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

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

III. Benefits and Services

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

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the TPA reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see item A, 1 and item A, 2 below).

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

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

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

A. Medical/Surgical Services

1) EMERGENCY Care

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

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

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

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

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

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

2) URGENT CARE

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

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

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

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

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

a) PREOPERATIVE and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

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

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

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

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

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

   i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit 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 TPA terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the TPA may request notification of the inpatient stay prior to the delivery or shortly thereafter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if

correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

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

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

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

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)

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

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

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

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

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

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

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the TPA if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the TPA. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the TPA.

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

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

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

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

14) Phase II Cardiac Rehabilitation

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

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

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

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

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

16) Oral Surgery

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

a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

e) Apicoectomy. (Excision of apex of tooth root.)

f) Excision of exostoses of the jaws and hard palate.

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

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

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

18) Transplants

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

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

i) Aplastic anemia

ii) Acute leukemia

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

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the TPA.

h) In addition to the above-listed diagnoses for covered transplants, the TPA may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the TPA determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants 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 TPA.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The TPA may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the TPA.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

   c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up

care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA.

   a) Outpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "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 TPA within 72 hours after the initial provision of service.

   d) Other
   Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section 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 TPA.

(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 TPA:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the TPA, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the TPA.

k) Other medical equipment and supplies as approved by the TPA. Rental or purchase of equipment/supplies is at the option of the TPA.

l) When PRIOR AUTHORIZED as determined by the TPA, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the TPA will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the TPA. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the TPA. Additional visits may be approved by the TPA. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any TPA under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and

dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for 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 TPA.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The TPA, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED 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 TPA or a contracted PROVIDER administers the injection. If the TPA or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.

d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED 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 TPAs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 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 TPA and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   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 TPA.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, 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 TPA.

c) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

d) All separately billed donor-related services, except for kidney transplants.

e) Non-human organ transplants or artificial organs.

7) Reproductive Services

a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c) Services for storage or processing of semen (sperm); donor sperm.

d) Harvesting of eggs and their cryopreservation.

e) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the TPA.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the TPA.

c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the TPA.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the TPA. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED 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 TPA and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) 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 TPA and/or PBM, or services received after the TPA and/or PBM coverage or eligibility terminates. Except when

a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under TPAs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding TPA will be the responsibility of the succeeding TPA unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding TPA's network. In this instance, the liability will remain with the previous TPA.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the TPA and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

   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 TPA.

v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the TPA. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the TPA.

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 TPA 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 TPA. The treatment of the complication must be a covered benefit of the TPA and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any TPA as part of this program.

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 TPA to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the TPA's and/or PBM's Control: If, due to circumstances not reasonably within the control of the TPA and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the TPA and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the TPA, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other

benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section 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 TPA has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the TPA any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the TPA may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The TPA will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the TPA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1) The persons it has paid or for whom it has paid,

2) Insurance companies, or

3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the TPA and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the TPA and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the TPA, provide any relevant and reasonably available information which the TPA believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the TPA and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the TPA's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The TPA, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the TPA, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The TPA may employ a professional staff to provide case management services. As part of this case management, the TPA or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the TPA agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the TPA's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the TPA. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

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

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the TPA or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The TPA and/or PBM might pay more than the TPA and/or PBM owes under the policy. If so, the TPA and/or PBM can recover the excess from YOU. The TPA and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the TPA and/or PBM.

Each PARTICIPANT agrees to reimburse the TPA and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the TPA and/or PBM. At the option of the TPA and/or PBM, benefits for future CHARGES may be reduced by the TPA and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

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

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a TPA or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the TPA provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The TPA'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

1) The third party or any liability or other insurance covering the third party.

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the TPA or DEPARTMENT to such extent.

The TPA'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the TPA'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the TPA'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the TPA or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the TPA or DEPARTMENT such additional information as is reasonably requested by the TPA or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the TPA'S or DEPARTMENT'S rights against a third party. The TPA or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the TPA or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the TPA or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the TPA or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the TPA or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the TPA or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the TPA or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in

making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the TPA or DEPARTMENT for all amounts theretofore or thereafter paid by the TPA or DEPARTMENT which would have otherwise been recoverable under such acts and the TPA or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the TPA or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the TPA and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the TPA, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the TPA and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the TPA and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating TPAs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the TPA and/or PBM. Contact the TPA and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the TPA and/or PBM. The TPA and/or PBM will advise YOU of YOUR

right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the TPA and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the TPA and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the TPA's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the TPA and/or PBM breached its contract with the Group Insurance Board.

500 MEDICARE PLUS COVERAGE

For PARTICIPANTS enrolled in MEDICARE Plus coverage, this Section 500 applies. PARTICIPANTS covered under this section must be covered by MEDICARE as the primary insurer.

I. DEFINITIONS

For the purpose of this Section 500 only, the following terms when used and capitalized in this Section, are in addition to, or a substitute for, the terms defined in Section 000 and Section 400.

ASSIGNMENT means that a PARTICIPANT'S physician or health care PROVIDER agrees (or is required by law) to accept the MEDICARE-approved amount as full payment for covered health care services.

BALANCE BILL means seeking: to bill, charge, or collect a deposit, remuneration or compensation from; to file or threaten to file with a credit reporting agency; or to have any recourse against a PARTICIPANT or any person acting on the PARTICIPANT'S behalf for health care costs for which he/she is not liable. The prohibition on recovery does not affect the PARTICIPANT'S liability for any deductibles, coinsurance or copayments, or for premiums owed under the BENEFIT PLAN.

BENEFIT PERIOD means the total duration of all successive CONFINEMENTS that are separated from each other by less than 60 days.

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

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

CHARGES means the reasonable CHARGES for items or services set by MEDICARE. The statewide/nationwide CONTRACTOR treats CHARGES for stays in a HOSPITAL or licensed SKILLED NURSING FACILITY as incurred on the date of admission. The statewide/nationwide CONTRACTOR treats all other CHARGES as incurred on the date the PARTICIPANT gets the service or item. BENEFITS are payable only up to the reasonable charge set by MEDICARE, except as stated in subsection B below. No agreement between the PARTICIPANT (or someone acting for the PARTICIPANT) and any other person, group, or PROVIDER of services will cause the BENEFIT PLAN to pay more.

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.

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.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

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

9) Spouse.[1]

10) DOMESTIC PARTNER, if elected.[2]

11) Child.[3, 4, 5]

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

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

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

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

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

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

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

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

c) 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.

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

[4] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

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

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

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

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

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

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

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

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

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

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

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

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

DURABLE MEDICAL EQUIPMENT: See MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT.

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 CONTRACTOR 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 CONTRACTOR 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.

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

GRIEVANCE: Means a written complaint filed with the CONTRACTOR and/or PBM concerning some aspect of the CONTRACTOR and/or PBM.

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

HOSPITAL: Means an institution that:

3) 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

4) Qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission (formerly known as the Joint Commission on Accreditation of Hospitals).

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

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses or DOMESTIC PARTNERS.

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

LIFETIME RESERVE DAYS mean additional days that MEDICARE will pay for when the PARTICIPANT is in a hospital for more than 90 days. The PARTICIPANT has a total of 60 reserve days that can be used during his/her lifetime. For each lifetime reserve day, MEDICARE pays all covered costs except for a daily coinsurance.

LIMITING CHARGE means the amount above the MEDICARE-approved amount billed by a NON-PARTICIPATING PROVIDER and allowed by MEDICARE.

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

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

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

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

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

8) 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 CONTRACTOR and/or PBM:

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

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

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

8) 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 means benefits available under Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE PLUS is a fee-for-service MEDICARE supplement plan administered by the statewide/nationwide CONTRACTOR for retirees enrolled in MEDICARE Parts A and B and pays for benefits defined under this section.

MEDICARE ELIGIBLE EXPENSES means health care expenses that are covered by MEDICARE Parts A and B, recognized as MEDICALLY NECESSARY and reasonable by MEDICARE, and that may or may not be fully reimbursed by MEDICARE.

NON-AFFILIATED PROVIDER means (1) a physician or health care PROVIDER that has decided not to provide services through MEDICARE and MEDICARE will not cover those services; or (2) a licensed health care PROVIDER who is not allowed to bill MEDICARE for services.

NON-PARTICIPATING PROVIDER means that a physician or health care PROVIDER has not signed an agreement to accept assignment for all MEDICARE covered services, but they can still choose to accept assignment for individual services.

PARTICIPANT means a SUBSCRIBER, or any of his/her DEPENDENTS, covered by MEDICARE for whom proper application for MEDICARE PLUS coverage has been made and for whom the appropriate PREMIUM has been paid.

PARTICIPATING PROVIDER means that a physician or health care PROVIDER has signed an agreement to accept assignment for all MEDICARE covered services.

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.

REASONABLE CHARGES means an amount for a health care service that is reasonable, as determined by the CONTRACTOR. The statewide/nationwide CONTRACTOR takes into consideration, among other factors (including national sources) determined by the statewide/nationwide CONTRACTOR: (1) amounts charged by health care PROVIDERS for similar health care services when provided in the same geographical area; (2) the statewide/nationwide CONTRACTOR' methodology guidelines; (3) pricing guidelines of any third party responsible pricing a claim; and (4) the negotiated rate determined by the statewide/nationwide CONTRACTOR in accordance with the applicable contract between the statewide/nationwide CONTRACTOR and a health care PROVIDER. As used herein, the term "area" means a county or other geographical area which the statewide/nationwide CONTRACTOR determines is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. Also, the amount the statewide/nationwide CONTRACTOR determines as reasonable may be less than the amount billed. This definition applies only to paragraph 6.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, DOMESTIC PARTNERS, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special

diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

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

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

II. BENEFITS AVAILABLE

BENEFITS are payable for REASONABLE CHARGES for the following services and supplies on or after the EFFECTIVE DATE according to the terms, conditions and provisions of the CONTRACT, if those services and supplies are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by the statewide/nationwide CONTRACTOR.

When services are provided by a NON-PARTICIPATING PROVIDER, BENEFITS are payable for amounts in excess of the MEDICARE-approved CHARGE up to the lesser of the actual amount charged by the NON-PARTICIPATING PROVIDER and the LIMITING CHARGE.

The BENEFITS of this section of the BENEFIT PLAN will automatically change to coincide with any changes in applicable MEDICARE deductible amounts and coinsurance percentage factors.

A. HOSPITAL INPATIENT BENEFITS

1) BENEFITS are payable for the MEDICARE Part A deductible during the first 60 days of CONFINEMENT.

2) BENEFITS are payable for the MEDICARE Part A HOSPITAL daily coinsurance from the 61st to the 90th day of a PARTICIPANT'S CONFINEMENT.

3) After a PARTICIPANT has been in a HOSPITAL for 90 days, Medicare pays an extra 60 reserve days during the PARTICIPANT'S lifetime. BENEFITS are payable for the MEDICARE Part A HOSPITAL coinsurance for each reserve day used by the PARTICIPANT.

If the PARTICIPANT has exhausted the lifetime reserve days during a previous BENEFIT PERIOD, BENEFITS will continue to be payable for an additional 30 days of CONFINEMENT beginning on the 91st day of CONFINEMENT. The PROVIDER shall accept our payment as payment in full and may not BALANCE BILL you.

4) After MEDICARE pays its 190-day lifetime hospital INPATIENT psychiatric care BENEFITS, the BENEFIT PLAN will pay the MEDICARE Part A ELIGIBLE EXPENSES for INPATIENT psychiatric HOSPITAL care for each day a PARTICIPANT is confined for psychiatric care beyond the MEDICARE lifetime limit but not to exceed a lifetime limit of 175 days CONFINEMENT under the BENEFIT PLAN. BENEFITS will not exceed a total of 365 days for your lifetime.

5) BENEFITS are payable for the MEDICARE Part A ELIGIBLE EXPENSES for blood to the extent not covered by MEDICARE.

B. SERVICES IN A LICENSED SKILLED NURSING FACILITY

1) For CONFINEMENT in a licensed SKILLED NURSING FACILITY certified by and participating in MEDICARE, while the CONFINEMENT is covered by MEDICARE, BENEFITS are payable for such a CONFINMENT, provided: (1) a PARTICIPANT receives care in a MEDICARE approved licensed SKILLED NURSING FACILITY and remains under continuous active medical supervision; and (2) the PARTICIPANT was a HOSPITAL INPATIENT for at least three days prior to CONFINEMENT in a licensed SKILLED NURSING FACILITY. BENEFITS are payable for up to a maximum of 120 days per BENEFIT PERIOD beginning on the first day of admission to the licensed SKILLED NURSING FACILITY.

2) For CONFINEMENT in a licensed SKILLED NURSING FACILITY not participating in MEDICARE, or when the CONFINEMENT is not covered by MEDICARE, BENEFITS are payable provided the PARTICIPANT is transferred within 24 hours of release from a HOSPITAL. BENEFITS are payable up to the maximum daily rate established for SKILLED CARE in that facility by the Department of Health and Family Services for purposes of reimbursement under the Medical Assistance Program under Wis. Stats. § 49.45 to 49.47. BENEFITS are payable for such care at that facility up to 30 days per CONFINEMENT. BENEFITS are payable only if the attending physician certifies that the SKILLED CARE is MEDICALLY NECESSARY. The physician must recertify this every seven days. BENEFITS are not payable for essentially domiciliary or CUSTODIAL CARE, or care which is available to the PARTICIPANT without CHARGE or under a governmental health care program (other than a program provided under Chapter 49, Wisconsin Statutes).

C. HOSPICE CARE

The PLAN will pay a PARTICIPANT'S coinsurance or co-payments for all MEDICARE PART A ELIGIBLE EXPENSES for HOSPICE CARE and respite care. HOSPICE CARE is available as long as the PARTICIPANT'S physician certifies that he/she is terminally ill and his/her care is eligible for payment under Part A of MEDICARE.

D. PROFESSIONAL and OTHER SERVICES.

The BENEFIT PLAN will pay the MEDICARE Part B deductible and all MEDICARE Part B ELIGIBLE EXPENSES, to the extent not paid by MEDICARE, or in the case of HOSPITAL outpatient department services paid under a prospective payment system, the COPAYMENT amount, for the following services:

1) Cataract lenses following cataract surgery and one pair of eyeglasses with standard frames (or one set of contract lenses) after cataract surgery that implants an intraocular lens.

2) Chemotherapy in a physician's office, freestanding clinic or HOSPITAL outpatient setting.

3) Prescription drugs covered by Medicare such as injections that can't be self-administered that a PARTICIPANT receives in a physician's office, certain oral cancer drugs, drugs used with some types of DURABLE MEDICAL EQUIPMENT, and under very limited circumstances, certain drugs a PARTICIPANT receives in a HOSPITAL OUTPATIENT setting.

4) Physical therapy, speech-language pathology services and occupational therapy when recommended by a physician.

5) Oxygen and rental of equipment and supplies for its administration.

6) Professional licensed ambulance service necessary to transport a PARTICIPANT to or from a HOSPITAL or licensed SKILLED NURSING FACILITY. Services include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance service is unavailable and such transportation is substantiated by a physician as being MEDICALLY NECESSARY.

7) MEDICAL SUPPLIES prescribed by a physician.

8) Rental of or purchase of DURABLE MEDICAL EQUIPMENT such as, but not limited to: wheelchairs, walkers and hospital type beds.

9) OUTPATIENT cardiac rehabilitation services.

10) Facility fees for approved surgical procedures in an ambulatory surgical center.

11) Blood processing and handling services for every unit of blood a PARTICIPANT receives.

12) Chiropractic services limited to those services to help correct a subluxation using manipulation of the spine. BENEFITS are not payable for any other services or tests ordered by a chiropractor (including x-rays or massage therapy).

13) X-rays, MRIs, CT scans, EKGs, and other diagnostic tests, other than laboratory tests.

14) Diabetes supplies and self-management training.

15) Physician services that are medically necessary or provided in connection with preventive services covered by MEDICARE. BENEFITS are also payable for services provided by health care PROVIDERS, such as physician assistants, nurse practitioners, social workers, and psychologists.

16) Foot exams and treatment if a PARTICIPANT has diabetes-related nerve damage and/or meets certain conditions determined by MEDICARE.

17) Kidney dialysis services and supplies. This includes dialysis medications, laboratory tests, home dialysis training and related equipment and supplies. In addition, BENEFITS are also payable for CHARGES for kidney disease education services prescribed by a physician.

18) Outpatient mental health care services. Coverage includes services generally provided in an OUTPATIENT setting, including visits with a psychiatrist or other physician, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist or clinical social worker.

19) Outpatient HOSPITAL services, OUTPATIENT medical and surgical services and supplies.

20) Prosthetic and orthotic items including arm, leg, back and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part of function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a physician or other health care PROVIDER.

21) Pulmonary rehabilitation programs if a PARTICIPANT has moderate to severe chronic obstructive pulmonary disease prescribed by a physician.

22) Services for treatment of a surgical or surgically-treated wound.

23) Tobacco smoking cessation counseling if a PARTICIPANT is diagnosed with an ILLNESS caused or complicated by tobacco use or takes a medicine that is affected by tobacco.

24) Physician services for heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a MEDICARE-certified facility. Also covered are immunosuppressive drugs if the transplant was eligible for MEDICARE payment, or an employer or union group health plan was required to pay before MEDICARE paid for the transplant.

25) Glaucoma tests once every 12 months for PARTICIPANTS at high risk for glaucoma.

E. Additional Services

1) Foreign Travel. BENEFITS are payable at 100% of the REASONABLE CHARGES for MEDICALLY NECESSARY health care services received by a PARTICIPANT in a foreign country.

2) Immunizations. BENEFITS are payable at 100% of the REASONABLE CHARGES for immunizations not covered by MEDICARE.

3) Chiropractic Services. BENEFITS are payable at 100% of the REASONABLE CHARGES for chiropractic services provided by a chiropractor within the scope of his/her license and not covered by MEDICARE per Wis. Stat. 632.875.

4) HOME CARE. BENEFITS are payable at 100% of the REASONABLE CHARGES for home care services described below:

a) Covered Services. This paragraph only if CHARGES for home care services are not covered elsewhere under this CONTRACT. A state licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the services. A PARTICIPANT should make sure the agency meets this requirement before services are provided. BENEFITS are payable for CHARGES for the following services when MEDICALLY NECESSARY for treatment:

   i) Part time or intermittent home nursing care by or under supervision of a registered nurse;

   ii) Part time or intermittent home health aide services when MEDICALLY NECESSARY as part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;

   iii) Physical, respiratory, occupational or speech therapy;

   iv) MEDICAL SUPPLIES, prescription drugs and BIOLOGICALS prescribed by a physician required to be administered by a professional PROVIDER; laboratory services by or on

behalf of a HOSPITAL, if needed under the home care plan. These items are covered to the extent they would be if the PARTICIPANT had been hospitalized;

v) Nutrition counseling provided or supervised by a registered dietician;

vi) Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. The PARTICIPANT'S attending physician must request or approve this evaluation.

MEDICARE benefits will not be duplicated.

b) Limitations. The following limits apply to home care services:

i) Home care is not covered unless the PARTICIPANT'S attending physician certifies that: (a) hospitalization or CONFINEMENT in a licensed SKILLED NURSING FACILITY would be needed if the PARTICIPANT didn't have home care; and (b) members of the PARTICIPANT'S IMMEDIATE FAMILY or others living with the PARTICIPANT couldn't give the PARTICIPANT the care and treatment he/she needs without undue hardship;

ii) If the PARTICIPANT was hospitalized just before home care started, the PARTICIPANT'S physician during his/her HOSPITAL stay must also approve the home care plan;

iii) BENEFITS are payable for CHARGES for up to 365 home care visits in any 12 month period per PARTICIPANT. Each visit by a person providing services under a home care plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit. Each period of up to four straight hours in a 24-hour period of home health aide service counts as one home care visit.

iv) If home care is covered under two or more health insurance CONTRACTS or plans, coverage is payable under only one of them. The same is true if the PARTICIPANT has home care coverage under this CONTRACT and another source;

v) The maximum weekly BENEFIT for this coverage won't be more than the weekly CHARGES for SKILLED CARE in a licensed SKILLED NURSING FACILITY, as determined by the statewide/nationwide CONTRACTOR.

5) Equipment and Supplies for Treatment of Diabetes. BENEFITS are payable at 100% of the REASONABLE CHARGES incurred for the installation and use of an insulin infusion pump, all other equipment and supplies, (except insulin and medical supplies for injection of insulin which include syringes, needles, alcohol swabs, and gauze) used in the treatment of diabetes, and charges for diabetic self-management education programs. This benefit is limited to the purchase of one pump per calendar year. You must use the pump for at least 30 days before the pump is purchased. Medicare benefits won't be duplicated.

6) BENEFITS for Kidney Disease. BENEFITS are payable for REASONABLE CHARGES for inpatient, outpatient and home treatment of kidney disease, if not covered elsewhere under the BENEFIT PLAN. These services must be necessary for a PARTICIPANT'S diagnosis and treatment. This includes dialysis treatment and kidney transplantation expenses of both donor and recipient. There's a maximum of $30,000 per year for these BENEFITS. The BENEFIT PLAN will not pay any BENEFITS for any CHARGES paid for, or covered by, MEDICARE.

7) Breast Reconstruction. BENEFITS are payable for REASONABLE CHARGES for breast reconstruction of the affected tissue incident to a mastectomy.

8) Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care. BENEFITS are payable for REASONABLE CHARGES for HOSPITAL or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided in a HOSPITAL or ambulatory surgery center, if any of the following applies:

   a) The PARTICIPANT is a child under the age of 5;

   b) The PARTICIPANT has a chronic disability that meets all of the conditions under s. 230.04(9r) (a) 2. a., b. and c., Wisconsin Statutes; or

   c) The PARTICIPANT has a medical condition that requires hospitalization or general anesthesia for dental care.

9) Health Care Services Provided by a NON-AFFILIATED PROVIDER. If a PARTICIPANT receives services from a NON-AFFLIATED PROVIDER, BENEFITS will be payable for REASONABLE CHARGES for those services provided the services are covered under this section.

F. Exclusions

The following services are excluded from BENEFITS, except as otherwise specifically provided:

1) Health care services MEDICARE does not cover, unless the BENEFIT PLAN specifically provides for them.

2) Health care services which neither a PARTICIPANT nor a party on the PARTICIPANT'S behalf has a legal obligation to pay in the absence of insurance.

3) Health care services to the extent that they are paid for by MEDICARE, or would have been paid for by MEDICARE if a PARTICIPANT is enrolled in MEDICARE Parts A and B; health care services to the extent that they are paid for by another government entity or program, directly or indirectly.

4) Personal comfort items. Examples include: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature.

5) CUSTODIAL CARE, including maintenance care and supportive care.

6) Cosmetic surgery.

7) Health care services received by a PARTICIPANT before his/her coverage becomes effective or after coverage ends.

8) Health care services that are deemed unreasonable and unnecessary by MEDICARE. This includes, but is not limited to, the following: drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed

using drugs or devices not approved by FDA; and services including drugs or devices, not considered safe and effective because they are EXPERIMENTAL or investigational except for the HIV drugs as described in Section 632.895(9) Wis. Stat. as amended.

9) Health care services received outside the United States, except as specifically stated in paragraph 6. a. of subsection B.

10) Amounts billed by a physician exceeding the MEDICARE approved amount, except as specifically stated in subsection B.

11) Health care services which are not medically necessary as determined by the statewide/nationwide CONTRACTOR, except for such health care services that MEDICARE covers.

12) Routine physical exams and any related diagnostic X-ray and laboratory tests covered by MEDICARE.

13) Private duty nursing.

14) Routine dental care.

15) Hearing aids; exams for fitting of hearing aids.

III. MISCELLANEOUS PROVISIONS

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the CONTRACTOR 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 CONTRACTOR and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the CONTRACTOR, provide any relevant and reasonably available information which the CONTRACTOR 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 CONTRACTOR and/or PBM but also disclosures to:

4) Health care PROVIDERS as necessary and appropriate for treatment,

5) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the CONTRACTOR's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

6) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The CONTRACTOR, 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 CONTRACTOR, 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 CONTRACTOR may employ a professional staff to provide case management services. As part of this case management, the CONTRACTOR 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:

4) The recommended treatment offers at least equal medical therapeutic value, and

5) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

6) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the CONTRACTOR agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the CONTRACTOR'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 CONTRACTOR. 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 CONTRACTOR 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 CONTRACTOR and/or PBM might pay more than the CONTRACTOR and/or PBM owes under the policy. If so, the CONTRACTOR and/or PBM can recover the excess from YOU. The CONTRACTOR 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 CONTRACTOR and/or PBM.

Each PARTICIPANT agrees to reimburse the CONTRACTOR 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 CONTRACTOR and/or PBM. At the option of the CONTRACTOR and/or PBM, benefits for future CHARGES may be reduced by the CONTRACTOR 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 CONTRACTOR or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the CONTRACTOR 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 CONTRACTOR'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

5) The third party or any liability or other insurance covering the third party.

6) The PARTICIPANT'S own uninsured motorist insurance coverage.

7) Under-insured motorist insurance coverage.

8) 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 CONTRACTOR or DEPARTMENT to such extent.

The CONTRACTOR'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 CONTRACTOR'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the CONTRACTOR'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the CONTRACTOR or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the CONTRACTOR or DEPARTMENT such

additional information as is reasonably requested by the CONTRACTOR or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the CONTRACTOR'S or DEPARTMENT'S rights against a third party. The CONTRACTOR 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 CONTRACTOR or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the CONTRACTOR 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 CONTRACTOR 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 CONTRACTOR or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the CONTRACTOR or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the CONTRACTOR 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 CONTRACTOR or DEPARTMENT for all amounts theretofore or thereafter paid by the CONTRACTOR or DEPARTMENT which would have otherwise been recoverable under such acts and the CONTRACTOR 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 CONTRACTOR 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 MEDICARE PLUS BENEFIT PLAN. Failure to do so could result in a delay in the claim being paid.

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 CONTRACTOR 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 CONTRACTOR and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating CONTRACTORs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the

CONTRACTOR's and/or PBM's administration of these benefits (for example, denial of claim or referral), YOU should contact the CONTRACTOR 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 CONTRACTOR and/or PBM. Contact the CONTRACTOR and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the CONTRACTOR'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 CONTRACTOR and/or PBM. The CONTRACTOR 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 CONTRACTOR and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the CONTRACTOR and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the CONTRACTOR's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of benefits under this section, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the CONTRACTOR and/or PBM breached its contract with the Group Insurance Board.

EXHIBIT 2

Standard Terms And Conditions (Request For Bids / Proposals)

1.0 SPECIFICATIONS: The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid/proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 DEVIATIONS AND EXCEPTIONS: Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 QUALITY: Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 QUANTITIES: The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 DELIVERY: Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 PRICING AND DISCOUNT: The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the contractor which are demonstrated to be industrywide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 UNFAIR SALES ACT: Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 ACCEPTANCE-REJECTION: The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 METHOD OF AWARD: Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 ORDERING: Purchase orders or releases via purchasing cards shall be placed directly to the contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements

are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW AND COMPLIANCE: This contract shall be governed under the laws of the State of Wisconsin. The contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel this contract if the contractor fails to follow the requirements of s. 77.66, Wis. Stats., and related statutes regarding certification for collection of sales and use tax. The State of Wisconsin also reserves the right to cancel this contract with any federally debarred contractor or a contractor that is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

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

17.0 ASSIGNMENT: No right or duty in whole or in part of the contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION / AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan by the contractor. An exemption occurs from this requirement if the contractor has a workforce of less than fifty (50) employees. Within fifteen (15) working days after the contract is awarded, the contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

19.2 The contractor agrees to post in conspicuous places, available for employees and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the contractor's becoming declared an "ineligible" contractor, termination of the contract, or withholding of payment.

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

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

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

23.0 INSURANCE RESPONSIBILITY: The contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employees engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin public records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot be copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin public records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employees and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

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

32.0 HOLD HARMLESS: The contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the contractor, or of any of its contractors, in prosecuting work under this agreement.

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

34.0 WORK CENTER PROGRAM: The successful bidder/proposer shall agree to implement processes that allow the State agencies, including the University of Wisconsin System, to satisfy the State's obligation to purchase goods and services produced by work centers certified under the State Use Law, s.16.752, Wis. Stat. This shall result in requiring the successful bidder/proposer to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses.

35.0 FORCE MAJEURE: Neither party shall be in default by reason of any failure in performance of this Agreement in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the party.

State of Wisconsin
Department of Administration
DOA-3681 (01/2001)
ss. 16, 19 and 51, Wis. Stats.

Division of Agency Services
Bureau of Procurement

EXHIBIT 3

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor; and

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential contractor shall certify in writing to the procuring agency that no relationship exists between the potential contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employee or who is retained as a contractor full-time by a State of Wisconsin agency from being retained as a contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.0831 Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

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

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the contractor. The contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

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

EXHIBIT 4

Department Terms and Conditions

1.0 ENTIRE AGREEMENT: This Contract, its exhibits, subsequent amendments and the documents incorporated by order of precedence contain the entire understanding between the parties on the subject matter hereof, and no representations, inducements, promises, or agreements, oral or otherwise, not embodied herein shall be of any force or effect. This Contract supersedes any other oral or written agreement entered into between the parties on the subject matter hereof.

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

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

In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state.

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

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

Contractor will comply with the provisions of Wis. Stat. § 134.98**.**

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

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

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

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

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

None of the Services to be provided by the Contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without prior written notification to, and approval of, the Department.

After execution of the Contract, ETF will provide a designated contact person and commit to a timely approval process for notification of a change in subcontractor(s) and/or delegated services.

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

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

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

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

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

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

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

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

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

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

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

Authorized personnel shall have access to interview any Contractor's or subcontractor's employee or authorized agent involved with this Contract in conjunction with any audit, review, or investigation deemed necessary by the State of Wisconsin.

7.0 **CRIMINAL BACKGROUND VERIFICATION:** The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://oser.state.wi.us/docview.asp?docid=6658). The Contractor is expected to perform background checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

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

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

to the Department's local computer network.

9.0 SECURITY OF PREMISES, EQUIPMENT, DATA AND PERSONNEL: The State of Wisconsin shall have the right, acting by itself or through its authorized representatives, to enter the premises of the Contractor at mutually agreeable times to inspect and copy the records of the Contractor and the Contractor's compliance with this section. In the course of performing Services under this Contract, the Contractor may have access to the personnel, premises, equipment, and other property, including data files, information, or materials (collectively referred to as "data") belonging to the State.

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

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

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

12.0 LIQUIDATED DAMAGES: The Contractor and Department acknowledge that it can be difficult to ascertain actual damages when a Contractor fails to carry out the responsibilities of this Contract. Because of that, the Contractor and Department will negotiate liquidated damages, as required by the State of Wisconsin, for this Contract. The Contractor agrees that the Department shall have the right to liquidate such damages, through deduction from the Contractor's invoices, in the amount equal to the damages incurred, or by direct billing to the Contractor.

The Department shall notify the Contractor in writing of any claim for liquidated damages pursuant to this section within thirty (30) Calendar Days after the Contractor's failure to perform in accordance with the terms and conditions of this Contract.

Notwithstanding the foregoing language, when necessary the Department will identify in the RFP specific financial penalties for failure of the Contractor to meet performance standards and guarantees that may be set forth in the RFP.

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

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

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

Level	Contractor	The Department	Allotted Time
First Second	Level 1 entity	Deputy Office Director Office	10 Business Days
	Level 2 entity	Director	20 Business Days
Third	Level 3 entity	Secretary	30 Business Days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is days from the date that the Invoking Party's notice was originally received by the other party. If the Third Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's

original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the section below. The time periods herein are in addition to those periods for a party to cure provided elsewhere in this Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

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

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

16.0 TERMINATION OF THIS CONTRACT: The Department may terminate this Contract at any time at its sole discretion by delivering one-hundred eighty (180) Calendar Days written notice to the Contractor.

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

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

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

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

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

The State of Wisconsin reserves the right to cancel this Contract in whole or in part without penalty in one (1) or more of the following occurrences:

- **(a)** If the Contractor intentionally furnished any statement, representation, warranty, or certification in connection with its Proposal which is materially false, incorrect, or incomplete;
- **(b)** If applicable, fails to follow the sales and use tax certification requirements of Wis. Stat. § 77.66;
- **(c)** Incurs a delinquent Wisconsin tax liability;
- **(d)** Fails to submit a non-discrimination or affirmative action plan per the requirements of Wis. Stat. § 16.765 and Wisconsin's Fair Employment Law, subch. II, Chapter 111 of the Wisconsin Statutes as required herein;
- **(e)** Is presently identified on the list of parties excluded from State of Wisconsin procurement and non-procurement Contracts;
- **(f)** Becomes a state or federal debarred Contractor, or becomes excluded from state Contracts, or;
- **(g)** Fails to maintain and keep in force all required insurance, permits and licenses as required per this Contract;
- **(h)** Fails to maintain the confidentiality of the State of Wisconsin's information that is considered to be Confidential Information or Protected Health Information;
- **(i)** Files a petition in bankruptcy, become insolvent, or otherwise takes action to dissolve as a legal entity; or,
- **(j)** If at any time the Contractor's performance threatens the health or safety of a State of Wisconsin employee, citizen, or customer.
- **(k)** Violation of any requirements in Section 22 regarding Confidential Information.

In the event of a termination for cause by the State of Wisconsin, the State of Wisconsin shall be liable for payments for

any work accepted by the State of Wisconsin prior to the date of termination.

18.0 **REMEDIES OF THE STATE:** The State of Wisconsin shall be free to invoke any and all remedies permitted under Wisconsin law. In particular, if the Contractor fails to perform as specified in this Contract, the State of Wisconsin may issue a written notice of default providing for at least a seven (7) Business Day period in which the Contractor shall have an opportunity to cure, provided that cure is possible, feasible, and approved in writing by the State of Wisconsin. Time allowed for cure of a default shall not diminish or eliminate the Contractor's liability. If the default remains, after opportunity to cure, then the State of Wisconsin may: (1) exercise any remedy provided in law or in equity or (2) terminate Contractor's Services.

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

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

19.0 **TRANSITIONAL SERVICES:** Upon cancellation, termination, or expiration of this Contract for any reason, the Contractor shall provide reasonable cooperation, assistance and Services, and shall assist the State of Wisconsin to facilitate the orderly transition of the work hereunder to the State of Wisconsin and or to an alternative Contractor selected for the transition upon written notice to the Contractor at least thirty (30) business days prior to termination or cancellation, and subject to the terms and conditions set forth herein.

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

21.0 **OWNERSHIP OF MATERIALS:** Except as otherwise provided in subsection (t) of Section 22, all information, data, reports and other materials as are existing and available from the Department and which the Department determines to be necessary to carry out the scope of Services under this Contract shall be furnished to the Contractor and shall be returned to the Department upon completion of this Contract. The Contractor shall not use it for any purpose other than carrying out the work described in this Contract.

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

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

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

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

22.0 **CONFIDENTIAL INFORMATION AND HIPAA BUSINESS ASSOCIATE AGREEMENT:** This Section is intended to cover handling of Confidential Information under state and federal law, and specifically to comply with the requirements of HIPAA, HITECH, and the Genetic Information Nondiscrimination Act (GINA) and the federal implementing regulations for those statutes requiring a written agreement with business associates.

(a) DEFINITIONS: As used in this Section, unless the context otherwise requires:

(1) Business Associate. "Business Associate" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Contractor (insert name of Contractor).

(2) Confidential Information has the meaning ascribed to it in Section 1.5 of the RFP.

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

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

(5) Individual Personal Information "Individual Personal Information" has the meaning ascribed to it at Wis. Admin. Code ETF § 10.70 (1).

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

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

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

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

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

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

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

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

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

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

(f) MANDATORY REPORTING: Contractor shall report to ETF in the manner set forth in Subsection (l) any use or disclosure or suspected use or disclosure of Confidential Information not provided for by this Contract, of which it becomes aware, including breaches or suspected breaches of unsecured Protected Health Information as required at 45 CFR 164.410.

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

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

(i) ACCOUNTING OF DISCLOSURES: Contractor shall maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.528.

(j) COMPLIANCE WITH SUBPART E OF 45 CFR 164: To the extent Contractor is to carry out one or more of ETF's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to a covered entity in the performance of such obligation; and

(k) INTERNAL PRACTICES: Contractor shall make its internal practices, books, and records available to the Secretary of the United States Department of Labor for purposes of determining compliance with the HIPAA Rules.

(l) CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** A list of any affected members (if available);
- **b.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **c.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **d.** The date of the discovery by Contractor;
- **e.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **f.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than one (1) business day before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

(m) CLASSIFICATION LABELS: Contractor shall ensure that all data classification labels contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed by the Department.

(n) SUBCONTRACTORS: If applicable, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit Confidential Information on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information.

(o) NOTICE OF LEGAL PROCEEDINGS: If Contractor or any of its employees, agents, or subcontractors is legally required in any administrative, regulatory or judicial proceeding to disclose any Confidential Information, contractor shall give the Department prompt notice (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

(p) MITIGATION: The Contractor shall take immediate steps to mitigate any harmful effects of the suspected or actual unauthorized use, disclosure, or loss of any Confidential Information provided to Contractor under this Contract. The Contractor shall reasonably cooperate with the Department's efforts to comply with the breach notification requirements of HIPAA, to seek appropriate injunctive relief or otherwise prevent or curtail such suspected or actual unauthorized use, disclosure or loss, or to recover its Confidential Information, including complying with a

reasonable corrective action plan, as directed by the Department.

(q) COMPLIANCE REVIEWS: The Department may conduct a compliance review of the Contractor's security procedures before and during this Contract term to protect Confidential Information.

(r) AMENDMENT: The Parties agree to take such action as is necessary to amend the Contract as necessary for compliance with the HIPAA Rules and other applicable law.

(s) SURVIVAL: The obligations of Contractor under this Section survive the termination of the underlying Contract.

(t) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION: Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

1. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to ETF or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;
4. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;
5. Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and
6. If required by ETF, transmit the Confidential Information to another contractor of ETF.

23.0 INDEMNIFICATION:

23.1 SCOPE OF INDEMNIFICATION FOR INTELLECTUAL PROPERTY RIGHTS INFRINGEMENT: In the event of a claim against the Parties for Intellectual Property Rights Infringement associated with a claim for benefits, Contractor agrees to defend, indemnify and hold harmless Board and Department ("Indemnified Parties") from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Board, Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section.

23.2 SCOPE OF OTHER INDEMNIFICATION: In addition to the foregoing Section, Contractor shall defend, indemnify and hold harmless the Indemnified Parties from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section, or liability arising from or in connection with the following: (a) Contractor's performance of or failure to perform any duties or obligations under any agreement between Contractor and any third party; (b) injury to persons (including death or illness) or damage to property caused by the act or omission of Contractor or Contractor Personnel; (c) any claims or losses for Services rendered by any subcontractor, person, or firm performing or supplying Services, materials, or supplies in connection with the Contractor's performance of this Contract; (d) any claims or losses resulting to any person or third party entity injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under this Contract in a manner not authorized by this Contract, or by Federal or State statutes or regulations; and (e) any failure of the Contractor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

23.3 INDEMNIFICATION NOTICE: Department shall give Contractor prompt written notice of such claim, suit, demand, or action (provided that a failure to give such prompt notice will not relieve Contractor of its indemnification obligations hereunder except to the extent Contractor can demonstrate actual, material prejudice to its ability to mount a defense as a result of such failure). Department will cooperate, assist, and consult with Contractor in the defense or investigation of any claim made or suit filed against Department resulting from Contractor's performance under the Contract.

23.4 NO INDEMNIFICATION OBLIGATIONS: Contractor shall as soon as practicable, notify Department of any claim made or suit filed against Contractor resulting from Contractor's obligations under this Contract if such claim may involve the Department. Department has no obligation to provide legal counsel or defense to Contractor if a suit, claim, or action is brought against Contractor or its subcontractors as a result of Contractor's performance of its obligations under this Contract. In addition, Department has no obligation for the payment of any judgments or the settlement of any claims against Contractor arising from or related to this Contract. Department has not waived any right or entitlement to claim sovereign immunity under this Contract.

23.5 CONTRACTOR'S DUTY TO INDEMNIFY: Contractor shall comply with its obligations to indemnify, defend and hold the Indemnified Parties harmless with regard to claims, damages, losses and/or expenses arising from a claim for benefits under the Plan as provided herein. Contractor shall be entitled to control the defense of any such claim and to defend or settle any such claim, in its sole discretion, with counsel of its own choosing; however, Contractor shall consult with Department regarding its defense of any claim and not settle or compromise any claim or action in a manner that imposes restrictions or obligations on Department, requires any financial payment by Department, or grants rights or concessions to a third party without first obtaining Department's prior written consent. Contractor shall have the right to assert any and all defenses on behalf of the Indemnified parties, including sovereign immunity.

In carrying out any provision of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters the Department acts as an agent of the State.

The Contractor shall at all times comply with and observe all federal and state laws and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct.

24.0 EQUITABLE RELIEF: The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury shall not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Contract or under applicable law.

25.0 RIGHT TO PUBLISH OR DISCLOSE: Throughout the term of this Contract, the Contractor must secure the Department's written approval prior to the release of any information which pertains to work or activities covered by this Contract.

The parties agree that it is a breach of this Contract to disclose any information to any person that the Department or its governing boards may not disclose under Wis. Stat. § 40.07. Contractor acknowledges that it will be liable for damage or injury to persons whose Confidential Information is disclosed by any officer, employee, agent, or subcontractor of the Contractor without proper authorization.

26.0 TIME IS OF THE ESSENCE: Timely provision of the Services required under this Contract shall be of the essence of the Contract, including the provisions of the Services within the time agreed or on a date specified herein.

27.0 IDENTIFICATION OF KEY PERSONNEL AND PERSONNEL CHANGES: The Department will designate a contract administrator, who shall have oversight for performance of the Department's obligations under this Contract. The Department shall not change the person designated without prior written notification to the Contractor.

The State of Wisconsin reserves the right to approve all individuals assigned to this project. The Contractor agrees to use its best effort to minimize personnel changes during the Contract term.

At the time of contract negotiations, the Contractor shall furnish the Department with names of all key personnel assigned to perform work under this Contract and furnish the Department with criminal background checks.

The Contractor will designate a contract administrator who shall have executive and administrative oversight for performance of the Contractor's obligations under this Contract. The Contractor shall not change this designation without prior written notice to the Department.

The Contractor may not divert key personnel for any period of time except in accordance with the procedure identified in this section. The Contractor shall provide a notice of proposed diversion or replacement to the single person of contact (SPOC) at least sixty (60) days in advance, together with the name and qualifications of the person(s) who will take the place of the diverted or replaced staff. At least thirty (30) days before the proposed diversion or replacement, the Department shall notify the SPOC whether the proposed diversion or replacement is approved or rejected, and if rejected shall provide reasons for the rejection. Such approval by the Department shall not be unreasonably withheld or delayed.

Replacement staff shall be on-site within two (2) weeks of the departure date of the person being replaced. The Contractor shall provide the Department with reasonable access to any staff diverted by the Contractor.

Replacement of key personnel shall be with persons of equal ability and qualifications. The Department has the right to conduct separate interviews of proposed replacements for key personnel. The Department shall have the right to approve, in writing, the replacement of key personnel. Such approval shall not be unreasonably withheld. Failure of the Contractor to promptly replace key personnel within thirty (30) Calendar Days after departure shall entitle the Department to terminate this Contract. The notice and justification must include identification of proposed substitute key personnel and must provide sufficient detail to permit evaluation of the impact of the change on the project and/or maintenance.

Any of the Contractor's staff that the Department deems unacceptable shall be promptly and without delay removed by the Contractor from the project and replaced by the Contractor within thirty (30) Calendar Days by another employee with acceptable experience and skills subject to the prior approval of the Department. Such approval by the Department will not be unreasonably withheld or delayed.

An unauthorized change by the Contractor of any Contracted Personnel designed as key personnel will result in the imposition of liquidated damages, as defined in this Contract.

28.0 DATA SECURITY AND PRIVACY AGREEMENT

(a) PURPOSE AND SCOPE OF APPLICATION: This Data Security and Privacy Agreement (Agreement) is designed to protect the Department of Employee Trust Fund's (ETF) Confidential Information and ETF Information Resources (defined below). This Agreement describes the data security and privacy obligations of Contractor and its sub-contractors that connect to ETF Information Resources and/or gain access to Confidential Information.

(b) DEFINED TERMS:

(1) **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) Individual Personal 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); or (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 by Contractor on FORM D –Designation of Confidential and Proprietary Information (DOA-3027). Pricing information cannot be held confidential.

(2) **ETF Information Resources** means those devices, networks and related infrastructure that ETF has obtained for use to conduct ETF business. Devices include but are not limited to, ETF-owned, managed, used through service agreements storage, processing, communications devices and related infrastructure on which ETF data is accessed, processed, stored, or communicated, and may include personally owned devices. Data includes, but is not limited to, Confidential Information, other ETF created or managed business and research data, metadata, and credentials created by or issued on behalf of ETF.

(c) ACCESS TO ETF INFORMATION RESOURCES: In any circumstance when Contractor is provided access to ETF Information Resources, it is solely Contractor's responsibility to ensure that its access does not result in any access by unauthorized individuals to ETF Information Resources. Contractors who access ETF's systems from any ETF location must at a minimum conform with ETF security standards that are in effect at the ETF location(s) where the access is provided. Any Contractor technology and/or systems that gain access to ETF Information Resources must comply with, at a minimum, the elements in the Computer System Security Requirements set forth in this Agreement.

(d) COMPLIANCE WITH APPLICABLE LAWS: Contractor agrees to comply with all applicable state and federal laws, as well as industry best practices, governing the collection, access, use, disclosure, safeguarding and destruction of Confidential Information.

(e) PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor agrees to hold ETF's Confidential Information, and any information derived from such information, in strictest confidence. Contractor will not access, use or disclose Confidential Information other than to carry out the purposes for which ETF disclosed the Confidential Information to Contractor, except as permitted or required by applicable law, or as otherwise authorized in writing by ETF. For avoidance of doubt, this provision prohibits Contractor from using for its own benefit Confidential Information or any information derived from such information. If required by a court of competent jurisdiction or an administrative body to disclose Confidential Information, Contractor will notify ETF in writing immediately upon receiving notice of such requirement and prior to any such disclosure, to give ETF an opportunity to oppose or otherwise respond to such disclosure (unless prohibited by law from doing so).

(f) REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES: The Contractor's transmission, transportation or storage of Confidential Information outside the United States, or access of Confidential Information from outside the United States, is prohibited except on prior written authorization by ETF.

(g) SAFEGUARD STANDARD: Contractor agrees to protect the privacy and security of Confidential Information according to all applicable laws and regulations, including HIPAA, by commercially-acceptable frameworks or standards such as the ISO/IEC 27000-series, NIST, 800-53, RFC 2196, IEC 62443, and SANS CIS Top 20. ISO 270001, etc. Security Controls, and no less rigorously than it protects its own confidential information, but in no case less than reasonable care. Contractor will implement, maintain and use appropriate administrative, technical and physical security measures to preserve the confidentiality, integrity and availability of the Confidential Information. All Confidential Information stored on portable devices or media must be encrypted in accordance with the Federal Information Processing Standards (FIPS) Publication 140-2. Contractor will ensure that all security measures are regularly reviewed including ongoing monitoring, an annual penetration and vulnerability test, and an annual security incident response test, and revised, no less than annually, to address evolving threats and vulnerabilities while Contractor has responsibility for the Confidential Information under the terms of this Agreement. Prior to agreeing to the terms of this Agreement, and periodically thereafter (no more frequently than annually) at ETF's request, Contractor will provide assurance, in the form of a third-party audit report or other documentation acceptable to ETF, such as SOC2 Type II, demonstrating that appropriate information security safeguards and controls are in place.

(h) INFORMATION SECURITY PLAN:

(1) Contractor acknowledges that ETF is required to comply with information security standards for the protection of Confidential Information as required by law, regulation and regulatory guidance, as well as ETF's internal security program for information and systems protection.

(2) Contractor will establish, maintain and comply with an information security plan (Information Security Plan), which will contain, at a minimum, such elements as those set forth in this Agreement.

(3) Contractor's Information Security Plan will be designed to:

- **a.** Ensure the privacy, security, integrity, availability, and confidentiality of Confidential Information;
- **b.** Protect against any anticipated threats or hazards to the security or integrity of such information;
- **c.** Protect against unauthorized access to or use of such information that could result in harm or inconvenience to the person that is the subject of such information;
- **d.** Reduce risks associated with Contractor having access to ETF Information Resources; and
- **e.** Comply with all applicable legal and regulatory requirements for data protection.

(4) On at least an annual basis, Contractor will review its Information Security Plan, update and revise it as needed, and submit it to ETF upon request. At ETF's request, Contractor will make modifications to its Information Security Plan or to the procedures and practices thereunder to conform to ETF's security requirements as they exist from time to time. If there are any significant

modifications to Contractor's Information Security Plan, Contractor will notify ETF within a reasonable period of time, not to exceed two weeks. Any significant modification must include the same or a higher framework or information security standard maturity level than what currently exists in the Plan.

(i) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION:

Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

(1) Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

(2) Where feasible, return to ETF, or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;

(3) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;

(4) Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;

(5) Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and

(6) If required by ETF, transmit the Confidential Information to another contractor of ETF.

(j) NOTIFICATION OF CORRESPONDENCE CONCERNING CONFIDENTIAL INFORMATION: Contractor agrees to notify ETF immediately, both orally and in writing, but in no event more than twenty-four (24) hours after Contractor receives correspondence or a complaint regarding Confidential Information, including but not limited to, correspondence or a complaint that originates from a regulatory agency or an individual.

(k) BREACHES OF CONFIDENTIAL INFORMATION:

CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure of ETF's Confidential Information, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** The nature of the unauthorized access, use or disclosure;
- **b.** A list of any affected members (if available);
- **c.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **d.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **e.** The date of the discovery by Contractor;
- **f.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **g.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than twenty-four (24) hours before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons

potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

COORDINATION OF BREACH RESPONSE ACTIVITIES:

(4) Contractor will fully cooperate with ETF's investigation of any breach involving Contractor, including but not limited to making witnesses, documents, HIPAA logs, systems logs, video recordings, or other pertinent or useful information available immediately upon Contractor's reporting of the breach and throughout the investigation. Contractor's full cooperation will include but not be limited to Contractor:

- **a.** Immediately preserving any potential forensic evidence relating to the breach, and remedying the breach as quickly as circumstances permit
- **b.** Within forty-eight (48) hours designating a contact person to whom ETF will direct inquiries, and who will communicate Contractor responses to ETF inquiries; Contractor will designate a Privacy Officer and Security Officer to serve as contacts for ETF.
- **c.** As rapidly as circumstances permit, applying appropriate resources to remedy the breach condition, investigate, document, restore ETF service(s) as directed by ETF, and undertake appropriate response activities such as working with ETF, its representative, and law enforcement to identify the breach, identify the perpetrator(s), and take appropriate actions to remediate the security vulnerability;
- **d.** Providing status reports at least every two (2) hours until the root cause of the breach is identified and a plan is devised to fully remediate the breach;
- **e.** Once the root cause of the breach is identified and a plan is devised to fully remediate the breach, providing status reports daily or at mutually agreed upon timeframes, to ETF on breach response activities, findings, analyses, and conclusions;
- **f.** Coordinating all media, law enforcement, or other breach notifications with ETF in advance of such notification(s), unless expressly prohibited by law; and
- **g.** Ensuring that knowledgeable Contractor staff is available on short notice, if needed, to participate in ETF-initiated meetings and/or conference calls regarding the breach.

ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS:

(5) Contractor will make itself and any employees, subcontractors, or agents assisting Contractor in the performance of its obligations available to ETF at no cost to ETF to testify as witnesses, or otherwise, in the event of a breach or other unauthorized disclosure of Confidential Information caused by Contractor that results in litigation, governmental investigations, or administrative proceedings against ETF, its directors, officers, agents or employees based upon a claimed violation of laws relating to security and privacy or arising out of this Agreement or the Contract.

(l) RETENTION OF LOGS:

(1) HIPAA logs (logs of any systems that have information relating to HIPAA) must be kept for six (6) years.

(2) Firewall logs must be kept for twelve (12) months.

(m) ADDITIONAL INSURANCE: In addition to the insurance required under the Agreement, Contractor at its sole cost and expense will obtain, keep in force, and maintain an insurance policy (or policies) that provides coverage for privacy and data security breaches. This specific type of insurance is typically referred to as Privacy, Technology and Data Security Liability, Cyber Liability, or Technology Professional Liability. In some cases, Professional Liability policies may include some coverage for privacy and/or data breaches. Regardless of the type of policy in place, it needs to include coverage for reasonable costs in investigating and responding to privacy and/or data breaches with the following minimum limits unless ETF specifies otherwise: $1,000,000 Each Occurrence and $5,000,000 Aggregate.

(n) INFORMATION SECURITY PLAN REQUIREMENTS:

(1) Contractor will develop, implement, and maintain a comprehensive Information Security Plan that is written in one or more readily accessible parts and contains administrative, technical, and physical safeguards. The safeguards contained in such program must be consistent with the safeguards for protection of Confidential Information and information of a similar character set forth in any state or federal regulations by which the person who owns or licenses such information may be regulated.

(2) Without limiting the generality of the foregoing, every comprehensive Information Security Plan will include, but not be limited to:

a. Designating one or more employees to maintain the comprehensive Information Security Plan;

b. Identifying and assessing internal and external risks to the security, confidentiality, and/or integrity of any electronic, paper or other records containing Confidential Information and of ETF Information Resources, and evaluating and improving, where necessary, the effectiveness of the current safeguards for limiting such risks, including but not limited to:

c. Ongoing employee (including temporary and contract employee) training;

d. Employee compliance with policies and procedures; and

e. Means, including Contractor staff, processes, and technology, for detecting information system intrusions, data breaches, and anomalous system behavior or activity, and for preventing security breaches, intrusions, or unauthorized access to information systems or networks.

f. Developing security policies for employees relating to the storage, access and transportation of records containing Confidential Information outside of business premises.

g. Imposing disciplinary measures for violations of the comprehensive Information Security Plan rules.

h. Preventing terminated employees from accessing records containing Confidential Information and/or ETF Information Resources.

i. Overseeing service providers, by:
- --Taking reasonable steps to select and retain third-party service providers that are capable of maintaining appropriate security measures to protect such Confidential Information and ETF Information Resources consistent with all applicable laws and regulations; and
- -- Requiring such third-party service providers by contract to implement and maintain such appropriate security measures for Confidential Information.

j. Placing reasonable restrictions upon physical access to records containing Confidential Information and ETF Information Resources and requiring storage of such records and data in locked facilities, storage areas or containers.

k. Restrict physical access to any network or data centers that may have access to Confidential Information or ETF Information Resources.

l. Requiring regular monitoring to ensure that the comprehensive Information Security Plan is operating in a manner reasonably calculated to prevent unauthorized access to or

unauthorized use of Confidential Information and ETF Information Resources; and upgrading information safeguards as necessary to limit risks.

m. Reviewing the scope of the security measures at least annually or whenever there is a material change in business practices that may reasonably implicate the security or integrity of records containing Confidential Information and of ETF Information Resources.

n. Documenting responsive actions taken in connection with any incident involving a breach, and mandating post-incident review of events and actions taken, if any, to make changes in business practices relating to protection of Confidential Information and ETF Information Resources.

(o) COMPUTER SYSTEM SECURITY REQUIREMENTS: To the extent that Contractor electronically stores or transmits Confidential Information or has access to any ETF Information Resources, it will include in its written, comprehensive Information Security Plan the establishment and maintenance of a security system covering its computers, including any wireless system, that, at a minimum, and to the extent technically feasible, will have the following elements:

(1) Secure user authentication protocols including:

a. Control of user IDs and other identifiers;
b. A secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;
c. Multi-Factor Authentication (MFA);
c. Control of data security passwords to ensure that such passwords are kept in a location and/or format that does not compromise the security of the data they protect;
d. Multi-factor authentication for system administrators and others with 'super-user' access rights;
e. Restricting access to active users and active user accounts only;
f. Blocking access to user identification after multiple unsuccessful attempts to gain access or the limitation placed on access for the particular system; and
g. Periodic review of user access, access rights and audit of user accounts.

(2) Secure access control measures that:

a. Restrict access to records and files containing Confidential Information and systems that may have access to ETF Information Resources to those who need such information to perform their job duties; and
b. Assign unique identifications plus passwords, which are not vendor supplied default passwords, to each person with computer access, which are reasonably designed to maintain the integrity of the security of the access controls.

(3) Encryption of all transmitted records and files containing Confidential Information.

(4) Adequate security of all networks that connect to ETF Information Resources or access Confidential Information, including wireless networks.

(5) Reasonable monitoring of systems, for unauthorized use of or access to Confidential Information and ETF Information Resources.

(6) Encryption of all Confidential Information stored on Contractor devices, including laptops or other portable storage devices.

(7) For files containing Confidential Information on a system that is connected to the Internet or that may have access to ETF Information Resources, reasonably up-to-date firewall, router and switch protection and operating system security patches, reasonably designed to maintain the integrity of the Confidential Information.

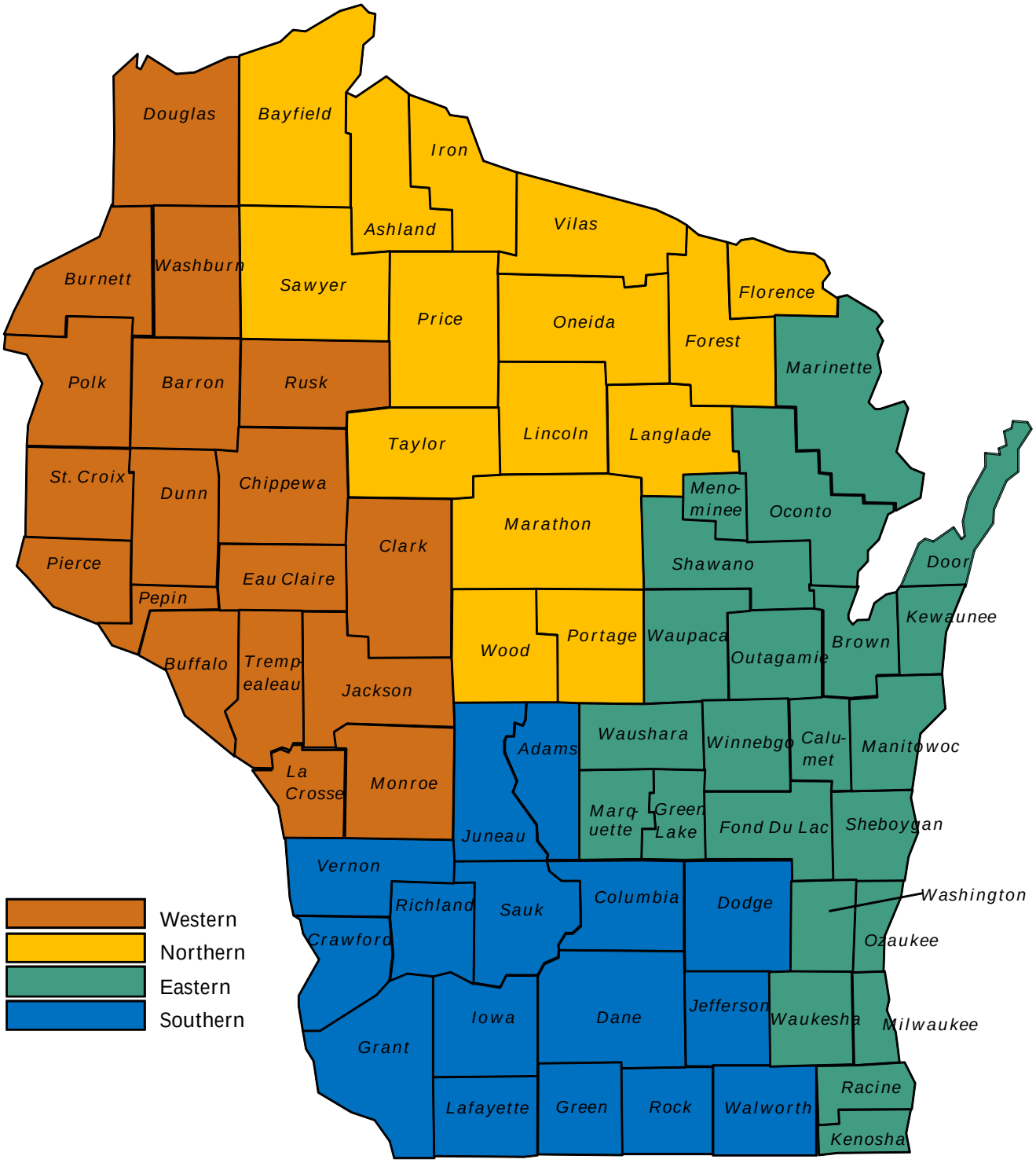
(8) Reasonably up-to-date versions of system security agent software, including intrusion detection systems, which must include malware protection and reasonably up-to-date patches and virus definitions, or a version of such software that can still be supported with up-to-date patches and virus definitions, and is set to receive the most current security updates on a regular basis.

(9) Education and training of employees on the proper use of the computer security system and the importance of Confidential Information and network security.

With reasonable notice to Contractor, ETF may require additional security measures which may be identified in additional guidance, contracts, communications or requirements.

State of Wisconsin
Department of Employee Trust Funds
Regional Map

RFP ETG0003
Exhibit 5: Map
Issued July 22, 2016



State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R07/2016)
§ 51.01(5) Wis. Stats. § 111.32(13m) Wis. Stats.

Department of Employee Trust Funds
801 W. Badger Road
P. O. Box 7931
Madison, WI 53707-7931

Contract

Commodity or Service:

Administrative Services for the State of Wisconsin Health Benefit Program

Contract No./Request for Bid/Proposal No:

ETG0003(N)
Authorized Board: Group Insurance Board

Contract Period: June 1, 2017 through December 31, 2020 with the optional renewal of three (3) two (2) year periods

1. This Contract is entered into by the State of Wisconsin, Department of Employee Trust Funds (Department), the State of Wisconsin Group Insurance Board (Board) and between Network Health Administrative Services, LLC. hereinafter referred to as the "Contractor", whose address and principal officer appears on page 2. The Department is the sole point of contact for this Contract.

2. Whereby the Department of Employee Trust Funds agrees to direct the purchase and the Contractor agrees to supply the Contract requirements cited in accordance with the State of Wisconsin standard terms and conditions and in accordance with the Contractor's proposal dated September 19, 2016, hereby made a part of this Contract by reference.

3. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employees or applicants for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s.51.01(5), Wis. Stats., sexual orientation as defined in s.111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

4. Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan. Contractors with an annual work force of less than fifty (50) employees are exempted from this requirement. Within fifteen (15) business days after the award of the Contract, the plan shall be submitted for approval to the Department. Technical assistance regarding this clause is provided by the Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931, 608.261.7952, or via e-mail at ETFProcurement@etf.wi.gov.

5. Contractor agrees to the Discount Guarantees and Gain Sharing Agreement in Exhibit B.

6. For purposes of administering this Contract, the order of precedence is:
   a) This Contract (Form DOA-3049) with Network Health Administrative Services, LLC;
   b) Exhibit A, Contract clarifications from ETF;
   c) Exhibit B, Discount Guarantees and Gain Sharing Agreement;
   d) RFP Exhibit 1 – State of Wisconsin Health Benefit Program Agreement, dated May 1, 2017;
   e) RFP Exhibit 4 – Department Terms and Conditions, dated April 26, 2017;
   f) Appendix 4a Claims Data Specifications – Medical, dated March 29, 2017;
   g) Appendix 5 Provider Data Specifications, dated March 29, 2017;
   h) Request for Proposal (RFP) ETG0003 dated July 22, 2016, including all appendices, attachments, and amendments thereto; and
   i) Contractor's proposal dated September 19, 2016.

Contract Number & Service: ETG0003(N) - Administrative Services for the State of Wisconsin Health Benefit Program

State of Wisconsin	Contractor to Complete
Department of Employee Trust Funds	Network Health Administrative Services, LLC
By Authorized Board *(Name)*	Legal Company Name
Group Insurance Board	Network Health
By *(Name)*	Trade Name
Michael Farrell	
Signature	Taxpayer Identification Number 46-2966177
Title	Company Address *(City, State, Zip)*
Chair Group Insurance Board	Coreen Dicus-Johnson
Phone	By *(print Name)*
608.266.9854 (A. John Voelker, Deputy Secretary)	
Date *(MM/DD/CCYY)*	Signature
	President and CEO
	Title
	920-720-1520
	Phone
	5/23/17
	Date *(MM/DD/CCYY)*

Exhibit A

Contract ETG0003: Clarifications and changes agreed to by the parties to the July 22, 2016 Request for Proposal (RFP) ETG0003 Administrative Services for the State of Wisconsin Health Benefit Program to be provided by Network Health Administrative Services to the State of Wisconsin Department of Employee Trust Funds for the Health Insurance Programs Offered by the State of Wisconsin Group Insurance Board.

The following are clarifications to Contract terms:

#	Document / Section	Section Description	Clarification
1	n/a	n/a	Any dispute, disagreement or question of interpretation of Exhibits 2, 3, or 4 (the Terms and Conditions) and the application of those Exhibits to the terms of this contract is subject to discussion and resolution under Exhibit 4, Section 13.0 (Contract Dispute Resolution) of the Department Terms and Conditions."
2	Exhibit 1 Section 130	Premiums	The language in this section is not intended to hold a Contractor liable for payment of actuarial services related to a review of claims experience, trends and other factors covered by the rate renewal reports submitted by a Contractor pursuant to this section.
3	Exhibit 1 Section 135B	Administrative Fee Adjustments	Language as shown was drafted with the intention to allow for administrative fee increases, as recommended by ETF's actuary. Should an administrative fee change be implemented for which the TPA disagrees, the process on contract dispute resolution is provided in Exhibit 4.0, Section 13.0.
4	Exhibit 1 Section 215A	Disease Management / Prior Authorizations / Utilization Review	The contract requires prior authorizations to include member out-of-pocket cost sharing information. The intent is to base the authorization on the provider status at time of the authorization review with disclosure about any anticipated provider status change for the length of the approval period and disclosure that the member's deductible, coinsurance and/or copayment applies. Member out-of-pocket costs do not need to be amount specific and instruction should be provided on how members can obtain specific cost-sharing information. The contract also states the Contractor is responsible for the cost of services not covered under the contract when the member has received a prior authorization. The intent is to hold the Contractor accountable if it errors by prior authorizing a service that is not covered under the contract.

#	Document / Section	Section Description	Clarification
5	Exhibit 1 Sections 230 and 230D	Provider Contracts Provider Contracts Shall Include Compliance Plans	Including the provider agreement requirements outlined in Section 230 and the compliance plans outlined in Section 230D in a policy, program or process for which the provider contract requires compliance, even though the provider contract does not specifically identify such items, is deemed to meet this contractual requirement.
6	Exhibit 4 Section 28.0 (i)(2)	Data Security and Privacy Agreement	1) The data should be destroyed; 2) unless Contractor can definitely prove to ETF that the data was de-identified; and 3) that Contractor confirms to ETF in writing that no crosswalk exists to re-identify the data.
7	n/a	n/a	Based on the contract negotiations that ETF has conducted over the last several weeks with each of the six contractors, ETF now believes it is appropriate to delete references in the RFP and Section 135B of RFP Exhibit 1 specifically stating that the contractors are fiduciaries. The duties that contractors will perform are delineated throughout the RFP and Exhibit 1. Case law confirms that whether or not a contract specifically states that a contractor is a fiduciary, courts have issued decisions finding that the duties and facts in a particular situation demonstrate that a contractor is a fiduciary.
8	Exhibit 4 Section 12.0	Liquidated Damages	It is the Department's intent that the Contractor will be able to utilize the process described in Exhibit 4, Section 13.0 (Contract Dispute Resolution) prior to the Department imposing any Liquidated Damages.

Wisconsin Department of Employee Trust Funds
Discount Guarantees for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Network Health**
Region **Eastern**

Vendor will provide 2018 expected overall level of discount.
ETF and Vendor will mutually agree on final starting point.

2018 Discount Target*

* A supplemental worksheet allows vendors to calculate this discount with enrollment and regional assumptions. Upon open enrollment these will be re-based accordingly.

2019 minimum level of discount**

2019 Discount Target

2020 minimum level of discount**

2020 Discount Target

**** Level will be recalibrated after 6-months of prior calendar year incurred claims and adjusted higher if appropriate and agreed to by both parties as a reasonable expectation for the calendar year.**

% of Actual Discount below Target	% of Total Admin Fees at Risk
	0%
	5%
	10%

Notes:
Actual Performance against Target Discounts will be calculated 6 months after the end of the Calendar Year with runout data available in the data warehouse at that time.
Large claims over $100,000, and any out-of-network claims, will be removed from the calculation.
Discount Percent is calculated as Total Submitted Eligible Charge less Total Allowed (state & member) divided by Total Submitted Eligible Charge.
Discount Guarantee is null and void if Gain-Sharing Actual PMPM is less than Target PMPM.

ETG0003

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Exhibit B

Vendor **Network Health**
Region **Eastern**

Annual Shared Savings will be calculated based on two factors:
(1) Performance of Actual versus Target PMPM
(2) Performance of Actual versus Target Clinical Performance Measures

Performance of Actual versus Target PMPM **Illustrative Calculation**

Prior Calendar Year allowed claims for those members who select vendor during open enrollment will be used as a starting point to determine a base aggregate PMPM. The data will be normalized to the vendor's network pricing. It is anticipated that this will include 12 months of incurred allowed claims. (TBD)

A claims completion factor will be applied to the allowed claims. This will be updated with runout during the settlement process with claims paid through June of the following Calendar Year. (TBD)

Total Calendar Year Incurred Claims

Apply Industry and Market Specific Trend (TBD) - Trend assumptions will be uniform across all vendors

Calendar Year Allowed PMPM Target

Amount of savings to be shared with vendor will vary by percentage of actual PMPM below Target PMPM based on the following Scale:

	CY 2018	CY 2019	CY 2020
% of Actual PMPM below Target	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**
< 3.00%	0%	0%	0%
3.00% - 6.00%	5%	7.5%	10%
> 6.00%	10%	17.5%	25%

Notes on PMPM:
1) Target PMPM will be set by March 1st of the current CY based on prior CY incurred claims with current year enrollment, adjustment for network pricing, completion factors and trend.
2) Performance of Actual versus Target PMPM will be calculated at the end of the CY when 6 months of runout is available in the data warehouse. This results in 18 months of runout for the Target PMPM and 6 months of runout for the Actual PMPM. Note that the Actual PMPM will have a completion factor applied.

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Network Health**
Region **Eastern**

Performance of Actual versus Target Clinical Performance Measures

In addition to the shared savings amounts based on Actual versus Target PMPM Calculations, payments will be reduced based on the percentage of clinical targets met by the vendor for the Calendar Year. If all clinical targets are met, payouts will be 100% of the PMPM calculations described above. If, for example, 75% of the clinical targets are met, payouts will be 75% of the PMPM calculations described above.

Clinical Targets for each year of the contract will be determined for each vendor individually by comparing actual baseline for each vendor to an ultimate target for each measure. The difference between the vendor's baseline and target will be the gap that should be closed over 3 years with equal improvement in each of the 3 years to reach the target. Examples are shown below:

	Baseline	Target	Gap	2018 Target	2019 Target	2020 Target
Vendor A	50%	90%	40%	63%	77%	90%
Vendor B	80%	90%	10%	83%	87%	90%
Vendor C	95%	90%	-5%	90%	90%	90%

ETG0003

Wisconsin Department of Employee Trust Funds
Discount Guarantee Development Worksheet

Exhibit B

Vendor **Network Health**
Region **Eastern**

		Preliminary Discount Guarantee			Final Discount Guarantee		
Region	Total Members	Expected Enrollment	Expected Distribution	Discount Guarantee	Open Enrollment	Final Distribution	Discount Guarantee
Eastern	63,766						
Northern	8,151						
Southern	113,299						
Western	21,024						
In-State	206,240						
Out-of-State	3,379						
Total Membership	209,619						

After open enrollment, a final discount guarantee will be developed based on vendor's actual enrollment.
Discount guarantees by region may not be altered during this process.

ETG0003

RFP ETG0003

Exhibit 1: State of Wisconsin Health Benefit Program Agreement

Issued May 1, 2017

State of Wisconsin Health Benefit Program Agreement

Issued by the State of Wisconsin

Department of Employee Trust Funds

On behalf of the Group Insurance Board

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000 DEFINITIONS

Unless otherwise defined herein, any term needing definition shall have the definition found in Uniform Benefits (of this AGREEMENT), the RFP, the PROPOSAL or in applicable Wisconsin law. These terms, when used and capitalized in this AGREEMENT are defined and limited to that meaning only:

AGREEMENT means the State of Wisconsin Health Benefit Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

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).

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).

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 attachments, supplements, endorsements riders and the CONTRACTOR'S PROPOSAL.

CONTRACTOR means the legal signatory to this AGREEMENT.

DAY means calendar DAY unless otherwise indicated.

DEPARTMENT means the State of Wisconsin Department of Employee Trust Funds.

DEPENDENT as defined in Uniform Benefits.

DOMESTIC PARTNER as defined in Uniform Benefits.

EFFECTIVE DATE means the date, as certified by the DEPARTMENT and shown on the records of the CONTRACTOR in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

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 program that provides group health BENEFITS to eligible State of Wisconsin and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

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.

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.

PBM means the Pharmacy Benefit Manager (PBM) which is a third party administrator that is contracted with the BOARD to administer the prescription drug benefits under this HEALTH BENEFIT PROGRAM. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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.

PROPOSAL means the complete response of a proposer submitted and setting forth the proposer's pricing for providing the services described in the Request for Proposal (RFP).

QUARTERLY means a period consisting of every consecutive three (3) months beginning January 2018.

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.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the CONTRACTOR for enrollment and who is entitled to BENEFITS.

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).

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETG0003 and in the PROPOSAL.

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 (forms 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).

110 Objectives

The BOARD's objectives of the HEALTH BENEFIT PROGRAM include, but are not limited to the following:

1) Management and delivery of health care services to PARTICIPANTS through contracted networks that provide for high-quality, cost-effective care.

2) To provide excellent customer service to PARTICIPANTS.

3) To offer networks of high value providers, and to incent PARTICIPANTS to choose benefit plan designs with high value providers.

4) To provide high-quality services at a competitive price.

5) Accurate, timely and responsive administration of health care claims.

6) 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.

7) To offer tools for PARTICIPANTS to increase engagement, including:

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

8) To ensure quality population health programs, including case management and disease management, which promote proactive management of PARTICIPANT health concerns.

9) 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 to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

3) Cooperate with the DEPARTMENT to develop procedures and protocols for sharing information as necessary.

4) Provide, in a format acceptable to the DEPARTMENT, at no cost and in a timely manner, all data and written or recorded material pertaining to this AGREEMENT.

5) Provide the specified level of services as indicated in this AGREEMENT to PARTICIPANTS.

6) Assist the DEPARTMENT with the administration of this AGREEMENT, including PARTICIPANT enrollment, record keeping, and general operations.

7) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT, including but not limited to, initial determination of eligibility for DEPENDENTS for disabled and full-time student status.

8) 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.

9) Have a mechanism, as approved by the DEPARTMENT, for handling complaints and grievances made by PARTICIPANTS.

   a) This includes a formal grievance procedure, which at a minimum complies with federal law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the 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.

10) Submit to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information.

11) Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in care from OUT-OF-NETWORK providers.

12) Comply with state and federal regulations pertaining to mandated or minimum BENEFITS which may be applicable to the CONTRACTOR under insurance statutes or as directed by the BOARD.

13) Provide DEPARTMENT approved materials to PARTICIPANTS as required under this AGREEMENT.

14) Provide notification of all significant events:

a) 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 (15%) percent 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 (51%) percent) interest in the CONTRACTOR or any transfer of ten (10%) percent or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the 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."

15) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT.

16) Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32.

17) Provide coverage for PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

18) 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.

19) Shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT.

20) 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, per Wis. Stat. § 40.02 (25) (b), eligible EMPLOYEES include:

1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS).

2) Elected state officials.

3) Members or EMPLOYEES of the legislature.

4) Any blind EMPLOYEES of the Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3.

5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance.

6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave (Wis. Stat. § 40.05 (4) (bm)).

7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority:

    a) Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

b) Any teacher who is a participating EMPLOYEE and who is employed by the UW System for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

c) Certain visiting faculty members in the UW System.

d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.

e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one (1) semester for academic year (nine (9) month) or six (6) months for annual (twelve (12) month) appointments.

f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of twenty-eight (28%) percent or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one (21%) percent or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.

g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.

h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospital and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.

8) ANNUITANTS and CONTINUANTS:

a) Any covered EMPLOYEE who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

b) The surviving spouse or DOMESTIC PARTNER of a SUBSCRIBER.

c) Covered EMPLOYEES who terminate employment, have attained minimum retirement age (fifty (50) for protective services or fifty-five (55) for all other categories), have twenty (20) years of WRS creditable service and defer their annuity are eligible to continue in the HEALTH BENEFIT PROGRAM if a timely application is submitted.

d) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll 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.

e) Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for coverage through the EMPLOYER.

f) Any retired public employee under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

125B Dependent Coverage Eligibility

Individual coverage covers only the SUBSCRIBER. All eligible DEPENDENTS listed on the application are covered under a family contract. A SUBSCRIBER cannot choose to exclude any eligible DEPENDENT from family coverage, unless that DEPENDENT is already covered under the HEALTH BENEFIT PROGRAM.

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

Notwithstanding the paragraph above, the birth or adoption of a child to a SUBSCRIBER under an individual benefit plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within sixty (60) DAYS of the birth, adoption, or placement for adoption.

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the 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.

125E Local Annuitants

LOCAL ANNUITANTS who cancel coverage for any reason are not eligible to reenroll in the program as a SUBSCRIBER.

125F Medicare Participants

ANNUITANTS and their DEPENDENTS, or surviving DEPENDENTS, who become enrolled in Medicare may continue to be covered at reduced PREMIUM rates, as specified by the BOARD.

Enrollment in Medicare by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the STATE or participating LOCAL EMPLOYER. Enrollment in Medicare Parts A and B is required for the EMPLOYEE and/or Medicare-eligible DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active EMPLOYEE'S group health benefit policy with another employer and that policy is the primary payer for Medicare Parts A and B charges, the ANNUITANT and/or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare reduced PREMIUM for coverage under this program.

As required by Medicare rules, Medicare is the primary payer for DOMESTIC PARTNERS age sixty-five (65) and older who are enrolled in Medicare, regardless of the work status of the SUBSCRIBER. The reduction in PREMIUM is available only when the coverage is provided under a non-employer group number.

Enrollment in Medicare by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the covered EMPLOYEE, ANNUITANT or DEPENDENT is required to pay a premium to enroll in the HOSPITAL portion of Medicare (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

130 Premiums

The BOARD determines the PREMIUM for its self-insured benefit plans as part of the HEALTH BENEFIT PROGRAM. This PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to:

1) Projection of incurred claims costs for the renewal benefit period.

2) The most recent thirty-six (36) months of incurred/paid triangular reports for the current benefit period.

3) Complete documentation of the methodology and assumptions utilized to develop the projected costs.

4) Disclosure of supporting data used in the calculation, including monthly paid claims and enrollment, network provider fee-structure analysis, provider negotiations updates, utilization analysis to report on unusual patterns, large claims analysis, trend analysis, and demographic analysis.

5) Substantiation of any proposed increase in fixed costs, such as administrative costs, via a thorough analysis of activities and costs covered by those fees.

6) Explanations for any unusual trend results (high or low relative to the market).

The CONTRACTOR will work with the BOARD'S consulting actuary independently to agree on a format, and the frequency of providing this data.

SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255.

The State of Wisconsin's current contribution toward the total health benefit for EMPLOYEES (non-retired) for both individual and family contracts is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The tiered structure is based on recommendations from the BOARD'S consulting actuary.

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 the Medicare HOSPTIAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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 coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. 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.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see Sections 125F and 220H.

135 Administrative Fee and Financial Administration

135A Invoicing and Banking

1) Claims Invoicing:

   a) The CONTRACTOR shall notify the DEPARTMENT every calendar week during the term of this AGREEMENT and inform the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. The amount due every week shall be the total amount of BENEFIT payments issued by the CONTRACTOR for the claims processed during the immediately prior calendar week (Saturday through Friday).

   b) The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT by the first Friday immediately following the DEPARTMENT'S receipt of the request for payment by the CONTRACTOR. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.

   c) The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within twenty (20) BUSINESS DAYS following month-end.

   d) The CONTRACTOR shall submit a claims invoice reconciliation report each month for the prior month. The report will reconcile the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. The weekly claims invoice must show claims by the benefit period in which they were incurred and by state and local subgroups.

2) Administrative Fee Invoicing:

   a) The CONTRACTOR must submit to the DEPARTMENT on the twentieth (20th) DAY of each calendar month (or the first BUSINESS DAY following the twentieth (20th) DAY of the calendar month), an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The monthly invoice must show the total amount of administration

fees, other approved fees and expenses due for the immediately following calendar month. The DEPARTMENT shall deposit funds into the bank account designated by the CONTRACTOR on the first BUSINESS DAY of the calendar month following the DEPARTMENT'S receipt of the invoice from the CONTRACTOR.

b) The CONTRACTOR shall be paid the administrative fee per month per PARTICIPANT as detailed in the CONTRACT. All administrative plan arrangement-related fees are included in the CONTRACTOR's administrative fee.

   The statewide/nationwide CONTRACTOR shall be paid for underwriting services to evaluate risk and submit recommendations for LOCAL EMPLOYERS requesting participation in the local HEALTH BENEFIT PROGRAM. The LOCAL EMPLOYER shall send payments for underwriting services to the DEPARTMENT. The DEPARTMENT shall forward one check for the appropriate amount shown in the Cost Proposal to the CONTRACTOR for their services.

3) Direct Pay SUBSCRIBER Invoicing:

   The CONTRACTOR shall not process any PREMIUM transactions related to enrollment, except for those direct pay SUBSCRIBERS.

135B Administrative Fee Adjustments

Administrative fee adjustments, if any, required as recommended by the BOARD's consulting actuary for BENEFIT changes, mandated BENEFIT payments, and/or operational changes, will occur on January 1 after the next contract period begins unless otherwise approved by the BOARD. The CONTRACTOR shall supply an administrative monthly invoice that must be based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The CONTRACTOR shall be paid the following administrative charge per month per PARTICIPANT for the AGREEMENT periods stated as follows:

Medical administration fee per individual and family contract. The medical administration fee includes, but is not limited to, the following:

1) Claims administration (including adjudication, payment, reprocessing, coordination of BENEFITS (excluding vendor recoveries), and overpayment collection).

2) Utilization review fees.

3) Network access fees.

4) MHSA claims administration.

5) Medical management (including medical review).

6) Disease management.

7) Customer service (to meet all requirements of this AGREEMENT, including all key personnel).

8) PARTICIPANT materials (including explanations of BENEFITS, summary of BENEFITS and coverage, web tools, ID cards, printing and mailing costs).

9) All required reports (including federally required reports and tax related forms).

10) Claims data extracts.

11) Administration, collection of, and passing through to the DEPARTMENT, premiums for direct pay SUBSCRIBERS (including reporting non-payment terminations).

12) IT services (including hardware and software).

13) Telecom (other program resource links, reporting, special usage or access requirements).

14) Required reviews (including fraud and abuse, and HOSPITAL bill).

15) Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing).

16) Telehealth services.

17) Twenty-four (24)-hour nurse line services.

18) Underwriting services (applies to a CONTRACTOR providing statewide/nationwide services under this AGREEMENT only).

135C Prohibited Fees

1) The CONTRACTOR is prohibited from including in their administrative fee:

   a) The cost to handle any claims paid outside of Uniform Benefits or IYC Medicare Plus administered by the statewide/nationwide CONTRACTOR.

   b) The cost to administer any optional health and wellness benefit(s) beyond Uniform Benefits, IYC Medicare Plus that is administered by the statewide/nationwide CONTRACTOR or the Well Wisconsin program.

2) The CONTRACTOR is prohibited from billing separate fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

135D Recovery of Overpayments

1) Overpayments:
   If it is determined that any payment has been made under this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or

shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.

If any overpayments made to ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments. Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR'S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments. Any overpayment caused by the CONTRACTOR'S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.

The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures.

2) The BOARD shall hold the CONTRACTOR and its directors, officers, and employees harmless from any liability for any overpayments and/or underpayments made to any ineligible former PARTICIPANT when payments result from a failure of the BOARD, the DEPARTMENT or any other State department or agency to make a timely report to the CONTRACTOR of any PARTICIPANT'S loss of eligibility.

   The DEPARTMENT shall not hold the CONTRACTOR responsible for any overpayments caused by DEPARTMENT or EMPLOYER errors or fraud by a person other than an employee of the CONTRACTOR.

   The CONTRACTOR shall assist the DEPARTMENT in identifying overpayments caused by such error or fraud.

3) The BOARD reserves the sole right to institute litigation for the purpose of recovering any overpayment. The BOARD reserves the right to join in any litigation instituted by the CONTRACTOR for the purpose of recovering any overpayment which is the responsibility of the CONTRACTOR.

4) The CONTRACTOR shall be given full credit for all refunds that result from recovery of any overpayment to the extent that the CONTRACTOR is held financially responsible for such overpayment within this AGREEMENT.

5) Disputes over Charges:

   Notwithstanding any other terms, conditions, and provisions of this AGREEMENT, the CONTRACTOR shall pay CHARGES as determined by the CONTRACTOR. Disputes as to CHARGES will be referred, on a timely basis, to the CONTRACTOR who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

   If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT shall contact the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR shall notify the DEPARTMENT about the lawsuit.

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 administrative fees or other 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:

1) Providers to request and receive electronic funds transfer (EFT) of claims payments for BENEFITS.

2) SUBSCRIBERS to submit EFT of direct pay PREMIUM payments. The CONTRACTOR must support other mechanisms for payment of direct pay PREMIUMS.

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.

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.

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. 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. The next roll-out for the new system is currently scheduled for 2018.

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.

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 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.

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 Claims Data Specifications document, all claims processed for PARTICIPANTS. At least ninety-five (95%) percent of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred (100%) percent of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

b) 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, 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. 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 and integrate the data as required under Section 240. 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 provided by the DEPARTMENT with 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 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 RFP, 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. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file. 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 and are the direct result of the CONTRACTOR's failure to meet the

DEPARTMENT'S data submission requirements or timelines and which the DEPARTMENT will deduct from any payment owed the CONTRACTOR in the payment period.

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.

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 Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits. All amounts recovered under this program shall be paid forty-five (45%) percent to the CONTRACTOR and fifty-five (55%) percent to the BOARD.

155D 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.

155E 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) 16 and provide a copy of the CPA's report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.) The audit report must be submitted annually.

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.

155F 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. For information see Section 135D.

2) Contractor Provider 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; and,

n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. 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 personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

4) The actual impact list (as soon as known).

5) A copy of any correspondence sent to affected PARTICIPANTS (this must be pre-approved by the DEPARTMENT).

6) A description of the steps taken to ensure a similar incident will not be repeated.

This notification requirement shall apply only to PHI or PII received or maintained by the CONTRACTOR pursuant to this AGREEMENT. The CONTRACTOR shall make good faith efforts to communicate with the DEPARTMENT about breaches by major provider groups if the CONTRACTOR knows those breaches affect PARTICIPANTS.

The CONTRACT shall notify the DEPARTMENT Program Manager and Privacy Officer no less than one (1) BUSINESS DAY before any external communications are made regarding a data breach.

155H 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.

155I 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 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) In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.

4) Membership changes and corrections not processed during the term of the contract will continue to be processed by the CONTRACTOR during the entire run-out period. During the entire run-out period, all performance standards and penalties remain in force.

5) The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT'S approval.

155J Transition Plan

During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. In the event that the CONTRACTOR terminates the CONTRACT, an updated

transition plan must accompany the notice of termination. In the event the BOARD terminates the CONTRACT, the CONTRACTOR must send an updated transition plan to the DEPARTMENT within thirty (30) DAYS of the written notice of termination to the CONTRACTOR. The transition plan must be approved by the DEPARTMENT prior to the transition begin date and must include the CONTRACTOR'S cooperation and participation in planning calls or meetings with the succeeding vendor.

The CONTRACTOR must administer a program run-out period to process claims and to handle related customer service inquiries. The run-out period begins on the CONTRACT termination date and will be no longer than one (1) year. The CONTRACTOR shall be paid three (3) months of administrative expenses based on the membership census as of November 1 of the last year of the contract. The administrative fee shall be the fee in effect during the last year the contract. The fee shall be paid in three (3) installments. The first installment shall be paid in December of the last year of the contact. The second installment shall be paid in January of the year of run-out. The final payment will be made no later than December of the year of run-out unless issues arise with data submission to the DEPARTMENT'S data warehouse. In the event of issues receiving run-out claims per the DEPARTMENT'S timeline, the DEPARTMENT will withhold the final fee payment until all run-out claims are received.

Leading up to and during the run-out period, the CONTRACTOR must:

1) Participate in all DEPARTMENT requested meetings.

2) Provide all reports for program close out.

3) Report on performance standards specified in Section 315.

4) Invoice the DEPARTMENT as specified in Section 135A.

5) Transmit program data to the new vendor.

6) Continue grievance, hospital bill audit, subrogation services and overage disabled dependent reviews.

7) Transmit run-out claims data to the DEPARTMENT'S data warehouse as specified in Section 150.

155K Health Underwriting for Statewide/Nationwide Contractor only

LOCAL EMPLOYERS with one or more employees requesting participation in the local HEALTH BENEFIT PROGRAM are subject to underwriting. The CONTRACTOR shall evaluate risk and submit a recommendation back to the DEPARTMENT for final approval by the BOARD'S actuary. The effective date shall be determined by the DEPARTMENT. The fees described in the Cost Proposal, or as agreed upon by the DEPARTMENT, shall be administered per Section 135A.

Employers with fifty-one (51) or more EMPLOYEES shall submit claims and enrollment experience including high cost claims data for the most recent available twenty-four (24) months along with the fees to the DEPARTMENT.

Employers with fifty (50) or less EMPLOYEES shall submit small employer information as required by the CONTRACTOR to the DEPARTMENT along with the fees.

The DEPARTMENT will submit information and appropriate fees to the 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.

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. 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) 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 Eligibility

The 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.

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

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 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 as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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. See Appendix 6, Guidance for DEPARTMENT Initiatives, for additional detail.

The current DEPARTMENT Initiatives 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) High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.

3) Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.

4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.

5) 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.

215C Quality Initiatives

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.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in Uniform Benefits to all PARTICIPANTS with the exception of the statewide/nationwide CONTRACTOR who must provide the BENEFITS and services listed in the IYC Medicare Plus certificate to all Medicare 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 high deductible health plan (HDHP) 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger 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 Preferred Provider Organization (PPO)

The BOARD may offer different copayment and deductible schedules for OUT-OF-NETWORK providers, except in the case of emergency, urgent care or when the services are not reasonably available IN-NETWORK.

If the PARTICIPANT resides in a CONTRACTOR'S service area, the PPO must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty IN-NETWORK provider when determining if that provider is reasonably available.

220G Medicare

The CONTRACTOR will provide BENEFITS and services as described in Uniform Benefits to PARTICIPANTS enrolled in Medicare with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS.

The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare.

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 EMPLOYEE, 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. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payer after this thirty (30)-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty (30) -month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer. No reduction in PREMIUM is available for active EMPLOYEES under this section.

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, change from or to the IYC HDHP).

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:

1) If a PARTICIPANT changes benefit plans.

2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER (or combination of spouse-to-DOMESTIC PARTNER) transfer resulting in a change of SUBSCRIBER, but does not change benefit plans.

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.

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. For HDHPs, medical and pharmacy accumulations are combined.

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.

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 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 audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year, which includes 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 commercially insured adult 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.

c) The results of the survey shall be used for the measurement of PARTICIPANT satisfaction as specified in the performance standards in Section 315G.

4) The DEPARTMENT will monitor health care quality and/or customer satisfaction using performance measures available in the data warehouse and visual business intelligence tool, and will establish performance metrics, baseline results, and target performance levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage performance improvement.

   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.

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 and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how 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.

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.

The 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 their provider network for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150.

The DEPARTMENT will use this data to ensure provider access standards are met. 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 (33%) percent 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 the following minimum requirements:

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 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 the access standards above, including accepting 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. 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 Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in Uniform Benefits with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS. Targets for claims processing performance standards and associated penalties are specified in Section 315C.

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. The CONTRACTOR shall pay claims of providers according to a time standard mutually established by the CONTRACTOR and the DEPARTMENT.

Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR shall provide the total dollar amount of claims paid by the HEALTH BENEFIT PROGRAM.

In accordance with state statute, the CONTRACTOR must maintain individual documentation used for claim adjudication for a minimum of seven (7) years.

240 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 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.

245 Grievances

245A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with the HHS-administered federal external review in accordance with federal law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections 245E, 245F, and 265A.

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 245A – H.

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

4) Notification of DEPARTMENT Administrative Review Rights (not all grievances eligible): Administrative review by DEPARTMENT staff, and/or the DEPARTMENT appeals process including filing an appeal with the BOARD, an administrative appeal hearing, consideration of the appeal by the BOARD, right to appeal the BOARD's final decision to circuit court; or,

5) Federal external review (not all grievances eligible).

245B 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.

245C 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.

245D 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.

245E Notification of Department Administrative Review Rights

In the final grievance decision letters, the CONTRACTOR shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR shall cite the specific Uniform Benefits contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision with the exception of the statewide/nationwide CONTRACTOR who will cite the specific IYC Medicare Plus contractual provision(s) for Medicare PARTICIPANTS.

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 HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

BOARD decisions can only be further reviewed as provided by Wis. Stat. § 40.08 (12) and Wis. Adm. Code ETF 11.15.

245F External Review

The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an 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.

245G 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.

245H 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.

245I 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.

245J 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.

250 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see Section 260D.

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.

255 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt. It is acceptable to credit the collected direct pay PREMIUM amount on the administrative monthly invoice provided that it contains itemized SUBSCRIBER level detail.

Direct pay PREMIUMS may be submitted to the CONTRACTOR via electronic funds transfer or 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.

260 Continuation

260A 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.

260B 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.

260C Conversion / Marketplace

The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment.

260D 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.

265 Miscellaneous Program Requirements

265A 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.

The CONTRACTOR is required to perform and/or manage the following activities by the date indicated:

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Nondiscrimination Testing Plan: The CONTRACTOR works with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.	Within thirty (30) DAYS of execution of this CONTRACT
Transition Plan: The transition plan is established in a mutually agreed upon format and submitted to the DEPARTMENT Program Manager or designee for review.	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2018 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	August 18, 2017
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 1, 2017
Employer Meeting: The CONTRACTOR attends the It's Your Choice EMPLOYER Kick-Off meeting.	Fall 2017 (Date TBD)
Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.	September 30, 2017
Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2017
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	September 2017 (Date TBD)
Employer Health Fairs: The CONTRACTOR shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area.	October – November 2017
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation.	November 16, 2017

Activity	Due Dates
Financial Administration: Financial administration requirements are operational, including but not limited to: • Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. • Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). • Direct pay invoicing process. • ACH mechanism for EFT of claims payments and direct pay PREMIUMS.	November 30, 2017
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2017
ID Cards: The CONTRACTOR issues welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018.	December 15, 2017
Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM are fully operational.	January 1, 2018
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2018
Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly.	January 15, 2018
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2018
Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2018
Claims Data: The claims data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	March 31, 2018

265B Account Management and Staffing

Upon execution of this CONTRACT, the CONTRACTOR shall designate an Account Manager and a backup, assigned to the DEPARTMENT for the life of the CONTRACT, who is accountable for and has the authority to:

1) Manage the entire range of services specified in the CONTRACT;

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

4) Implement the DEPARTMENT changes to benefit plan design and procedures; and,

5) Resolve general administrative problems identified by the DEPARTMENT.

The Account Manager or backup must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the contract. The Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR shall resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR must have a designated Information Technology contact and a backup Information Technology contact who will have overall responsibility for the information technology aspects of the CONTRACT. The Information Technology contact shall be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR shall provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. The CONTRACTOR shall ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT, have the experience and credentials necessary to perform the work required. The CONTRACTOR shall provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS.

The CONTRACTOR shall notify the DEPARTMENT if the Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to deny the CONTRACTOR'S designees.

The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must acknowledge receipt of the inquiry from the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the payroll processing centers and/or other payroll.

The CONTRACTOR shall provide onsite staff attendance at the annual IYC EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the annual IT'S YOUR CHOICE OPEN ENROLLMENT period.

The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR'S operations and policies.

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the 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 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting HEALTH BENEFIT PROGRAM services.

265C Customer Service

The CONTRACTOR shall operate a dedicated 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 315D 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, EMPLOYER group);

5) The representative that handled the inquiry;

6) For phone inquiries, the length of call; and,

7) The resolution of the inquiry (including a resolution code using a coding scheme).

Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request.

At the DEPARTMENT'S request, the CONTRACTOR must provide the policies and procedures related to the operation of the customer service department. The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each 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.

265D 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.).

265E 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.

265F 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR.

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.

265G 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 "personal information", as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;

2) Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,

3) Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record that would violate Wis. Stat. § 40.07 (1) or (2), respectively, if the disclosure was made by the DEPARTMENT.

265H 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.

265I Subrogation and Other Payers

The CONTRACTOR shall correspond with PARTICIPANTS to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other payers such as worker's compensation, insurance contracts, or government-sponsored benefit programs.

The CONTRACTOR shall have authority to retain any attorneys or law firms regarding such subrogation rights and lawsuits involving such rights to represent the BOARD to pursue the BOARD'S subrogation rights in accordance with this AGREEMENT. Any subrogation settlement agreed to by the CONTRACTOR shall be deemed acceptable by the BOARD. The CONTRACTOR may forego subrogation where, at the CONTRACTOR'S discretion, the circumstances in a particular subrogation matter warrant such a decision.

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel or utilize in-house counsel to provide the BOARD with subrogation litigation services on the BOARD'S behalf at a contingency fee not to exceed thirty (30%) percent for outside legal counsel or twenty (20%) percent for in-house counsel of net dollars recovered by such counsel, with those attorneys' fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

For such subrogation matters, the BOARD shall not pay or provide any additional reimbursement for the outside legal counsel's or in-house counsel's legal fees, expenses, costs and disbursements incurred by such counsel while providing subrogation-related legal services and such legal fees, expenses, costs and disbursements are included in, and will be paid out of, the maximum thirty (30%) percent contingency fee that is paid to the outside legal counsel or twenty (20%) percent fee paid to in-house counsel as set forth in this subsection. The CONTRACTOR will not be paid or receive any portion of the contingency fee that is paid to the outside legal counsel if outside legal counsel is hired. The BOARD shall be solely responsible and liable for paying the contingency fee to outside legal counsel for its attorneys' fees, legal costs and disbursements incurred by the outside legal counsel representing the BOARD in subrogation cases, not the CONTRACTOR. The CONTRACTOR is not responsible or liable for paying the contingency fee or any outside counsel attorneys' fees, legal costs and disbursements.

265J 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.

265K Other

The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the HEALTH BENEFIT PROGRAM.

265L 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.

265M Conflict of Interest

During the term of this AGREEMENT, the CONTRACTOR shall have no interest, direct or indirect, that would conflict in any manner or degree with the performance of services required under this AGREEMENT.

Without limiting the generality of the preceding paragraph, the CONTRACTOR agrees that it shall not, during the initial AGREEMENT period and any extension thereof, acquire or hold any business interest that conflicts with the CONTRACTOR'S ability relating to its performance of its services under this AGREEMENT.

The CONTRACTOR shall not engage in any conduct which violates, or induces others to violate, the provision of the Wisconsin statutes regarding the conduct of public employees. If a BOARD member or an organization in which a BOARD member holds at least ten (10%) percent interest is a party to this AGREEMENT, then this AGREEMENT is voidable by the BOARD unless appropriate disclosure has been made to the Wisconsin Ethics Commission.

300 DELIVERABLES

305 Reporting Requirements

As required by the CONTRACT, the CONTRACTOR must submit reports to the DEPARTMENT. Reports must be submitted by SECURE email to the DEPARTMENT, the DEPARTMENT'S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify reporting requirements as deemed necessary to monitor the CONTRACT and programs.

Instructions and specific due dates will be provided by the DEPARTMENT annually.

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the 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 Invoicing	The CONTRACTOR notifies the DEPARTMENT every calendar week during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. *(See Section 135A, 1, a.)*	Weekly
3) Administrative Fee Invoice	The CONTRACTOR submits to the DEPARTMENT an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. *(See Section 135A, 2, a.)*	Monthly
4) 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, 1.)*	Monthly
5) Bank Reconciliation Report	The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. *(See Section 135A, 1, c.)*	Monthly
6) Claims Invoice Reconciliation Report	The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. *(See Section 135A, 1, d.)*	Monthly

Report	Description	Frequency
7) 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 265C.)*	Monthly
8) 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, 2..)*	Monthly
9) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155F, 2.)*	Quarterly
10) Hospital Bill Audit	The CONTRACTOR performs a HOSPITAL bill audit process for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and provides results of material findings to the DEPARTMENT. *(See Section 155C.)*	Quarterly
11) 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
12) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
13) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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, High Tech Radiology, Low Back Surgery, Shared Decision Making, and Advance Care Planning. *(See Section 215B.)*	Semi-annually
14) 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 215C.)*	Semi-annually
15) 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.)*	Semi-annually

Report	Description	Frequency
16) 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
17) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. *(See Section 225, 3, b.)*	Annually
18) 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
19) 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
20) 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.)*	Annually
21) 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
22) 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
23) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year. *(See Section 225, 3, a.)*	Annually
24) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually

Report	Description	Frequency
25) Rate Renewal Reports	To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. *(See Section 130.)*	Annually
26) 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 16 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 DEPARTMENT Program Manager or designee. *(See Section 265A.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. *(See Sections 265A and 265B.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. *(See Section 155F, 2 and Section 265A.)*	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section 205B, 2.)*	Upon identification of issue
5) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section 265B.)*	April August

Deliverable	Description	Frequency
7) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. *(See Section 230A.)*	June
8) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July
9) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
10) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
11) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
12) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. *(See Section 140B, 1.)*	October
13) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
14) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
15) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 265D, 1a and 1p.)*	As directed by the DEPARTMENT
16) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred 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
17) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 265B.)*	As needed
18) Recovery of Overpayments	The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures. *(See Section 135F.)*	As needed
19) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 245K.)*	As needed

Deliverable	Description	Frequency
20) Notification of Legal Action Against PARTICIPANT in Dispute over Charges	If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit's status in a mutually agreeable format. *(See Section 135F.)*	As needed
21) Notification of 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 personal 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 155G.)*	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 245F.)*	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, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. *(See Section 155J.)*	During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • The HEALTH BENEFIT PROGRAM provider directory or directions on how to request a printed copy of the provider directory. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. *(See Section 230C.)*	See description
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. *(See Section 245B.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. *(See Section 245D.)*	See description
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment. *(See Section 260C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed
10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

Performance standards are specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book-of-business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT upon realization that a standard will not be met, prior to the deadline.

The penalties assessed in Section 150B and Section 315 shall not exceed twenty-five (25%) percent of the CONTRACTOR'S total administrative fee in any given quarter. After implementation, all performance standards will be measured by the DEPARTMENT on a QUARTERLY basis and assessed based on PARTICIPANT counts as of the first calendar DAY of the quarter, as determined by DEPARTMENT enrollment records. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

Section	Performance Category	Maximum Penalty
315A	Implementation	Three (3%) percent
315B	Account Management	Three (3%) percent
315C	Claims Processing	Four (4%) percent
315D	Customer Service	Four (4%) percent
315E	Data Management	Four (4%) percent
315F	Enrollment	Four (4%) percent
315G	Other	Three (3%) percent
	TOTAL	Twenty-five (25%) percent

315A Implementation

The CONTRACTOR shall complete the task by the date specified below. If an alternate date is approved by the DEPARTMENT in the implementation plan, the CONTRACTOR shall complete the task by the alternate date. The total penalties for this performance category shall not exceed three (3%) percent of the total estimated administrative fee for year one (1) of the CONTRACT.

Performance Standards – three (3%) percent Penalty	Penalties
1) Program Information: All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards – three (3%) percent Penalty	Penalties
2) Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) Customer Service: The CONTRACTOR's dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained no later than September 30, 2017. (*See Section 265A.)*	
4) Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. *(See Section 265A.)*	
5) Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 265A.)*	
6) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. *(See Section 265A.)*	
7) Financial Administration: Financial administration requirements are operational no later than November 30, 2017. *(See Section 265A.)*	
8) Grievance Procedure: The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT'S review and approval. *(See Section 265A.)*	
9) ID Cards: No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018. *(See Section 265A.)*	
10) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018. *(See Section 265A.)*	

Performance Standards – three (3%) percent Penalty	Penalties
11) Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
12) Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly no later than January 31, 2018. *(See Section 265A.)*	
13) Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than February 28, 2018. *(See Section 265A.)*	
14) Claims Data Transfer: The claims data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than March 31, 2018. *(See Section 265A.)*	

315B Account Management

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(*See *Section 265B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey

Performance Standards	Penalties
2) **Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 265D, 1.)*	Five thousand ($5,000) dollars per incident

315C Claims Processing

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Financial Accuracy:** At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid in the correct amount divided by the total claim dollars paid. *(See Section 235.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
2) **Processing Accuracy:** At least ninety-seven (97%) percent level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section 235.)*	
3) **Claims Processing Time:** At least ninety-five (95%) percent of all claims received must be processed within fifteen (15) BUSINESS DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 235.)*	

315D Customer Service

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Call Answer Timeliness**: At least eighty (80%) percent of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)

Performance Standards	Penalties
2) Call Abandonment Rate: Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
3) Open Call Resolution Turn-Around-Time: At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section 265C.)*	
4) Inquiry Resolution Tracking Document/Log: Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request. *(See Section 265C.)*	
5) Electronic Written Inquiry Response: At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section 265C.)*	

315E Data Management

The DEPARTMENT will specify the timetable and dates for which the claims and provider data transfers must be provided. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Claims Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a and 150B, 1.)*	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, 2.)*	

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 155G.)*	

315F Enrollment

The CONTRACTOR shall report QUARTERLY any DAY for which any of the following standards are not met. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 150A, 4, a and c.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Enrollment Discrepancies: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. *(See Section 150A, 4, a.)*	
3) ID Cards: The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
4) ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID cards by December 15 (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.)*	

Performance Standards	Penalties
5) Direct Pay Terminations: The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section 255.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

315G Other

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155E.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Grievance Resolution: Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. *(See Section 245C.)*	
3) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	
4) PARTICIPANT Satisfaction Surveys: The CONTRACTOR shall achieve at or above a ninety (90%) percent satisfaction rating (defined as “top three-boxes” using a zero (0) to ten (10) rating scale with ten (10) being the highest ranking) on the health plan rating question on the CAHPS survey tool or other survey instrument as approved by the DEPARTMENT. *(See Section 225, 3, c.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
5) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident

Performance Standards	Penalties
6) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

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 2018.

These are the Uniform Benefits or "Summary Plan Description" offered under the Health Benefit Program.

This portion of the Agreement is often excerpted and provided to PARTICIPANTS as their Summary Plan Description.

The contractor shall not alter the language, benefits or exclusions and limitations, herein.

These Uniform Benefits are provided to SUBSCRIBERS via the It's Your Choice materials as their Summary Plan Description. The language in this section is written to the audience of the PARTICIPANT. Included in this section is a set of definitions which is specific to Uniform Benefits. The contractor does not need to recreate the description of benefits nor distribute it to PARTICIPANTS.

These Uniform Benefits are provided to a SUBSCRIBER who is a retired public employee under Wis. Stat. § 40.02 (25) (b) 11, or any DEPENDENT of such an employee, and, if eligible, has acted under Wis. Stat. § 40.51 (10) to elect group health insurance coverage. SUBSCRIBERS or DEPENDENTS who are ineligible and unenrolled in Medicare may join Program Option 16. SUBSCRIBERS or DEPENDENTS who are eligible and enrolled in Medicare may join Program Option 12. Benefits will be provided to SUBSCRIBERS via the Local Annuitant Health Program (LAHP) materials.

I. Schedule of Benefits

All benefits are paid according to the terms of this contract between the THIRD PARTY ADMINISTRATOR(S) (TPA), the PBM, and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the contract. The SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, EMERGENCY services received from an OUT-OF-NETWORK PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE.

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

This Summary Plan Description applies to services received from IN-NETWORK PROVIDERS. If any OUT-OF-NETWORK benefits are available, YOU will be provided with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by OUT-OF-NETWORK PROVIDERS. OUT-OF-NETWORK DEDUCTIBLE amounts do not accumulate to the IN-NETWORK OUT-OF-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 TPA before such services are obtained.

The covered benefits are subject to the following:

1) DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Annual medical DEDUCTIBLE	$250 individual/$500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	None.	$1,500 per individual plan / $3,000 per family plan The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the plan pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).
Annual medical COINSURANCE	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies OOPL except as described below.	BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL.
Annual medical OUT-OF-POCKET LIMIT (OOPL)	$1,250 PARTICIPANT / $2,500 aggregate family limit except as described below.[1]	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]	After DEDUCTIBLE: $2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN pays 100%.	Covered 100%.	BENEFIT PLAN pays 100%.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $75 COPAYMENT (counts towards to OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit).[2]	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. §632.895 (16), covered 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	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 and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). 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 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Prescription Drugs	See below.	See below.	After DEDUCTIBLE: subject to medical DEDUCTIBLE above. After DEDUCTIBLE, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2]Federally required preventive services are covered at 100%.

[3] State of Wisconsin MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the MEDICARE Prime Uniform Benefits SCHEDULE OF BENEFITS.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical DEDUCTIBLE	None.	$250 individual / $500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	$500 individual / $1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). When an individual within a family plan meets the $500 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.	$1,500 per individual plan / $3,000 per family plan. The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the BENEFIT PLAN pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical COINSURANCE	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLEMEDICAL EQUIPMENT, cochlear implants and hearing aids.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visits, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.	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.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / 10% applies to medical services except for office visits, and as described below. COINSURANCE applies to OOPL except as described below.
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]	$1,250 individual / $2,500 aggregate family limit except as described below.[1]	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOPL.[1]	$2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
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	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15 per visit. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.	PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
Cochlear Implants for PARTICIPANTS age 18 and older	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLANS pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), BENEFIT PLANS pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
		treatment per PARTICIPANT per calendar year.		treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.
Prescription Drugs	See below.	See below.	See below.	After DEDUCTIBLE: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2] Federally required preventive services are covered at 100%.

[3] Wisconsin Public Employer MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the PO2 Uniform Benefits SCHEDULE OF BENEFITS.

1) Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE

2) Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.

3) Diagnostic Services Limitations: PRIOR AUTHORIZATION may be required.

4) Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): Covered up to 50 visits per PARTICIPANT for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional MEDICALLY NECESSARY visits may be available when PRIOR AUTHORIZED by the TPA, up to a maximum of 50 additional visits per therapy per PARTICIPANT per calendar year.

5) Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when MEDICALLY NECESSARY and PRIOR AUTHORIZED by the TPA; and HOSPITAL CHARGES. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for PARTICIPANTS under 18 years of age are payable as described in the preceding grid.

6) Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), hearing aids for PARTICIPANTS under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.

7) Home Care Benefits Maximum: 50 visits per PARTICIPANT per calendar year. 50 additional MEDICALLY NECESSARY visits per PARTICIPANT per calendar year may be available when authorized by the TPA.

8) HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the TPA.

9) Transplants: Limited to transplants listed in Benefits and Services Section.

10) Licensed Skilled Nursing Home Maximum: 120 days per BENEFIT PERIOD payable for SKILLED CARE.

11) Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.

12) Vision Services: One routine exam per PARTICIPANT per calendar year. Non-routine eye exams are covered as MEDICALLY NECESSARY. (Contact lens fittings are not part of the routine exam and are not covered.)

13) Oral Surgery: Limited to procedures listed in Benefits and Services Section.

14) Temporomandibular Disorders as required by Wis. Stat. §632.895 (11): The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per PARTICIPANT per calendar year. Intraoral splints are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

15) Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services Section.

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.

b) Preventive Prescription Drugs:

i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.

ii) Under the HDHP, preventive prescription drugs are not subject to the DEDUCTIBLE; however, if the preventive prescription drug is not covered at 100% as required by federal law, a COPAYMENT will be required according to the provisions of this program's benefits.

iii) The PBM will publish a list of prescriptions drugs affected by these provisions.

Prescription Drug Copayments:
Level 1 COPAYMENT: $5.00
The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:
Level 2 COINSURANCE: 20% ($50 max)
The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 COINSURANCE: 40% ($150 max)
The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOPL:
Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $600 per individual or $1,200 per family for all PARTICIPANTS.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): no annual OOPL.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS
Specialty Drug Cost Share:
Level 4 COPAYMENT: $50
The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 COINSURANCE: 40% ($200 max)
The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

3) **Certain grandfathered erectile dysfunction medication as defined by the PBM (Viagra and Caverject Injection):** the 40% Level 4 COINSURANCE ($200 max) applies to these prescription medications. However, the COINSURANCE does not accumulate toward any OOPL. YOU must continue to pay Level 4 COINSURANCE for these drugs even after other annual OOPLs have been met.

4) **Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.

5) **Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits description, are defined and limited to that meaning only:

ADVANCE CARE PLANNING: A process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. ADVANCE CARE PLANNING includes:

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

3) Weighing YOUR options about what kind of care and treatment YOU would want or not want.

4) Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive.

5) Communicating YOUR wishes and any documents with YOUR family, friends, clergy, other advisors and physician and other health care professionals.

BED AND BOARD: Means all usual and customary HOSPITAL CHARGES for: (a) Room and meals; and (b) all general care needed by registered bed patients.

BENEFIT PERIOD: Means the total duration of CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CHARGE: An amount for a health care service from a PROVIDER that is reasonable, as determined by the TPA. The TPA considers, as part of determination of CHARGE:

1) Amounts charged for similar health care services in the same general area under comparable circumstances,

2) the TPA's methodology guidelines,

3) pricing guidelines of any third party responsible for pricing a claim,

4) the negotiated rate determined between the TPA and an IN-NETWORK PROVIDER, and

5) other factors.

The term “area” means a county or other geographical area which the TPA determines is appropriate to obtain a representative cross section of amounts. For example, the “area” may be an entire state.

In some cases the amount the TPA determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the health care service. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: A specified percentage of the CHARGES that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the IN-NETWORK PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

DEPENDENT: Means, as provided herein, the SUBSCRIBER'S:

1) Spouse.[1]

2) DOMESTIC PARTNER, if elected.[2]

3) Child.[3, 4, 5]

4) Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19. [3, 4, 5]

5) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.[3, 4, 5]

6) Stepchild.[1, 3, 4, 5]

7) Child of the DOMESTIC PARTNER insured on the policy.[2, 3, 4, 5]

8) Grandchild if the parent is a DEPENDENT child.[3, 4, 5, 6]

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

[2] A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

[3] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, 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.

[4] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

[5] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

[6] A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

DOMESTIC PARTNER: Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

1) Each individual is at least 18 years old and otherwise competent to enter into a contract.

2) Neither individual is married to, or in a domestic partnership with, another individual.

3) The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.

4) The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY.

5) The two individuals agree to be responsible for each other's basic living expenses.

6) The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

   a) Only one of the individuals has legal ownership of the residence.

   b) One or both of the individuals have one or more additional residences not shared with the other individual.

   c) One of the individuals leaves the common residence with the intent to return.

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 TPA and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

ELIGIBLE EMPLOYEE: As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.

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 TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the TPA and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the TPA and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

GENERIC EQUIVALENT: Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

GRIEVANCE: Means a written complaint filed with the TPA and/or PBM concerning some aspect of the TPA and/or PBM. Some examples would be a rejection of a claim, denial of a formal REFERRAL, etc.

HABILITATION SERVICES: Means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A benefit plan that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OOPL set by the IRS. An HDHP does not pay any health care costs until the annual DEDUCTIBLE has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the TPA.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

2) qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission of Accreditation of HOSPITALS.

The term HOSPITAL does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal HOSPITAL.

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses or DOMESTIC PARTNERS.

INJURY: Means bodily damage that results directly and independently of all other causes from an accident.

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The TPA agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the TPA in advance of the services being provided.

LEVEL "M" DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be on the MEDICARE PRESCRIPTION DRUG PLAN'S MEDICARE Part D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the TPA.

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the TPA after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the TPA:

1) Used primarily to treat an ILLNESS or INJURY, and

2) generally not useful to a person in the absence of an ILLNESS or INJURY, and

3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and

4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the TPA and/or PBM:

1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and

2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and

3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and

4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICARE: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

MEDICAID: Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this TPA.

NATURAL TOOTH: Means a tooth that would not have required restoration in the absence of a PARTICIPANT’S trauma or INJURY, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM’S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

1) Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician.

2) Re-assessment and intervention (individual and group).

3) Diabetes outpatient self-management training services (individual and group sessions).

4) Dietitian visit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-NETWORK PROVIDER: A PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the TPA'S professional directory of providers. Care from an OUT-OF-NETWORK PROVIDER may require PRIOR-AUTHORIZATION from the TPA unless it is EMERGENCY or URGENT CARE.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the allowed amount. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PHARMACY BENEFIT MANAGER (PBM): The PBM is a THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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 TPA before obtaining the services. Unless otherwise indicated by YOUR TPA, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the TPA and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the TPA PRIOR AUTHORIZATION form and approved by the TPA in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each TPA and are described in the It's Your Choice materials. The authorization from the TPA will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED visits and the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the TPA before services are rendered.

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-

language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

SELF-ADMINISTERED 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 TPA to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a TPA or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The TPA or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, DOMESTIC PARTNERS, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

SKILLED NURSING FACILITY: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a SKILLED NURSING FACILITY.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

SUBSCRIBER: An ELIGIBLE EMPLOYEE or annuitant who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits.

THIRD PARTY ADMINISTRATOR (TPA): The THIRD PARTY ADMINISTRATOR who is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the TPA, when taking into consideration, among other factors determined by the TPA, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases the amount the TPA determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. TPA approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits and Services

The benefits and services provided under the Health Benefit Program are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of IN-NETWORK chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the TPA reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see item A, 1 and item A, 2 below).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the TPA's written PRIOR AUTHORIZATION for covered services from an OUT-OF-NETWORK PROVIDER or YOU will be financially responsible for the services. The TPA may also require PRIOR AUTHORIZATION for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached SCHEDULE OF BENEFITS, a PARTICIPANT, in consideration of the employer's payment of the applicable TPA and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the TPA and/or PBM.

A. Medical/Surgical Services

1) EMERGENCY Care

a) Medical care for an EMERGENCY, as defined in Section II. Refer to the SCHEDULE OF BENEFITS for information on the EMERGENCY room COPAYMENT.

b) YOU should use IN-NETWORK HOSPITAL EMERGENCY rooms whenever possible. If YOU are not able to reach YOUR IN-NETWORK PROVIDER, go to the nearest appropriate medical facility. If YOU must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU call the TPA by the next business day or as soon as possible and tell the TPA where YOU received EMERGENCY care. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA. In addition to the cost sharing described in the SCHEDULE OF BENEFITS, EMERGENCY care from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.

c) It is recommended, to expedite claims processing, that YOU (or another individual on YOUR behalf) notify the TPA of EMERGENCY or URGENT CARE OUT-OF-NETWORK HOSPITAL admissions or facility CONFINEMENTS by the next business day after admission or as soon

as reasonably possible. This will help to expedite claims payment. OUT-OF-AREA SERVICE means medical care received outside the defined SERVICE AREA.

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

xiv) Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the EMERGENCY room.

2) URGENT CARE

a) Medical care received in an URGENT CARE situation as defined in Section II. URGENT CARE is not EMERGENCY care. It does not include care that can be safely postponed until the PARTICIPANT can receive care from an IN-NETWORK PROVIDER.

b) YOU must receive URGENT CARE from an IN-NETWORK PROVIDER if YOU are in the SERVICE AREA, unless it is not reasonably possible. If YOU are out of the SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If YOU must go to an

OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU contact YOUR TPA by the next business day or as soon as possible and tell the TPA where YOU received URGENT CARE; this will expedite claims payment. URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA.

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

3) Surgical Services
Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include:

a) PREOPERATIVE and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

This does not include oral surgery procedures, which are covered as described under item 16 of this section.

PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the TPA for any PARTICIPANT who has not completed an optimal regimen of conservative care for low back pain (LBP). PRIOR AUTHORIZATION is not required for a PARTICIPANT who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PARTICIPANTS seeking surgical treatment of LBP must participate in a credible SHARED DECISION MAKING (SDM) program provided by the TPA or its contracted PROVIDERS consistent with the PRIOR AUTHORIZATION requirement.

4) Reproductive Services and Contraceptives
The following services do not require a REFERRAL to an IN-NETWORK PROVIDER who specializes in obstetrics and gynecology, however, the TPA may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

   i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit 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 TPA terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the TPA may request notification of the inpatient stay prior to the delivery or shortly thereafter.

5) Medical Services
MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an IN-NETWORK PROVIDER (or a PROVIDER that was PRIOR AUTHORIZED by YOUR TPA).

a) Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

b) Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

c) Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

d) Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e) MEDICALLY NECESSARY travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the PARTICIPANT by the TPA. It does not apply to travel required for work. (See Exclusions, Section IV, A, 2, e.)

f) Injectable and infusible medications, except for SELF-ADMINISTERED INJECTABLE medications.

g) NUTRITIONAL COUNSELING provided by a participating registered dietician or an IN-NETWORK PROVIDER.

h) A second opinion from an IN-NETWORK PROVIDER or when PRIOR AUTHORIZED by the TPA.

i) Preventive services as required by the federal Patient Protection and Affordable Care Act.

6) Anesthesia Services
Covered when provided in connection with other medical and surgical services covered under these Uniform Benefits. It will also include anesthesia services for dental care as provided under item B, 1, c of this section.

7) Radiation Therapy and Chemotherapy
Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an IN-NETWORK PROVIDER.

8) Detoxification Services
Covers MEDICALLY NECESSARY detoxification services provided by an IN-NETWORK PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an IN-NETWORK PROVIDER.

9) Ambulance Service
Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the TPA) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the TPA'S SERVICE AREA, the TPA or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or urgent transportation is obtained.

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if

correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PRIOR AUTHORIZATIONS are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11) Outpatient Rehabilitation, Physical, Speech and Occupation Therapy
MEDICALLY NECESSARY HABILITATION or REHABILITATION SERVICES and treatment as a result of ILLNESS or INJURY, provided by an IN-NETWORK PROVIDER. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be PRIOR AUTHORIZED by the TPA if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12) Home Care Benefits
Care and treatment of a PARTICIPANT under a plan of care. The IN-NETWORK PROVIDER must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)

d) MEDICAL SUPPLIES, drugs and medicines prescribed by an IN-NETWORK PROVIDER; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.

e) NUTRITIONAL COUNSELING. A registered dietician must give or supervise these services.

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

Home care will not be covered unless the attending physician certifies that:

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A PARTICIPANT may have been CONFINED IN A HOSPITAL just before home care started. If so, the home care plan must be approved, at its start, by the PROVIDER who was the primary PROVIDER of care during the HOSPITAL CONFINEMENT.

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the TPA if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the TPA. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the TPA.

Covers ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

Covers a one-time in-home palliative consult after the PARTICIPANT receives a terminal diagnosis regardless of whether his or her life expectancy is 6 months or less.

HOSPICE CARE is available to a PARTICIPANT who is CONFINED. Inpatient CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a TPA-approved or MEDICARE-certified HOSPICE CARE facility.

When benefits are payable under both this HOSPICE CARE benefit and the Home Care Benefits, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14) Phase II Cardiac Rehabilitation

Services must be approved by the TPA and provided in an outpatient department of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of:

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

15) Extraction of NATURAL TEETH and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/or total replacement (limited to, bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the TPA before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

16) Oral Surgery

PARTICIPANTS should contact the TPA prior to any oral surgery to determine if PRIOR AUTHORIZATION by the TPA is required. When performed by IN-NETWORK PROVIDERS, approved surgical procedures are as follows:

a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

e) Apicoectomy. (Excision of apex of tooth root.)

f) Excision of exostoses of the jaws and hard palate.

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

18) Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the TPA in order to be a covered transplant. Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

a) Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:

i) Aplastic anemia

ii) Acute leukemia

iii) Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the TPA.

h) In addition to the above-listed diagnoses for covered transplants, the TPA may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the TPA determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants 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 TPA.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The TPA may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the TPA.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

   c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
   EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up

care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA.

   a) Outpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "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 TPA within 72 hours after the initial provision of service.

   d) Other
   Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section 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 TPA.

(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 TPA:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the TPA, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the TPA.

k) Other medical equipment and supplies as approved by the TPA. Rental or purchase of equipment/supplies is at the option of the TPA.

l) When PRIOR AUTHORIZED as determined by the TPA, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the TPA will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the TPA. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the TPA. Additional visits may be approved by the TPA. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any TPA under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and

dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for 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 TPA.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The TPA, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED 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 TPA or a contracted PROVIDER administers the injection. If the TPA or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.

d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED 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 TPAs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 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 TPA and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   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 TPA.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, 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 TPA.

c) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

d) All separately billed donor-related services, except for kidney transplants.

e) Non-human organ transplants or artificial organs.

7) Reproductive Services

a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c) Services for storage or processing of semen (sperm); donor sperm.

d) Harvesting of eggs and their cryopreservation.

e) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the TPA.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the TPA.

c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the TPA.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the TPA. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED 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 TPA and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) 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 TPA and/or PBM, or services received after the TPA and/or PBM coverage or eligibility terminates. Except when

a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under TPAs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding TPA will be the responsibility of the succeeding TPA unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding TPA's network. In this instance, the liability will remain with the previous TPA.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the TPA and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

   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 TPA.

v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the TPA. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the TPA.

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 TPA 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 TPA. The treatment of the complication must be a covered benefit of the TPA and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any TPA as part of this program.

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 TPA to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the TPA's and/or PBM's Control: If, due to circumstances not reasonably within the control of the TPA and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the TPA and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the TPA, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other

benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section 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 TPA has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the TPA any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the TPA may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The TPA will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the TPA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1) The persons it has paid or for whom it has paid,

2) Insurance companies, or

3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the TPA and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the TPA and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the TPA, provide any relevant and reasonably available information which the TPA believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the TPA and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the TPA's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The TPA, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the TPA, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The TPA may employ a professional staff to provide case management services. As part of this case management, the TPA or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the TPA agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the TPA's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the TPA. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the TPA or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The TPA and/or PBM might pay more than the TPA and/or PBM owes under the policy. If so, the TPA and/or PBM can recover the excess from YOU. The TPA and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the TPA and/or PBM.

Each PARTICIPANT agrees to reimburse the TPA and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the TPA and/or PBM. At the option of the TPA and/or PBM, benefits for future CHARGES may be reduced by the TPA and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a TPA or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the TPA provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The TPA'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

1) The third party or any liability or other insurance covering the third party.

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the TPA or DEPARTMENT to such extent.

The TPA'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the TPA'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the TPA'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the TPA or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the TPA or DEPARTMENT such additional information as is reasonably requested by the TPA or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the TPA'S or DEPARTMENT'S rights against a third party. The TPA or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the TPA or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the TPA or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the TPA or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the TPA or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the TPA or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the TPA or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in

making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the TPA or DEPARTMENT for all amounts theretofore or thereafter paid by the TPA or DEPARTMENT which would have otherwise been recoverable under such acts and the TPA or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the TPA or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the TPA and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the TPA, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the TPA and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the TPA and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating TPAs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the TPA and/or PBM. Contact the TPA and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the TPA and/or PBM. The TPA and/or PBM will advise YOU of YOUR

right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the TPA and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the TPA and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the TPA's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the TPA and/or PBM breached its contract with the Group Insurance Board.

EXHIBIT 2

Standard Terms And Conditions (Request For Bids / Proposals)

1.0 SPECIFICATIONS: The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid/proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 DEVIATIONS AND EXCEPTIONS: Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 QUALITY: Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 QUANTITIES: The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 DELIVERY: Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 PRICING AND DISCOUNT: The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the contractor which are demonstrated to be industrywide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 UNFAIR SALES ACT: Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 ACCEPTANCE-REJECTION: The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 METHOD OF AWARD: Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 ORDERING: Purchase orders or releases via purchasing cards shall be placed directly to the contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements

are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW AND COMPLIANCE: This contract shall be governed under the laws of the State of Wisconsin. The contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel this contract if the contractor fails to follow the requirements of s. 77.66, Wis. Stats., and related statutes regarding certification for collection of sales and use tax. The State of Wisconsin also reserves the right to cancel this contract with any federally debarred contractor or a contractor that is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

16.0 ANTITRUST ASSIGNMENT: The contractor and the State of Wisconsin recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State of Wisconsin (purchaser). Therefore, the contractor hereby assigns to the State of Wisconsin any and all claims for such overcharges as to goods, materials or services purchased in connection with this contract.

17.0 ASSIGNMENT: No right or duty in whole or in part of the contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION / AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan by the contractor. An exemption occurs from this requirement if the contractor has a workforce of less than fifty (50) employees. Within fifteen (15) working days after the contract is awarded, the contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

19.2 The contractor agrees to post in conspicuous places, available for employees and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the contractor's becoming declared an "ineligible" contractor, termination of the contract, or withholding of payment.

20.0 PATENT INFRINGEMENT: The contractor selling to the State of Wisconsin the articles described herein guarantees the articles were manufactured or produced in accordance with applicable federal labor laws. Further, that the sale or use of the articles described herein will not infringe any United States patent. The contractor covenants that it will at its own expense defend every suit which shall be brought against the State of Wisconsin (provided that such contractor is promptly notified of such suit, and all papers therein are delivered to it) for any alleged infringement of any patent by reason of the sale or use of such articles, and agrees that it will pay all costs, damages, and profits recoverable in any such suit.

21.0 SAFETY REQUIREMENTS: All materials, equipment, and supplies provided to the State of Wisconsin must comply fully with all safety requirements as set forth by the Wisconsin Administrative Code and all applicable OSHA Standards.

22.0 WARRANTY: Unless otherwise specifically stated by the bidder/proposer, equipment purchased as a result of this request shall be warranted against defects by the bidder/proposer for one (1) year from date of receipt. The equipment manufacturer's standard warranty shall apply as a minimum and must be honored by the contractor.

23.0 INSURANCE RESPONSIBILITY: The contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employees engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin public records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot be copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin public records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employees and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

31.0 PROMOTIONAL ADVERTISING / NEWS RELEASES: Reference to or use of the State of Wisconsin, any of its departments, agencies or other subunits, or any state official or employee for commercial promotion is prohibited. News releases pertaining to this procurement shall not be made without prior approval of the State of Wisconsin. Release of broadcast e-mails pertaining to this procurement shall not be made without prior written authorization of the contracting agency.

32.0 HOLD HARMLESS: The contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the contractor, or of any of its contractors, in prosecuting work under this agreement.

33.0 FOREIGN CORPORATION: A foreign corporation (any corporation other than a Wisconsin corporation) which becomes a party to this Agreement is required to conform to all the requirements of Chapter 180, Wis. Stats., relating to a foreign corporation and must possess a certificate of authority from the Wisconsin Department of Financial Institutions, unless the corporation is transacting business in interstate commerce or is otherwise exempt from the requirement of obtaining a certificate of authority. Any foreign corporation which desires to apply for a certificate of authority should contact the Department of Financial Institutions, Division of Corporation, P. O. Box 7846, Madison, WI 53707-7846; telephone (608) 261-7577.

34.0 WORK CENTER PROGRAM: The successful bidder/proposer shall agree to implement processes that allow the State agencies, including the University of Wisconsin System, to satisfy the State's obligation to purchase goods and services produced by work centers certified under the State Use Law, s.16.752, Wis. Stat. This shall result in requiring the successful bidder/proposer to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses.

35.0 FORCE MAJEURE: Neither party shall be in default by reason of any failure in performance of this Agreement in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the party.

State of Wisconsin
Department of Administration
DOA-3681 (01/2001)
ss. 16, 19 and 51, Wis. Stats.

Division of Agency Services
Bureau of Procurement

EXHIBIT 3

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor; and

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential contractor shall certify in writing to the procuring agency that no relationship exists between the potential contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employee or who is retained as a contractor full-time by a State of Wisconsin agency from being retained as a contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.0831 Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

7.0 RECORDKEEPING AND RECORD RETENTION: The contractor shall establish and maintain adequate records of all expenditures incurred under the contract. All records must be kept in accordance with generally accepted accounting procedures. All procedures must be in accordance with federal, state and local ordinances.

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the contractor. The contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

8.0 INDEPENDENT CAPACITY OF CONTRACTOR: The parties hereto agree that the contractor, its officers, agents, and employees, in the performance of this agreement shall act in the capacity of an independent contractor and not as an officer, employee, or agent of the state. The contractor agrees to take such steps as may be necessary to ensure that each subcontractor of the contractor will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the state.

EXHIBIT 4

Department Terms and Conditions

1.0 ENTIRE AGREEMENT: This Contract, its exhibits, subsequent amendments and the documents incorporated by order of precedence contain the entire understanding between the parties on the subject matter hereof, and no representations, inducements, promises, or agreements, oral or otherwise, not embodied herein shall be of any force or effect. This Contract supersedes any other oral or written agreement entered into between the parties on the subject matter hereof.

This Contract may be amended at any time by written mutual agreement, but any such amendment shall be without prejudice to any claim arising prior to the date of the change. No one, except duly authorized officers or agents of the Contractor and the Department, shall alter or amend this Contract. No change in this Contract shall be valid unless evidenced by an amendment that is signed by such officers of the Contractor and the Department.

2.0 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW: In the event of a conflict between this Contract and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state.

The Contractor shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the Department upon request.

The Contractor acknowledges that Wis. Stat. § 40.07 specifically exempts information related to individuals in the records of the Department of Employee Trust Funds from the Wisconsin Public Records Law. Contractor shall treat any such records provided to or accessed by Contractor as non-public records as set forth in Wis. Stat. § 40.07.

Contractor will comply with the provisions of Wis. Stat. § 134.98**.**

3.0 LEGAL RELATIONS: The Contractor shall at all times comply with and observe all federal and State laws, local laws, ordinances, and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct. This includes but is not limited to laws regarding compensation, hours of work, conditions of employment and equal opportunities for employment.

In carrying out any provisions of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters that the Department acts as an agent of the State.

The Contractor accepts full liability and agrees to hold harmless the State, the Department's governing boards, the Department, its employees, agents and contractors for any act or omission of the Contractor, or any of its employees, in connection with this Contract.

No employee of the Contractor may represent himself or herself as an employee of the Department or the State.

4.0 CONTRACTOR: The Contractor will be the sole point of contact with regard to contractual matters, including the performance of Services and the payment of any and all charges resulting from contractual obligations.

None of the Services to be provided by the Contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without prior written notification to, and approval of, the Department.

After execution of the Contract, ETF will provide a designated contact person and commit to a timely approval process for notification of a change in subcontractor(s) and/or delegated services.

The Contractor shall be solely responsible for its actions and those of its agents, employees or subcontractors under this Contract. The Contractor will be responsible for Contract performance when subcontractors are used. Subcontractors must abide by all terms and conditions of this Contract.

Neither the Contractor nor any of the foregoing parties has the authority to act or speak on behalf of the State of Wisconsin.

The Contractor will be responsible for payment of any losses by subcontractors or agents.

Any notice required or permitted to be given shall be deemed to have been given on the date of delivery or three (3) Business Days after mailing by the United States Postal Service, certified or registered mail-receipt requested. In the event the Contractor moves or updates contact information, the Contractor shall inform the Department of such changes in writing within ten (10) Business Days. The Department shall not be held responsible for payments delayed due to the Contractor's failure to provide such notice.

5.0 **CONTRACTOR PERFORMANCE:** Work under this Contract shall be performed in a timely, professional and diligent matter by qualified and efficient personnel and in conformity with the strictest quality standards mandated or recommended by all generally-recognized organizations establishing quality standards for the work of the type to be performed hereunder. The Contractor shall be solely responsible for controlling the manner and means by which it and its employees or its subcontractors perform the Services, and the Contractor shall observe, abide by, and perform all of its obligations in accordance with all legal and Contract requirements.

Without limiting the foregoing, the Contractor shall control the manner and means of the Services so as to perform the work in a reasonably safe manner and comply fully with all applicable codes, regulations and requirements imposed or enforced by any government agencies. Notwithstanding the foregoing, any stricter standard provided in plans, specifications or other documents incorporated as part of this Contract shall govern.

The Contractor shall provide the Services with all due skill, care, and diligence, in accordance with accepted industry practices and legal requirements, and to the Department's satisfaction; the Department's decision in that regard shall be final and conclusive.

All Contractor's Services under this Contract shall be performed in material compliance with the applicable federal and state laws and regulations in effect at the time of performance, except when imposition of a newly enacted or revised law or regulation would result in an unconstitutional impairment of this Contract.

The Contractor will make commercially reasonable efforts to ensure that Contractor's professional and managerial staff maintain a working knowledge and understanding of all federal and state laws, regulations, and administrative code appropriate for the performance of their respective duties, as well as contemplated changes in such law which affect or may affect the Service under this Contract.

The Contractor shall maintain a written contingency plan describing in detail how it will continue operations and Services under the Contract in certain events including, but not limited to, strike and disaster, and shall submit it to the Department upon request.

6.0 **AUDIT PROVISION:** The Contractor and its authorized subcontractors are subject to audits by the State of Wisconsin, the Legislative Audit Bureau (LAB), an independent Certified Public Accountant (CPA), or other representatives as authorized by the State of Wisconsin. The Contractor will cooperate with such efforts and provide all requested information permitted under the law.

Authorized personnel shall have access to interview any Contractor's or subcontractor's employee or authorized agent involved with this Contract in conjunction with any audit, review, or investigation deemed necessary by the State of Wisconsin.

7.0 **CRIMINAL BACKGROUND VERIFICATION:** The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://oser.state.wi.us/docview.asp?docid=6658). The Contractor is expected to perform background checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

8.0 **COMPLIANCE WITH ON-SITE PARTY RULES AND REGULATIONS:** Contractor and the State of Wisconsin agree that their employees, while working at or visiting the premises of the other party, shall comply with all internal rules and regulations of the other party, including security procedures, and all applicable federal, state, and local laws and regulations applicable to the location where said employees are working or visiting.

The Department is responsible for allocating building and equipment access, as well as any other necessary Services available from the Department that may be used by the Contractor. Any use of the Department facilities, equipment, internet access, and/or services shall only be for project purposes as authorized by the Department. The Contractor will provide its own personal computers, which must comply with the Department security policies before connection

to the Department's local computer network.

9.0 SECURITY OF PREMISES, EQUIPMENT, DATA AND PERSONNEL: The State of Wisconsin shall have the right, acting by itself or through its authorized representatives, to enter the premises of the Contractor at mutually agreeable times to inspect and copy the records of the Contractor and the Contractor's compliance with this section. In the course of performing Services under this Contract, the Contractor may have access to the personnel, premises, equipment, and other property, including data files, information, or materials (collectively referred to as "data") belonging to the State.

The Contractor shall be responsible for damage to the State's equipment, workplace, and its contents, or for the loss of data, when such damage or loss is caused by the Contractor, contracted personnel, or subcontractors, and shall reimburse the State accordingly upon demand. This remedy shall be in addition to any other remedies available to the State by law or in equity.

10.0 BREACH NOT WAIVER: A failure to exercise any right, or a delay in exercising any right, power or remedy hereunder on the part of either party shall not operate as a waiver thereof. Any express waiver shall be in writing and shall not affect any event or default other than the event or default specified in such waiver. A waiver of any covenant, term or condition contained herein shall not be construed as a waiver of any subsequent breach of the same covenant, term or condition. The making of any payment to the Contractor under this Contract shall not constitute a waiver of default, evidence of proper Contractor performance, or acceptance of any defective item or Services furnished by the Contractor.

11.0 SEVERABILITY: The provisions of this Contract shall be deemed severable and the unenforceability of any one or more provisions shall not affect the enforceability of any of the other provisions. If any provision of this Contract, for any reason, is declared to be invalid, unenforceable, or illegal, the parties shall substitute an enforceable provision that, to the maximum extent possible in accordance with applicable law, preserves the original intentions and economic positions of the parties.

12.0 LIQUIDATED DAMAGES: The Contractor and Department acknowledge that it can be difficult to ascertain actual damages when a Contractor fails to carry out the responsibilities of this Contract. Because of that, the Contractor and Department will negotiate liquidated damages, as required by the State of Wisconsin, for this Contract. The Contractor agrees that the Department shall have the right to liquidate such damages, through deduction from the Contractor's invoices, in the amount equal to the damages incurred, or by direct billing to the Contractor.

The Department shall notify the Contractor in writing of any claim for liquidated damages pursuant to this section within thirty (30) Calendar Days after the Contractor's failure to perform in accordance with the terms and conditions of this Contract.

Notwithstanding the foregoing language, when necessary the Department will identify in the RFP specific financial penalties for failure of the Contractor to meet performance standards and guarantees that may be set forth in the RFP.

13.0 CONTRACT DISPUTE RESOLUTION: In the event of any dispute or disagreement between the parties under this Contract, whether with respect to the interpretation of any provision of this Contract, or with respect to the performance of either party hereto, except for breach of Contractor's intellectual property rights, each party shall appoint a representative to meet for the purpose of endeavoring to resolve such dispute or negotiate for and adjustment to such provision.

No legal action of any kind, except for the seeking of equitable relief in the case of the public's health, safety or welfare, may begin in regard to the dispute until this dispute resolution procedure has been elevated to the Contractor's highest executive authority and the equivalent executive authority within the Department, and either of the representatives in good faith concludes, after a good faith attempt to resolve the dispute, that amicable resolution through continued negotiation of the matter at issue does not appear likely.

The party believing itself aggrieved (the "Invoking Party") shall call for progressive management involvement in the dispute negotiation by delivering written notice to the other party. Such notice shall be without prejudice to the Invoking Party's right to any other remedy permitted by this Contract. After such notice, the parties shall use all reasonable efforts to arrange personal meetings and/or telephone conferences as needed, at mutually convenient times and places, between authorized negotiators for the parties at the following successive management levels, each of which shall have a period of allotted time as specified below which to attempt to resolve the dispute:

Level	Contractor	The Department	Allotted Time
First Second	Level 1 entity	Deputy Office Director Office	10 Business Days
	Level 2 entity	Director	20 Business Days
Third	Level 3 entity	Secretary	30 Business Days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is days from the date that the Invoking Party's notice was originally received by the other party. If the Third Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's

original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the section below. The time periods herein are in addition to those periods for a party to cure provided elsewhere in this Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

14.0 **CONTROLLING LAW:** All questions as to the execution, validity, interpretation, construction and performance of this Contract shall be construed in accordance with the laws of the State of Wisconsin, without regard to any conflicts of laws or choice of law principles. Any court proceeding arising or related to this Contract or a party's obligations hereunder shall be exclusively brought and exclusively maintained in the State of Wisconsin, Dane County Circuit Court, or in the District Court of the United States Western District (if jurisdiction is proper in federal court), or upon appeal to the appellate courts of corresponding jurisdiction, and Contractor hereby consents to the exclusive jurisdiction and exclusive venue therein and waives any right to object to such jurisdiction or venue. To the extent that in any jurisdiction Contractor may now or hereafter be entitled to claim for itself or its assets immunity from suit, execution, attachment (before or after judgment) or other legal process, Contractor, to the extent it may effectively do so, irrevocably agrees not to claim, and it hereby waives, the same.

15.0 **RIGHT TO SUSPEND OPERATIONS:** If, at any time during the period of this Contract, the Department determines that the best interest of the Department or its governing boards would be best served by the Contractor's temporarily holding of all Services, the Department will promptly notify the Contractor. Upon receipt of such notice, the Contractor shall suspend all Services.

16.0 **TERMINATION OF THIS CONTRACT:** The Department may terminate this Contract at any time at its sole discretion by delivering one-hundred eighty (180) Calendar Days written notice to the Contractor.

Upon termination, the Department's liability shall be limited to the prorated cost of the Services performed as of the date of termination plus expenses incurred with the prior written approval of the Department.

If the Contractor terminates this Contract, it shall refund all payments made hereunder by the Department to the Contractor for work not completed or not accepted by the Department. Such termination shall require written notice to that effect to be delivered by the Contractor to the Department not less than one-hundred eighty (180) Calendar Days prior to said termination.

Upon any termination of this Contract, the Contractor shall perform the Services specified in a transition plan if so requested by the Department; provided, however, that except as expressly set forth otherwise herein, the Contractor shall not be obligated to perform such Services unless all amounts due to the Contractor under this Contract, including payment for the transition Services, have been paid. Failure of the Contractor to comply with a transition plan upon request and upon payment shall constitute a separate breach for which the Contractor shall be liable.

Upon the expiration or termination for any reason, each party shall be released from all obligations to the other arising after the expiration date or termination date, except for those that by their terms survive such termination or expiration.

17.0 **TERMINATION FOR CAUSE:** If the Contractor fails to perform any material requirement of this Contract, breaches any material requirement of this Contract, or if the Contractor's full and satisfactory performance of this Contract is substantially endangered, the Department may terminate this Contract. Before terminating this Contract, the Department shall give written notice of its intent to terminate to Contractor after a thirty (30) Day written notice and cure period.

The State of Wisconsin reserves the right to cancel this Contract in whole or in part without penalty in one (1) or more of the following occurrences:

- **(a)** If the Contractor intentionally furnished any statement, representation, warranty, or certification in connection with its Proposal which is materially false, incorrect, or incomplete;
- **(b)** If applicable, fails to follow the sales and use tax certification requirements of Wis. Stat. § 77.66;
- **(c)** Incurs a delinquent Wisconsin tax liability;
- **(d)** Fails to submit a non-discrimination or affirmative action plan per the requirements of Wis. Stat. § 16.765 and Wisconsin's Fair Employment Law, subch. II, Chapter 111 of the Wisconsin Statutes as required herein;
- **(e)** Is presently identified on the list of parties excluded from State of Wisconsin procurement and non-procurement Contracts;
- **(f)** Becomes a state or federal debarred Contractor, or becomes excluded from state Contracts, or;
- **(g)** Fails to maintain and keep in force all required insurance, permits and licenses as required per this Contract;
- **(h)** Fails to maintain the confidentiality of the State of Wisconsin's information that is considered to be Confidential Information or Protected Health Information;
- **(i)** Files a petition in bankruptcy, become insolvent, or otherwise takes action to dissolve as a legal entity; or,
- **(j)** If at any time the Contractor's performance threatens the health or safety of a State of Wisconsin employee, citizen, or customer.
- **(k)** Violation of any requirements in Section 22 regarding Confidential Information.

In the event of a termination for cause by the State of Wisconsin, the State of Wisconsin shall be liable for payments for

any work accepted by the State of Wisconsin prior to the date of termination.

18.0 **REMEDIES OF THE STATE:** The State of Wisconsin shall be free to invoke any and all remedies permitted under Wisconsin law. In particular, if the Contractor fails to perform as specified in this Contract, the State of Wisconsin may issue a written notice of default providing for at least a seven (7) Business Day period in which the Contractor shall have an opportunity to cure, provided that cure is possible, feasible, and approved in writing by the State of Wisconsin. Time allowed for cure of a default shall not diminish or eliminate the Contractor's liability. If the default remains, after opportunity to cure, then the State of Wisconsin may: (1) exercise any remedy provided in law or in equity or (2) terminate Contractor's Services.

If the Contractor fails to remedy any delay or other problem in its performance of this Contract after receiving reasonable notice from the State of Wisconsin to do so, the Contractor shall reimburse the State of Wisconsin for all reasonable costs incurred as a direct consequence of the Contractor's delay, action, or inaction.

In case of failure to deliver Services in accordance with or Services from other sources as necessary, Contractor shall be responsible for the additional cost, including purchase price and administrative fees. This remedy shall be in addition to any other legal remedies available to the State of Wisconsin.

19.0 **TRANSITIONAL SERVICES:** Upon cancellation, termination, or expiration of this Contract for any reason, the Contractor shall provide reasonable cooperation, assistance and Services, and shall assist the State of Wisconsin to facilitate the orderly transition of the work hereunder to the State of Wisconsin and or to an alternative Contractor selected for the transition upon written notice to the Contractor at least thirty (30) business days prior to termination or cancellation, and subject to the terms and conditions set forth herein.

20.0 **ADDITIONAL INSURANCE RESPONSIBILITY:** The Contractor shall exercise due diligence in providing Services under this Contract. In order to protect the Board's governing the Department and any Department employee against liability, cost, or expenses (including reasonable attorney fees) which may be incurred or sustained as a result of Contractors errors or other failure to comply with the terms of this Contract, the selected Contractor shall maintain errors and omissions insurance including coverage for network and privacy risks, breach of privacy and wrongful disclosure of information in an amount acceptable to the Department with a minimum of **$1,000,000** and **$5,000,000** aggregate per claim in force during this Contract period and for a period of three (3) years thereafter for Services completed. Contractor shall furnish the Department with a certificate of insurance for such amount. Further, this certificate shall designate the State of Wisconsin Employee Trust Funds and its affiliated boards as additional insured parties. The Department reserves the right to require higher or lower limits where warranted.

21.0 **OWNERSHIP OF MATERIALS:** Except as otherwise provided in subsection (t) of Section 22, all information, data, reports and other materials as are existing and available from the Department and which the Department determines to be necessary to carry out the scope of Services under this Contract shall be furnished to the Contractor and shall be returned to the Department upon completion of this Contract. The Contractor shall not use it for any purpose other than carrying out the work described in this Contract.

The Department will be furnished without additional charge all data, models, information, reports, and other materials associated with and generated under this Contract by the Contractor.

The Department shall solely own all customized software, documents, and other materials developed under this Contract. Use of such software, documents, and materials by the Contractor shall only be with the prior written approval of the Department.

This Contract shall in no way affect or limit the Department's rights to use, disclose or duplicate, for any purpose whatsoever, all information and data pertaining to the Department or covered individuals and generated by the claims administration and other Services provided by Contractor under this Contract.

All files (paper or electronic) containing any Wisconsin claimant or employee information and all records created and maintained in the course of the work specified by this Contract are the sole and exclusive property of the Department. Contractor may maintain copies of such files during the term of this Contract as may be necessary or appropriate for its performance of this Contract. Moreover, Contractor may maintain copies of such files after the term of this Contract (i) for one hundred twenty (120) days after termination, after which all such files shall be transferred to the Department or destroyed by Contractor, except for any files as to which a claim has been made, and (ii) for an unlimited period of time after termination for Contractor's use for statistical purposes, if Contractor first deletes all information in the records from which the identity of a claimant or employee could be determined and certifies to the Department that all personal identifiers have been removed from the retained files.

22.0 **CONFIDENTIAL INFORMATION AND HIPAA BUSINESS ASSOCIATE AGREEMENT:** This Section is intended to cover handling of Confidential Information under state and federal law, and specifically to comply with the requirements of HIPAA, HITECH, and the Genetic Information Nondiscrimination Act (GINA) and the federal implementing regulations for those statutes requiring a written agreement with business associates.

(a) DEFINITIONS: As used in this Section, unless the context otherwise requires:

(1) Business Associate. "Business Associate" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Contractor (insert name of Contractor).

(2) Confidential Information has the meaning ascribed to it in Section 1.5 of the RFP.

(3) Covered Entity. "Covered Entity" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Department of Employee Trust Funds.

(4) HIPAA Rules. "HIPAA Rules" mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(5) Individual Personal Information "Individual Personal Information" has the meaning ascribed to it at Wis. Admin. Code ETF § 10.70 (1).

(6) Medical Record. "Medical Record" has the meaning ascribed to it at Wis. Admin. Code ETF 10.01 (3m).

(b) PROVISION OF CONFIDENTIAL INFORMATION FOR CONTRACTED SERVICES: ETF, a different business associate of ETF or a contractor performing Services for ETF may provide Confidential Information to the Contractor under this Contract as the Department determines is necessary for the proper administration of this Contract, as provided by Wis. Stat. § 40.07 (1m) (d) and (3).

(c) DUTY TO SAFEGUARD CONFIDENTIAL INFORMATION: The Contractor shall safeguard Confidential Information supplied to the Contractor or its employees under this Contract. In addition, the Contractor will only share Confidential Information with its employees on a need-to-know basis. Should the Contractor fail to properly protect Confidential Information, any cost the Department pays to mitigate the failure will be subtracted from the Contractor's invoice(s).

(d) USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor shall:

(1) Not use or disclose Confidential Information for any purpose other than as permitted or required by this Contract or as required by law. Contractor shall not use or disclose member names, addresses, or other data for any purpose other than specifically provided for in this Contract;

(2) Make uses and disclosures and requests for any Confidential Information following the minimum necessary standard in the HIPAA Rules;

(3) Use appropriate safeguards to prevent use or disclosure of Confidential Information other than as provided for by this Contract, and with respect to Protected Health Information, comply with Subpart C of 45 CFR Part 164;

(4) Not use or disclose Confidential Information in a manner that would violate Subpart E of 45 CFR Part 164 or Wis. Stat. § 40.07 if done by ETF; and

(5) If applicable, be allowed to use or disclose Confidential Information for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided the disclosures are required by law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been or is suspected of being breached.

(e) COMPLIANCE WITH ELECTRONIC TRANSACTIONS AND CODE SET STANDARDS: The Contractor shall comply with each applicable requirements of 45 C.F.R. Part 162 if the Contractor conducts standard transactions, as that term is defined in HIPAA, for or on behalf of ETF.

(f) MANDATORY REPORTING: Contractor shall report to ETF in the manner set forth in Subsection (l) any use or disclosure or suspected use or disclosure of Confidential Information not provided for by this Contract, of which it becomes aware, including breaches or suspected breaches of unsecured Protected Health Information as required at 45 CFR 164.410.

(g) DESIGNATED RECORD SET: Contractor shall make available Protected Health Information in a designated record set to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.524.

(h) AMENDMENT IN DESIGNATED RECORD SET: Contractor shall make any amendment to Protected Health Information in a designated record set as directed or agreed to by ETF pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy ETF's obligations under 45 CFR 164.526.

(i) ACCOUNTING OF DISCLOSURES: Contractor shall maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.528.

(j) COMPLIANCE WITH SUBPART E OF 45 CFR 164: To the extent Contractor is to carry out one or more of ETF's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to a covered entity in the performance of such obligation; and

(k) INTERNAL PRACTICES: Contractor shall make its internal practices, books, and records available to the Secretary of the United States Department of Labor for purposes of determining compliance with the HIPAA Rules.

(l) CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** A list of any affected members (if available);
- **b.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **c.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **d.** The date of the discovery by Contractor;
- **e.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **f.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than one (1) business day before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

(m) CLASSIFICATION LABELS: Contractor shall ensure that all data classification labels contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed by the Department.

(n) SUBCONTRACTORS: If applicable, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit Confidential Information on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information.

(o) NOTICE OF LEGAL PROCEEDINGS: If Contractor or any of its employees, agents, or subcontractors is legally required in any administrative, regulatory or judicial proceeding to disclose any Confidential Information, contractor shall give the Department prompt notice (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

(p) MITIGATION: The Contractor shall take immediate steps to mitigate any harmful effects of the suspected or actual unauthorized use, disclosure, or loss of any Confidential Information provided to Contractor under this Contract. The Contractor shall reasonably cooperate with the Department's efforts to comply with the breach notification requirements of HIPAA, to seek appropriate injunctive relief or otherwise prevent or curtail such suspected or actual unauthorized use, disclosure or loss, or to recover its Confidential Information, including complying with a

reasonable corrective action plan, as directed by the Department.

(q) COMPLIANCE REVIEWS: The Department may conduct a compliance review of the Contractor's security procedures before and during this Contract term to protect Confidential Information.

(r) AMENDMENT: The Parties agree to take such action as is necessary to amend the Contract as necessary for compliance with the HIPAA Rules and other applicable law.

(s) SURVIVAL: The obligations of Contractor under this Section survive the termination of the underlying Contract.

(t) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION: Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

1. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to ETF or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;
4. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;
5. Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and
6. If required by ETF, transmit the Confidential Information to another contractor of ETF.

23.0 INDEMNIFICATION:

23.1 SCOPE OF INDEMNIFICATION FOR INTELLECTUAL PROPERTY RIGHTS INFRINGEMENT: In the event of a claim against the Parties for Intellectual Property Rights Infringement associated with a claim for benefits, Contractor agrees to defend, indemnify and hold harmless Board and Department ("Indemnified Parties") from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Board, Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section.

23.2 SCOPE OF OTHER INDEMNIFICATION: In addition to the foregoing Section, Contractor shall defend, indemnify and hold harmless the Indemnified Parties from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section, or liability arising from or in connection with the following: (a) Contractor's performance of or failure to perform any duties or obligations under any agreement between Contractor and any third party; (b) injury to persons (including death or illness) or damage to property caused by the act or omission of Contractor or Contractor Personnel; (c) any claims or losses for Services rendered by any subcontractor, person, or firm performing or supplying Services, materials, or supplies in connection with the Contractor's performance of this Contract; (d) any claims or losses resulting to any person or third party entity injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under this Contract in a manner not authorized by this Contract, or by Federal or State statutes or regulations; and (e) any failure of the Contractor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

23.3 INDEMNIFICATION NOTICE: Department shall give Contractor prompt written notice of such claim, suit, demand, or action (provided that a failure to give such prompt notice will not relieve Contractor of its indemnification obligations hereunder except to the extent Contractor can demonstrate actual, material prejudice to its ability to mount a defense as a result of such failure). Department will cooperate, assist, and consult with Contractor in the defense or investigation of any claim made or suit filed against Department resulting from Contractor's performance under the Contract.

23.4 NO INDEMNIFICATION OBLIGATIONS: Contractor shall as soon as practicable, notify Department of any claim made or suit filed against Contractor resulting from Contractor's obligations under this Contract if such claim may involve the Department. Department has no obligation to provide legal counsel or defense to Contractor if a suit, claim, or action is brought against Contractor or its subcontractors as a result of Contractor's performance of its obligations under this Contract. In addition, Department has no obligation for the payment of any judgments or the settlement of any claims against Contractor arising from or related to this Contract. Department has not waived any right or entitlement to claim sovereign immunity under this Contract.

23.5 CONTRACTOR'S DUTY TO INDEMNIFY: Contractor shall comply with its obligations to indemnify, defend and hold the Indemnified Parties harmless with regard to claims, damages, losses and/or expenses arising from a claim for benefits under the Plan as provided herein. Contractor shall be entitled to control the defense of any such claim and to defend or settle any such claim, in its sole discretion, with counsel of its own choosing; however, Contractor shall consult with Department regarding its defense of any claim and not settle or compromise any claim or action in a manner that imposes restrictions or obligations on Department, requires any financial payment by Department, or grants rights or concessions to a third party without first obtaining Department's prior written consent. Contractor shall have the right to assert any and all defenses on behalf of the Indemnified parties, including sovereign immunity.

In carrying out any provision of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters the Department acts as an agent of the State.

The Contractor shall at all times comply with and observe all federal and state laws and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct.

24.0 EQUITABLE RELIEF: The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury shall not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Contract or under applicable law.

25.0 RIGHT TO PUBLISH OR DISCLOSE: Throughout the term of this Contract, the Contractor must secure the Department's written approval prior to the release of any information which pertains to work or activities covered by this Contract.

The parties agree that it is a breach of this Contract to disclose any information to any person that the Department or its governing boards may not disclose under Wis. Stat. § 40.07. Contractor acknowledges that it will be liable for damage or injury to persons whose Confidential Information is disclosed by any officer, employee, agent, or subcontractor of the Contractor without proper authorization.

26.0 TIME IS OF THE ESSENCE: Timely provision of the Services required under this Contract shall be of the essence of the Contract, including the provisions of the Services within the time agreed or on a date specified herein.

27.0 IDENTIFICATION OF KEY PERSONNEL AND PERSONNEL CHANGES: The Department will designate a contract administrator, who shall have oversight for performance of the Department's obligations under this Contract. The Department shall not change the person designated without prior written notification to the Contractor.

The State of Wisconsin reserves the right to approve all individuals assigned to this project. The Contractor agrees to use its best effort to minimize personnel changes during the Contract term.

At the time of contract negotiations, the Contractor shall furnish the Department with names of all key personnel assigned to perform work under this Contract and furnish the Department with criminal background checks.

The Contractor will designate a contract administrator who shall have executive and administrative oversight for performance of the Contractor's obligations under this Contract. The Contractor shall not change this designation without prior written notice to the Department.

The Contractor may not divert key personnel for any period of time except in accordance with the procedure identified in this section. The Contractor shall provide a notice of proposed diversion or replacement to the single person of contact (SPOC) at least sixty (60) days in advance, together with the name and qualifications of the person(s) who will take the place of the diverted or replaced staff. At least thirty (30) days before the proposed diversion or replacement, the Department shall notify the SPOC whether the proposed diversion or replacement is approved or rejected, and if rejected shall provide reasons for the rejection. Such approval by the Department shall not be unreasonably withheld or delayed.

Replacement staff shall be on-site within two (2) weeks of the departure date of the person being replaced. The Contractor shall provide the Department with reasonable access to any staff diverted by the Contractor.

Replacement of key personnel shall be with persons of equal ability and qualifications. The Department has the right to conduct separate interviews of proposed replacements for key personnel. The Department shall have the right to approve, in writing, the replacement of key personnel. Such approval shall not be unreasonably withheld. Failure of the Contractor to promptly replace key personnel within thirty (30) Calendar Days after departure shall entitle the Department to terminate this Contract. The notice and justification must include identification of proposed substitute key personnel and must provide sufficient detail to permit evaluation of the impact of the change on the project and/or maintenance.

Any of the Contractor's staff that the Department deems unacceptable shall be promptly and without delay removed by the Contractor from the project and replaced by the Contractor within thirty (30) Calendar Days by another employee with acceptable experience and skills subject to the prior approval of the Department. Such approval by the Department will not be unreasonably withheld or delayed.

An unauthorized change by the Contractor of any Contracted Personnel designed as key personnel will result in the imposition of liquidated damages, as defined in this Contract.

28.0 DATA SECURITY AND PRIVACY AGREEMENT

(a) PURPOSE AND SCOPE OF APPLICATION: This Data Security and Privacy Agreement (Agreement) is designed to protect the Department of Employee Trust Fund's (ETF) Confidential Information and ETF Information Resources (defined below). This Agreement describes the data security and privacy obligations of Contractor and its sub-contractors that connect to ETF Information Resources and/or gain access to Confidential Information.

(b) DEFINED TERMS:

(1) **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) Individual Personal 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); or (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 by Contractor on FORM D –Designation of Confidential and Proprietary Information (DOA-3027). Pricing information cannot be held confidential.

(2) **ETF Information Resources** means those devices, networks and related infrastructure that ETF has obtained for use to conduct ETF business. Devices include but are not limited to, ETF-owned, managed, used through service agreements storage, processing, communications devices and related infrastructure on which ETF data is accessed, processed, stored, or communicated, and may include personally owned devices. Data includes, but is not limited to, Confidential Information, other ETF created or managed business and research data, metadata, and credentials created by or issued on behalf of ETF.

(c) ACCESS TO ETF INFORMATION RESOURCES: In any circumstance when Contractor is provided access to ETF Information Resources, it is solely Contractor's responsibility to ensure that its access does not result in any access by unauthorized individuals to ETF Information Resources. Contractors who access ETF's systems from any ETF location must at a minimum conform with ETF security standards that are in effect at the ETF location(s) where the access is provided. Any Contractor technology and/or systems that gain access to ETF Information Resources must comply with, at a minimum, the elements in the Computer System Security Requirements set forth in this Agreement.

(d) COMPLIANCE WITH APPLICABLE LAWS: Contractor agrees to comply with all applicable state and federal laws, as well as industry best practices, governing the collection, access, use, disclosure, safeguarding and destruction of Confidential Information.

(e) PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor agrees to hold ETF's Confidential Information, and any information derived from such information, in strictest confidence. Contractor will not access, use or disclose Confidential Information other than to carry out the purposes for which ETF disclosed the Confidential Information to Contractor, except as permitted or required by applicable law, or as otherwise authorized in writing by ETF. For avoidance of doubt, this provision prohibits Contractor from using for its own benefit Confidential Information or any information derived from such information. If required by a court of competent jurisdiction or an administrative body to disclose Confidential Information, Contractor will notify ETF in writing immediately upon receiving notice of such requirement and prior to any such disclosure, to give ETF an opportunity to oppose or otherwise respond to such disclosure (unless prohibited by law from doing so).

(f) REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES: The Contractor's transmission, transportation or storage of Confidential Information outside the United States, or access of Confidential Information from outside the United States, is prohibited except on prior written authorization by ETF.

(g) SAFEGUARD STANDARD: Contractor agrees to protect the privacy and security of Confidential Information according to all applicable laws and regulations, including HIPAA, by commercially-acceptable frameworks or standards such as the ISO/IEC 27000-series, NIST, 800-53, RFC 2196, IEC 62443, and SANS CIS Top 20. ISO 270001, etc. Security Controls, and no less rigorously than it protects its own confidential information, but in no case less than reasonable care. Contractor will implement, maintain and use appropriate administrative, technical and physical security measures to preserve the confidentiality, integrity and availability of the Confidential Information. All Confidential Information stored on portable devices or media must be encrypted in accordance with the Federal Information Processing Standards (FIPS) Publication 140-2. Contractor will ensure that all security measures are regularly reviewed including ongoing monitoring, an annual penetration and vulnerability test, and an annual security incident response test, and revised, no less than annually, to address evolving threats and vulnerabilities while Contractor has responsibility for the Confidential Information under the terms of this Agreement. Prior to agreeing to the terms of this Agreement, and periodically thereafter (no more frequently than annually) at ETF's request, Contractor will provide assurance, in the form of a third-party audit report or other documentation acceptable to ETF, such as SOC2 Type II, demonstrating that appropriate information security safeguards and controls are in place.

(h) INFORMATION SECURITY PLAN:

(1) Contractor acknowledges that ETF is required to comply with information security standards for the protection of Confidential Information as required by law, regulation and regulatory guidance, as well as ETF's internal security program for information and systems protection.

(2) Contractor will establish, maintain and comply with an information security plan (Information Security Plan), which will contain, at a minimum, such elements as those set forth in this Agreement.

(3) Contractor's Information Security Plan will be designed to:

- **a.** Ensure the privacy, security, integrity, availability, and confidentiality of Confidential Information;
- **b.** Protect against any anticipated threats or hazards to the security or integrity of such information;
- **c.** Protect against unauthorized access to or use of such information that could result in harm or inconvenience to the person that is the subject of such information;
- **d.** Reduce risks associated with Contractor having access to ETF Information Resources; and
- **e.** Comply with all applicable legal and regulatory requirements for data protection.

(4) On at least an annual basis, Contractor will review its Information Security Plan, update and revise it as needed, and submit it to ETF upon request. At ETF's request, Contractor will make modifications to its Information Security Plan or to the procedures and practices thereunder to conform to ETF's security requirements as they exist from time to time. If there are any significant

modifications to Contractor's Information Security Plan, Contractor will notify ETF within a reasonable period of time, not to exceed two weeks. Any significant modification must include the same or a higher framework or information security standard maturity level than what currently exists in the Plan.

(i) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION:

Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

(1) Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

(2) Where feasible, return to ETF, or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;

(3) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;

(4) Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;

(5) Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and

(6) If required by ETF, transmit the Confidential Information to another contractor of ETF.

(j) NOTIFICATION OF CORRESPONDENCE CONCERNING CONFIDENTIAL INFORMATION: Contractor agrees to notify ETF immediately, both orally and in writing, but in no event more than twenty-four (24) hours after Contractor receives correspondence or a complaint regarding Confidential Information, including but not limited to, correspondence or a complaint that originates from a regulatory agency or an individual.

(k) BREACHES OF CONFIDENTIAL INFORMATION:

CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure of ETF's Confidential Information, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** The nature of the unauthorized access, use or disclosure;
- **b.** A list of any affected members (if available);
- **c.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **d.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **e.** The date of the discovery by Contractor;
- **f.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **g.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than twenty-four (24) hours before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons

potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

COORDINATION OF BREACH RESPONSE ACTIVITIES:

(4) Contractor will fully cooperate with ETF's investigation of any breach involving Contractor, including but not limited to making witnesses, documents, HIPAA logs, systems logs, video recordings, or other pertinent or useful information available immediately upon Contractor's reporting of the breach and throughout the investigation. Contractor's full cooperation will include but not be limited to Contractor:

- **a.** Immediately preserving any potential forensic evidence relating to the breach, and remedying the breach as quickly as circumstances permit
- **b.** Within forty-eight (48) hours designating a contact person to whom ETF will direct inquiries, and who will communicate Contractor responses to ETF inquiries; Contractor will designate a Privacy Officer and Security Officer to serve as contacts for ETF.
- **c.** As rapidly as circumstances permit, applying appropriate resources to remedy the breach condition, investigate, document, restore ETF service(s) as directed by ETF, and undertake appropriate response activities such as working with ETF, its representative, and law enforcement to identify the breach, identify the perpetrator(s), and take appropriate actions to remediate the security vulnerability;
- **d.** Providing status reports at least every two (2) hours until the root cause of the breach is identified and a plan is devised to fully remediate the breach;
- **e.** Once the root cause of the breach is identified and a plan is devised to fully remediate the breach, providing status reports daily or at mutually agreed upon timeframes, to ETF on breach response activities, findings, analyses, and conclusions;
- **f.** Coordinating all media, law enforcement, or other breach notifications with ETF in advance of such notification(s), unless expressly prohibited by law; and
- **g.** Ensuring that knowledgeable Contractor staff is available on short notice, if needed, to participate in ETF-initiated meetings and/or conference calls regarding the breach.

ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS:

(5) Contractor will make itself and any employees, subcontractors, or agents assisting Contractor in the performance of its obligations available to ETF at no cost to ETF to testify as witnesses, or otherwise, in the event of a breach or other unauthorized disclosure of Confidential Information caused by Contractor that results in litigation, governmental investigations, or administrative proceedings against ETF, its directors, officers, agents or employees based upon a claimed violation of laws relating to security and privacy or arising out of this Agreement or the Contract.

(l) RETENTION OF LOGS:

(1) HIPAA logs (logs of any systems that have information relating to HIPAA) must be kept for six (6) years.

(2) Firewall logs must be kept for twelve (12) months.

(m) ADDITIONAL INSURANCE: In addition to the insurance required under the Agreement, Contractor at its sole cost and expense will obtain, keep in force, and maintain an insurance policy (or policies) that provides coverage for privacy and data security breaches. This specific type of insurance is typically referred to as Privacy, Technology and Data Security Liability, Cyber Liability, or Technology Professional Liability. In some cases, Professional Liability policies may include some coverage for privacy and/or data breaches. Regardless of the type of policy in place, it needs to include coverage for reasonable costs in investigating and responding to privacy and/or data breaches with the following minimum limits unless ETF specifies otherwise: $1,000,000 Each Occurrence and $5,000,000 Aggregate.

(n) INFORMATION SECURITY PLAN REQUIREMENTS:

(1) Contractor will develop, implement, and maintain a comprehensive Information Security Plan that is written in one or more readily accessible parts and contains administrative, technical, and physical safeguards. The safeguards contained in such program must be consistent with the safeguards for protection of Confidential Information and information of a similar character set forth in any state or federal regulations by which the person who owns or licenses such information may be regulated.

(2) Without limiting the generality of the foregoing, every comprehensive Information Security Plan will include, but not be limited to:

a. Designating one or more employees to maintain the comprehensive Information Security Plan;

b. Identifying and assessing internal and external risks to the security, confidentiality, and/or integrity of any electronic, paper or other records containing Confidential Information and of ETF Information Resources, and evaluating and improving, where necessary, the effectiveness of the current safeguards for limiting such risks, including but not limited to:

c. Ongoing employee (including temporary and contract employee) training;

d. Employee compliance with policies and procedures; and

e. Means, including Contractor staff, processes, and technology, for detecting information system intrusions, data breaches, and anomalous system behavior or activity, and for preventing security breaches, intrusions, or unauthorized access to information systems or networks.

f. Developing security policies for employees relating to the storage, access and transportation of records containing Confidential Information outside of business premises.

g. Imposing disciplinary measures for violations of the comprehensive Information Security Plan rules.

h. Preventing terminated employees from accessing records containing Confidential Information and/or ETF Information Resources.

i. Overseeing service providers, by:

--Taking reasonable steps to select and retain third-party service providers that are capable of maintaining appropriate security measures to protect such Confidential Information and ETF Information Resources consistent with all applicable laws and regulations; and

-- Requiring such third-party service providers by contract to implement and maintain such appropriate security measures for Confidential Information.

j. Placing reasonable restrictions upon physical access to records containing Confidential Information and ETF Information Resources and requiring storage of such records and data in locked facilities, storage areas or containers.

k. Restrict physical access to any network or data centers that may have access to Confidential Information or ETF Information Resources.

l. Requiring regular monitoring to ensure that the comprehensive Information Security Plan is operating in a manner reasonably calculated to prevent unauthorized access to or

unauthorized use of Confidential Information and ETF Information Resources; and upgrading information safeguards as necessary to limit risks.

m. Reviewing the scope of the security measures at least annually or whenever there is a material change in business practices that may reasonably implicate the security or integrity of records containing Confidential Information and of ETF Information Resources.

n. Documenting responsive actions taken in connection with any incident involving a breach, and mandating post-incident review of events and actions taken, if any, to make changes in business practices relating to protection of Confidential Information and ETF Information Resources.

(o) COMPUTER SYSTEM SECURITY REQUIREMENTS: To the extent that Contractor electronically stores or transmits Confidential Information or has access to any ETF Information Resources, it will include in its written, comprehensive Information Security Plan the establishment and maintenance of a security system covering its computers, including any wireless system, that, at a minimum, and to the extent technically feasible, will have the following elements:

(1) Secure user authentication protocols including:

a. Control of user IDs and other identifiers;
b. A secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;
c. Multi-Factor Authentication (MFA);
c. Control of data security passwords to ensure that such passwords are kept in a location and/or format that does not compromise the security of the data they protect;
d. Multi-factor authentication for system administrators and others with 'super-user' access rights;
e. Restricting access to active users and active user accounts only;
f. Blocking access to user identification after multiple unsuccessful attempts to gain access or the limitation placed on access for the particular system; and
g. Periodic review of user access, access rights and audit of user accounts.

(2) Secure access control measures that:

a. Restrict access to records and files containing Confidential Information and systems that may have access to ETF Information Resources to those who need such information to perform their job duties; and
b. Assign unique identifications plus passwords, which are not vendor supplied default passwords, to each person with computer access, which are reasonably designed to maintain the integrity of the security of the access controls.

(3) Encryption of all transmitted records and files containing Confidential Information.

(4) Adequate security of all networks that connect to ETF Information Resources or access Confidential Information, including wireless networks.

(5) Reasonable monitoring of systems, for unauthorized use of or access to Confidential Information and ETF Information Resources.

(6) Encryption of all Confidential Information stored on Contractor devices, including laptops or other portable storage devices.

(7) For files containing Confidential Information on a system that is connected to the Internet or that may have access to ETF Information Resources, reasonably up-to-date firewall, router and switch protection and operating system security patches, reasonably designed to maintain the integrity of the Confidential Information.

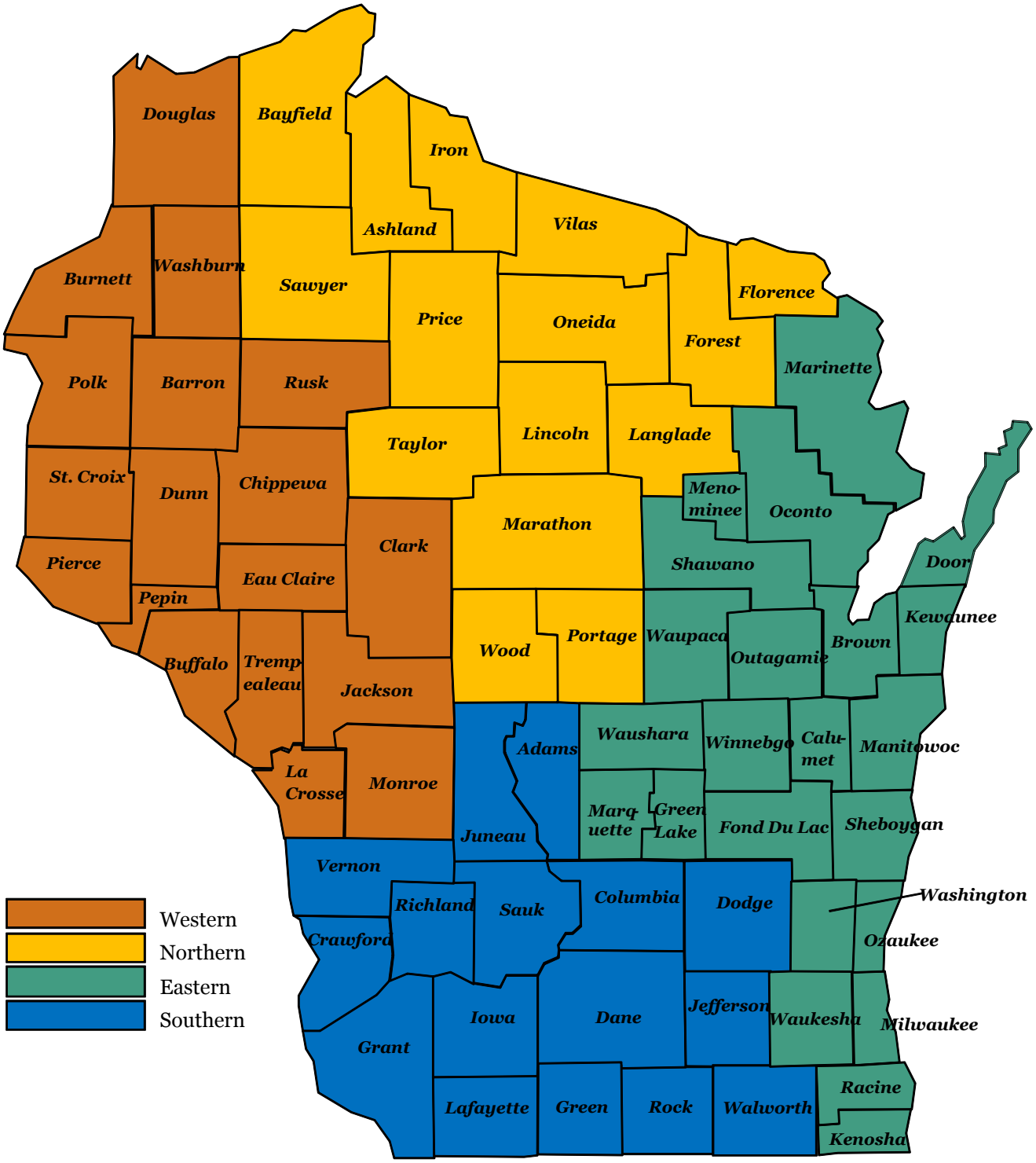
(8) Reasonably up-to-date versions of system security agent software, including intrusion detection systems, which must include malware protection and reasonably up-to-date patches and virus definitions, or a version of such software that can still be supported with up-to-date patches and virus definitions, and is set to receive the most current security updates on a regular basis.

(9) Education and training of employees on the proper use of the computer security system and the importance of Confidential Information and network security.

With reasonable notice to Contractor, ETF may require additional security measures which may be identified in additional guidance, contracts, communications or requirements.

State of Wisconsin
Department of Employee Trust Funds
Regional Map

RFP ETG0003
Exhibit 5: Map
Issued July 22, 2016



State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R07/2016)
§ 51.01(5) Wis. Stats. § 111.32(13m) Wis. Stats.

Department of Employee Trust Funds
801 W. Badger Road
P. O. Box 7931
Madison, WI 53707-7931

Contract

Commodity or Service:

Administrative Services for the State of Wisconsin Health Benefit Program

Contract No./Request for Bid/Proposal No:

ETG0003(S)
Authorized Board: Group Insurance Board

Contract Period: June 1, 2017 through December 31, 2020 with the optional renewal of three (3) two (2) year periods

1. This Contract is entered into by the State of Wisconsin, Department of Employee Trust Funds (Department), the State of Wisconsin Group Insurance Board (Board) and between Security Administrative Services. hereinafter referred to as the "Contractor", whose address and principal officer appears on page 2. The Department is the sole point of contact for this Contract.

2. Whereby the Department of Employee Trust Funds agrees to direct the purchase and the Contractor agrees to supply the Contract requirements cited in accordance with the State of Wisconsin standard terms and conditions and in accordance with the Contractor's proposal dated September 19, 2016, hereby made a part of this Contract by reference.

3. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employees or applicants for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s.51.01(5), Wis. Stats., sexual orientation as defined in s.111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

4. Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan. Contractors with an annual work force of less than fifty (50) employees are exempted from this requirement. Within fifteen (15) business days after the award of the Contract, the plan shall be submitted for approval to the Department. Technical assistance regarding this clause is provided by the Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931, 608.261.7952, or via e-mail at ETFProcurement@etf.wi.gov.

5. Contractor agrees to the Discount Guarantees and Gain Sharing Agreement in Exhibit B.

6. For purposes of administering this Contract, the order of precedence is:
   a) This Contract (Form DOA-3049) with Security Administrative Services;
   b) Exhibit A, Contract clarifications from ETF;
   c) Exhibit B, Discount Guarantees and Gain Sharing Agreement;
   d) RFP Exhibit 1 – State of Wisconsin Health Benefit Program Agreement, dated May 1, 2017;
   e) RFP Exhibit 4 – Department Terms and Conditions, dated April 26, 2017;
   f) Appendix 4a Claims Data Specifications – Medical, dated March 29, 2017;
   g) Appendix 5 Provider Data Specifications, dated March 29, 2017;
   h) Request for Proposal (RFP) ETG0003 dated July 22, 2016, including all appendices, attachments, and amendments thereto; and
   i) Contractor's proposal dated September 19, 2016.

Contract Number & Service: ETG0003(S) - Administrative Services for the State of Wisconsin Health Benefit Program

State of Wisconsin Department of Employee Trust Funds	Contractor to Complete
By Authorized Board *(Name)* **Group Insurance Board**	Legal Company Name **Security Health Plan of Wisconsin, Inc**
By *(Name)* **Michael Farrell**	Trade Name
Signature	Taxpayer Identification Number **39-1572880**
Title **Chair** Group Insurance Board	Company Address *(City, State, Zip)* 1515 N. Saint Joseph Avenue Marshfield, WI 54449
Phone 608.266.9854 (A. John Voelker, Deputy Secretary)	By *(print Name)* Julie Brussow
Date *(MM/DD/CCYY)*	Signature Julie Brussow
	Title Chief Executive Officer
	Phone 715-221-9678
	Date *(MM/DD/CCYY)* 05/01/2017

Exhibit A

Contract ETG0003(S): Clarifications and changes agreed to by the parties to the July 22, 2016 Request for Proposal (RFP) ETG0003 Administrative Services for the State of Wisconsin Health Benefit Program to be provided by Security Administrative Services to the State of Wisconsin Department of Employee Trust Funds for the Health Insurance Programs Offered by the State of Wisconsin Group Insurance Board.

The following are clarifications to Contract terms:

#	Document / Section	Section Description	Clarification
1	n/a	n/a	Any dispute, disagreement or question of interpretation of Exhibits 2, 3, or 4 (the Terms and Conditions) and the application of those Exhibits to the terms of this contract is subject to discussion and resolution under Exhibit 4, Section 13.0 (Contract Dispute Resolution) of the Department Terms and Conditions."
2	Exhibit 1 Section 130	Premiums	The language in this section is not intended to hold a Contractor liable for payment of actuarial services related to a review of claims experience, trends and other factors covered by the rate renewal reports submitted by a Contractor pursuant to this section.
3	Exhibit 1 Section 135B	Administrative Fee Adjustments	Language as shown was drafted with the intention to allow for administrative fee increases, as recommended by ETF's actuary. Should an administrative fee change be implemented for which the TPA disagrees, the process on contract dispute resolution is provided in Exhibit 4.0, Section 13.0.
4	Exhibit 1 Section 215A	Disease Management / Prior Authorizations / Utilization Review	The contract requires prior authorizations to include member out-of-pocket cost sharing information. The intent is to base the authorization on the provider status at time of the authorization review with disclosure about any anticipated provider status change for the length of the approval period and disclosure that the member's deductible, coinsurance and/or copayment applies. Member out-of-pocket costs do not need to be amount specific and instruction should be provided on how members can obtain specific cost-sharing information. The contract also states the Contractor is responsible for the cost of services not covered under the contract when the member has received a prior authorization. The intent is to hold the Contractor accountable if it errors by prior authorizing a service that is not covered under the contract.

#	Document / Section	Section Description	Clarification
5	Exhibit 1 Sections 230 and 230D	Provider Contracts Provider Contracts Shall Include Compliance Plans	Including the provider agreement requirements outlined in Section 230 and the compliance plans outlined in Section 230D in a policy, program or process for which the provider contract requires compliance, even though the provider contract does not specifically identify such items, is deemed to meet this contractual requirement.
6	Exhibit 4 Section 28.0 (i)(2)	Data Security and Privacy Agreement	1) The data should be destroyed; 2) unless Contractor can definitely prove to ETF that the data was de-identified; and 3) that Contractor confirms to ETF in writing that no crosswalk exists to re-identify the data.
7	n/a	n/a	Based on the contract negotiations that ETF has conducted over the last several weeks with each of the six contractors, ETF now believes it is appropriate to delete references in the RFP and Section 135B of RFP Exhibit 1 specifically stating that the contractors are fiduciaries. The duties that contractors will perform are delineated throughout the RFP and Exhibit 1. Case law confirms that whether or not a contract specifically states that a contractor is a fiduciary, courts have issued decisions finding that the duties and facts in a particular situation demonstrate that a contractor is a fiduciary.
8	Exhibit 4 Section 12.0	Liquidated Damages	It is the Department's intent that the Contractor will be able to utilize the process described in Exhibit 4, Section 13.0 (Contract Dispute Resolution) prior to the Department imposing any Liquidated Damages.

Wisconsin Department of Employee Trust Funds
Discount Guarantees for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Security Health**
Region **Northern**

Vendor will provide 2018 expected overall level of discount.
ETF and Vendor will mutually agree on final starting point.

2018 Discount Target*

* A supplemental worksheet allows vendors to calculate this discount with enrollment and regional assumptions. Upon open enrollment these will be re-based accordingly.

2019 minimum level of discount**

2019 Discount Target

2020 minimum level of discount**

2020 Discount Target

**** Level will be recalibrated after 6-months of prior calendar year incurred claims and adjusted higher if appropriate and agreed to by both parties as a reasonable expectation for the calendar year.**

% of Actual Discount below Target	% of Total Admin Fees at Risk
	0%
	5%
	10%

Notes:
Actual Performance against Target Discounts will be calculated 6 months after the end of the Calendar Year with runout data available in the data warehouse at that time.
Large claims over $100,000, and any out-of-network claims, will be removed from the calculation.
Discount Percent is calculated as Total Submitted Eligible Charge less Total Allowed (state & member) divided by Total Submitted Eligible Charge.
Discount Guarantee is null and void if Gain-Sharing Actual PMPM is less than Target PMPM.

ETG0003

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Exhibit B

Vendor **Security Health**
Region **Northern**

Annual Shared Savings will be calculated based on two factors:
(1) Performance of Actual versus Target PMPM
(2) Performance of Actual versus Target Clinical Performance Measures

Performance of Actual versus Target PMPM

Illustrative Calculation

Prior Calendar Year allowed claims for those members who select vendor during open enrollment will be used as a starting point to determine a base aggregate PMPM. The data will be normalized to the vendor's network pricing. It is anticipated that this will include 12 months of incurred allowed claims. (TBD)

A claims completion factor will be applied to the allowed claims. This will be updated with runout during the settlement process with claims paid through June of the following Calendar Year. (TBD)

Total Calendar Year Incurred Claims

Apply Industry and Market Specific Trend (TBD) - Trend assumptions will be uniform across all vendors

Calendar Year Allowed PMPM Target

Amount of savings to be shared with vendor will vary by percentage of actual PMPM below Target PMPM based on the following Scale:

	CY 2018	CY 2019	CY 2020
% of Actual PMPM below Target	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**
< 3.00%	0%	0%	0%
3.00% - 6.00%	5%	7.5%	10%
> 6.00%	10%	17.5%	25%

Notes on PMPM:
1) Target PMPM will be set by March 1st of the current CY based on prior CY incurred claims with current year enrollment, adjustment for network pricing, completion factors and trend.
2) Performance of Actual versus Target PMPM will be calculated at the end of the CY when 6 months of runout is available in the data warehouse. This results in 18 months of runout for the Target PMPM and 6 months of runout for the Actual PMPM. Note that the Actual PMPM will have a completion factor applied.

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Security Health**
Region **Northern**

Performance of Actual versus Target Clinical Performance Measures

In addition to the shared savings amounts based on Actual versus Target PMPM Calculations, payments will be reduced based on the percentage of clinical targets met by the vendor for the Calendar Year. If all clinical targets are met, payouts will be 100% of the PMPM calculations described above. If, for example, 75% of the clinical targets are met, payouts will be 75% of the PMPM calculations described above.

Clinical Targets for each year of the contract will be determined for each vendor individually by comparing actual baseline for each vendor to an ultimate target for each measure. The difference between the vendor's baseline and target will be the gap that should be closed over 3 years with equal improvement in each of the 3 years to reach the target. Examples are shown below:

	Baseline	Target	Gap	2018 Target	2019 Target	2020 Target
Vendor A	50%	90%	40%	63%	77%	90%
Vendor B	80%	90%	10%	83%	87%	90%
Vendor C	95%	90%	-5%	90%	90%	90%

ETG0003

Wisconsin Department of Employee Trust Funds
Discount Guarantee Development Worksheet

Exhibit B

Vendor **Security Health**
Region **Northern**

		Preliminary Discount Guarantee			Final Discount Guarantee		
Region	Total Members	Expected Enrollment	Expected Distribution	Discount Guarantee	Open Enrollment	Final Distribution	Discount Guarantee
Eastern	63,766						
Northern	8,151						
Southern	113,299						
Western	21,024						
In-State	206,240						
Out-of-State	3,379						
Total Membership	209,619						

After open enrollment, a final discount guarantee will be developed based on vendor's actual enrollment.
Discount guarantees by region may not be altered during this process.

ETG0003

RFP ETG0003

Exhibit 1: State of Wisconsin Health Benefit Program Agreement

Issued May 1, 2017

State of Wisconsin Health Benefit Program Agreement

Issued by the State of Wisconsin

Department of Employee Trust Funds

On behalf of the Group Insurance Board

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000 DEFINITIONS

Unless otherwise defined herein, any term needing definition shall have the definition found in Uniform Benefits (of this AGREEMENT), the RFP, the PROPOSAL or in applicable Wisconsin law. These terms, when used and capitalized in this AGREEMENT are defined and limited to that meaning only:

AGREEMENT means the State of Wisconsin Health Benefit Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

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).

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).

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 attachments, supplements, endorsements riders and the CONTRACTOR'S PROPOSAL.

CONTRACTOR means the legal signatory to this AGREEMENT.

DAY means calendar DAY unless otherwise indicated.

DEPARTMENT means the State of Wisconsin Department of Employee Trust Funds.

DEPENDENT as defined in Uniform Benefits.

DOMESTIC PARTNER as defined in Uniform Benefits.

EFFECTIVE DATE means the date, as certified by the DEPARTMENT and shown on the records of the CONTRACTOR in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

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 program that provides group health BENEFITS to eligible State of Wisconsin and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

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.

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.

PBM means the Pharmacy Benefit Manager (PBM) which is a third party administrator that is contracted with the BOARD to administer the prescription drug benefits under this HEALTH BENEFIT PROGRAM. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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.

PROPOSAL means the complete response of a proposer submitted and setting forth the proposer's pricing for providing the services described in the Request for Proposal (RFP).

QUARTERLY means a period consisting of every consecutive three (3) months beginning January 2018.

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.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the CONTRACTOR for enrollment and who is entitled to BENEFITS.

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).

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETG0003 and in the PROPOSAL.

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 (forms 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).

110 Objectives

The BOARD's objectives of the HEALTH BENEFIT PROGRAM include, but are not limited to the following:

1) Management and delivery of health care services to PARTICIPANTS through contracted networks that provide for high-quality, cost-effective care.

2) To provide excellent customer service to PARTICIPANTS.

3) To offer networks of high value providers, and to incent PARTICIPANTS to choose benefit plan designs with high value providers.

4) To provide high-quality services at a competitive price.

5) Accurate, timely and responsive administration of health care claims.

6) 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.

7) To offer tools for PARTICIPANTS to increase engagement, including:

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

8) To ensure quality population health programs, including case management and disease management, which promote proactive management of PARTICIPANT health concerns.

9) 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 to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

3) Cooperate with the DEPARTMENT to develop procedures and protocols for sharing information as necessary.

4) Provide, in a format acceptable to the DEPARTMENT, at no cost and in a timely manner, all data and written or recorded material pertaining to this AGREEMENT.

5) Provide the specified level of services as indicated in this AGREEMENT to PARTICIPANTS.

6) Assist the DEPARTMENT with the administration of this AGREEMENT, including PARTICIPANT enrollment, record keeping, and general operations.

7) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT, including but not limited to, initial determination of eligibility for DEPENDENTS for disabled and full-time student status.

8) 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.

9) Have a mechanism, as approved by the DEPARTMENT, for handling complaints and grievances made by PARTICIPANTS.

   a) This includes a formal grievance procedure, which at a minimum complies with federal law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the 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.

10) Submit to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information.

11) Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in care from OUT-OF-NETWORK providers.

12) Comply with state and federal regulations pertaining to mandated or minimum BENEFITS which may be applicable to the CONTRACTOR under insurance statutes or as directed by the BOARD.

13) Provide DEPARTMENT approved materials to PARTICIPANTS as required under this AGREEMENT.

14) Provide notification of all significant events:

a) 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 (15%) percent 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 (51%) percent) interest in the CONTRACTOR or any transfer of ten (10%) percent or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the 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."

15) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT.

16) Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32.

17) Provide coverage for PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

18) 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.

19) Shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT.

20) 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, per Wis. Stat. § 40.02 (25) (b), eligible EMPLOYEES include:

1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS).

2) Elected state officials.

3) Members or EMPLOYEES of the legislature.

4) Any blind EMPLOYEES of the Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3.

5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance.

6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave (Wis. Stat. § 40.05 (4) (bm)).

7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority:

    a) Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

b) Any teacher who is a participating EMPLOYEE and who is employed by the UW System for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

c) Certain visiting faculty members in the UW System.

d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.

e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one (1) semester for academic year (nine (9) month) or six (6) months for annual (twelve (12) month) appointments.

f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of twenty-eight (28%) percent or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one (21%) percent or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.

g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.

h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospital and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.

8) ANNUITANTS and CONTINUANTS:

a) Any covered EMPLOYEE who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

b) The surviving spouse or DOMESTIC PARTNER of a SUBSCRIBER.

c) Covered EMPLOYEES who terminate employment, have attained minimum retirement age (fifty (50) for protective services or fifty-five (55) for all other categories), have twenty (20) years of WRS creditable service and defer their annuity are eligible to continue in the HEALTH BENEFIT PROGRAM if a timely application is submitted.

d) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll 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.

e) Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for coverage through the EMPLOYER.

f) Any retired public employee under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

125B Dependent Coverage Eligibility

Individual coverage covers only the SUBSCRIBER. All eligible DEPENDENTS listed on the application are covered under a family contract. A SUBSCRIBER cannot choose to exclude any eligible DEPENDENT from family coverage, unless that DEPENDENT is already covered under the HEALTH BENEFIT PROGRAM.

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

Notwithstanding the paragraph above, the birth or adoption of a child to a SUBSCRIBER under an individual benefit plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within sixty (60) DAYS of the birth, adoption, or placement for adoption.

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the 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.

125E Local Annuitants

LOCAL ANNUITANTS who cancel coverage for any reason are not eligible to reenroll in the program as a SUBSCRIBER.

125F Medicare Participants

ANNUITANTS and their DEPENDENTS, or surviving DEPENDENTS, who become enrolled in Medicare may continue to be covered at reduced PREMIUM rates, as specified by the BOARD.

Enrollment in Medicare by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the STATE or participating LOCAL EMPLOYER. Enrollment in Medicare Parts A and B is required for the EMPLOYEE and/or Medicare-eligible DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active EMPLOYEE'S group health benefit policy with another employer and that policy is the primary payer for Medicare Parts A and B charges, the ANNUITANT and/or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare reduced PREMIUM for coverage under this program.

As required by Medicare rules, Medicare is the primary payer for DOMESTIC PARTNERS age sixty-five (65) and older who are enrolled in Medicare, regardless of the work status of the SUBSCRIBER. The reduction in PREMIUM is available only when the coverage is provided under a non-employer group number.

Enrollment in Medicare by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the covered EMPLOYEE, ANNUITANT or DEPENDENT is required to pay a premium to enroll in the HOSPITAL portion of Medicare (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

130 Premiums

The BOARD determines the PREMIUM for its self-insured benefit plans as part of the HEALTH BENEFIT PROGRAM. This PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to:

1) Projection of incurred claims costs for the renewal benefit period.

2) The most recent thirty-six (36) months of incurred/paid triangular reports for the current benefit period.

3) Complete documentation of the methodology and assumptions utilized to develop the projected costs.

4) Disclosure of supporting data used in the calculation, including monthly paid claims and enrollment, network provider fee-structure analysis, provider negotiations updates, utilization analysis to report on unusual patterns, large claims analysis, trend analysis, and demographic analysis.

5) Substantiation of any proposed increase in fixed costs, such as administrative costs, via a thorough analysis of activities and costs covered by those fees.

6) Explanations for any unusual trend results (high or low relative to the market).

The CONTRACTOR will work with the BOARD'S consulting actuary independently to agree on a format, and the frequency of providing this data.

SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255.

The State of Wisconsin's current contribution toward the total health benefit for EMPLOYEES (non-retired) for both individual and family contracts is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The tiered structure is based on recommendations from the BOARD'S consulting actuary.

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 the Medicare HOSPTIAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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 coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. 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.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see Sections 125F and 220H.

135 Administrative Fee and Financial Administration

135A Invoicing and Banking

1) Claims Invoicing:

   a) The CONTRACTOR shall notify the DEPARTMENT every calendar week during the term of this AGREEMENT and inform the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. The amount due every week shall be the total amount of BENEFIT payments issued by the CONTRACTOR for the claims processed during the immediately prior calendar week (Saturday through Friday).

   b) The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT by the first Friday immediately following the DEPARTMENT'S receipt of the request for payment by the CONTRACTOR. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.

   c) The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within twenty (20) BUSINESS DAYS following month-end.

   d) The CONTRACTOR shall submit a claims invoice reconciliation report each month for the prior month. The report will reconcile the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. The weekly claims invoice must show claims by the benefit period in which they were incurred and by state and local subgroups.

2) Administrative Fee Invoicing:

   a) The CONTRACTOR must submit to the DEPARTMENT on the twentieth (20th) DAY of each calendar month (or the first BUSINESS DAY following the twentieth (20th) DAY of the calendar month), an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The monthly invoice must show the total amount of administration

fees, other approved fees and expenses due for the immediately following calendar month. The DEPARTMENT shall deposit funds into the bank account designated by the CONTRACTOR on the first BUSINESS DAY of the calendar month following the DEPARTMENT'S receipt of the invoice from the CONTRACTOR.

b) The CONTRACTOR shall be paid the administrative fee per month per PARTICIPANT as detailed in the CONTRACT. All administrative plan arrangement-related fees are included in the CONTRACTOR's administrative fee.

   The statewide/nationwide CONTRACTOR shall be paid for underwriting services to evaluate risk and submit recommendations for LOCAL EMPLOYERS requesting participation in the local HEALTH BENEFIT PROGRAM. The LOCAL EMPLOYER shall send payments for underwriting services to the DEPARTMENT. The DEPARTMENT shall forward one check for the appropriate amount shown in the Cost Proposal to the CONTRACTOR for their services.

3) Direct Pay SUBSCRIBER Invoicing:

   The CONTRACTOR shall not process any PREMIUM transactions related to enrollment, except for those direct pay SUBSCRIBERS.

135B Administrative Fee Adjustments

Administrative fee adjustments, if any, required as recommended by the BOARD's consulting actuary for BENEFIT changes, mandated BENEFIT payments, and/or operational changes, will occur on January 1 after the next contract period begins unless otherwise approved by the BOARD. The CONTRACTOR shall supply an administrative monthly invoice that must be based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The CONTRACTOR shall be paid the following administrative charge per month per PARTICIPANT for the AGREEMENT periods stated as follows:

Medical administration fee per individual and family contract. The medical administration fee includes, but is not limited to, the following:

1) Claims administration (including adjudication, payment, reprocessing, coordination of BENEFITS (excluding vendor recoveries), and overpayment collection).

2) Utilization review fees.

3) Network access fees.

4) MHSA claims administration.

5) Medical management (including medical review).

6) Disease management.

7) Customer service (to meet all requirements of this AGREEMENT, including all key personnel).

8) PARTICIPANT materials (including explanations of BENEFITS, summary of BENEFITS and coverage, web tools, ID cards, printing and mailing costs).

9) All required reports (including federally required reports and tax related forms).

10) Claims data extracts.

11) Administration, collection of, and passing through to the DEPARTMENT, premiums for direct pay SUBSCRIBERS (including reporting non-payment terminations).

12) IT services (including hardware and software).

13) Telecom (other program resource links, reporting, special usage or access requirements).

14) Required reviews (including fraud and abuse, and HOSPITAL bill).

15) Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing).

16) Telehealth services.

17) Twenty-four (24)-hour nurse line services.

18) Underwriting services (applies to a CONTRACTOR providing statewide/nationwide services under this AGREEMENT only).

135C Prohibited Fees

1) The CONTRACTOR is prohibited from including in their administrative fee:

   a) The cost to handle any claims paid outside of Uniform Benefits or IYC Medicare Plus administered by the statewide/nationwide CONTRACTOR.

   b) The cost to administer any optional health and wellness benefit(s) beyond Uniform Benefits, IYC Medicare Plus that is administered by the statewide/nationwide CONTRACTOR or the Well Wisconsin program.

2) The CONTRACTOR is prohibited from billing separate fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

135D Recovery of Overpayments

1) Overpayments:
   If it is determined that any payment has been made under this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or

shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.

If any overpayments made to ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments. Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR'S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments. Any overpayment caused by the CONTRACTOR'S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.

The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures.

2) The BOARD shall hold the CONTRACTOR and its directors, officers, and employees harmless from any liability for any overpayments and/or underpayments made to any ineligible former PARTICIPANT when payments result from a failure of the BOARD, the DEPARTMENT or any other State department or agency to make a timely report to the CONTRACTOR of any PARTICIPANT'S loss of eligibility.

   The DEPARTMENT shall not hold the CONTRACTOR responsible for any overpayments caused by DEPARTMENT or EMPLOYER errors or fraud by a person other than an employee of the CONTRACTOR.

   The CONTRACTOR shall assist the DEPARTMENT in identifying overpayments caused by such error or fraud.

3) The BOARD reserves the sole right to institute litigation for the purpose of recovering any overpayment. The BOARD reserves the right to join in any litigation instituted by the CONTRACTOR for the purpose of recovering any overpayment which is the responsibility of the CONTRACTOR.

4) The CONTRACTOR shall be given full credit for all refunds that result from recovery of any overpayment to the extent that the CONTRACTOR is held financially responsible for such overpayment within this AGREEMENT.

5) Disputes over Charges:

   Notwithstanding any other terms, conditions, and provisions of this AGREEMENT, the CONTRACTOR shall pay CHARGES as determined by the CONTRACTOR. Disputes as to CHARGES will be referred, on a timely basis, to the CONTRACTOR who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

   If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT shall contact the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR shall notify the DEPARTMENT about the lawsuit.

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 administrative fees or other 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:

1) Providers to request and receive electronic funds transfer (EFT) of claims payments for BENEFITS.

2) SUBSCRIBERS to submit EFT of direct pay PREMIUM payments. The CONTRACTOR must support other mechanisms for payment of direct pay PREMIUMS.

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.

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.

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. 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. The next roll-out for the new system is currently scheduled for 2018.

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.

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 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.

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 Claims Data Specifications document, all claims processed for PARTICIPANTS. At least ninety-five (95%) percent of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred (100%) percent of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

b) 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, 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. 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 and integrate the data as required under Section 240. 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 provided by the DEPARTMENT with 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 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 RFP, 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. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file. 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 and are the direct result of the CONTRACTOR's failure to meet the

DEPARTMENT'S data submission requirements or timelines and which the DEPARTMENT will deduct from any payment owed the CONTRACTOR in the payment period.

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.

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 Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits. All amounts recovered under this program shall be paid forty-five (45%) percent to the CONTRACTOR and fifty-five (55%) percent to the BOARD.

155D 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.

155E 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) 16 and provide a copy of the CPA's report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.) The audit report must be submitted annually.

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.

155F 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. For information see Section 135D.

2) Contractor Provider 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; and,

n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. 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 personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

4) The actual impact list (as soon as known).

5) A copy of any correspondence sent to affected PARTICIPANTS (this must be pre-approved by the DEPARTMENT).

6) A description of the steps taken to ensure a similar incident will not be repeated.

This notification requirement shall apply only to PHI or PII received or maintained by the CONTRACTOR pursuant to this AGREEMENT. The CONTRACTOR shall make good faith efforts to communicate with the DEPARTMENT about breaches by major provider groups if the CONTRACTOR knows those breaches affect PARTICIPANTS.

The CONTRACT shall notify the DEPARTMENT Program Manager and Privacy Officer no less than one (1) BUSINESS DAY before any external communications are made regarding a data breach.

155H 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.

155I 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 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) In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.

4) Membership changes and corrections not processed during the term of the contract will continue to be processed by the CONTRACTOR during the entire run-out period. During the entire run-out period, all performance standards and penalties remain in force.

5) The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT'S approval.

155J Transition Plan

During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. In the event that the CONTRACTOR terminates the CONTRACT, an updated

transition plan must accompany the notice of termination. In the event the BOARD terminates the CONTRACT, the CONTRACTOR must send an updated transition plan to the DEPARTMENT within thirty (30) DAYS of the written notice of termination to the CONTRACTOR. The transition plan must be approved by the DEPARTMENT prior to the transition begin date and must include the CONTRACTOR'S cooperation and participation in planning calls or meetings with the succeeding vendor.

The CONTRACTOR must administer a program run-out period to process claims and to handle related customer service inquiries. The run-out period begins on the CONTRACT termination date and will be no longer than one (1) year. The CONTRACTOR shall be paid three (3) months of administrative expenses based on the membership census as of November 1 of the last year of the contract. The administrative fee shall be the fee in effect during the last year the contract. The fee shall be paid in three (3) installments. The first installment shall be paid in December of the last year of the contact. The second installment shall be paid in January of the year of run-out. The final payment will be made no later than December of the year of run-out unless issues arise with data submission to the DEPARTMENT'S data warehouse. In the event of issues receiving run-out claims per the DEPARTMENT'S timeline, the DEPARTMENT will withhold the final fee payment until all run-out claims are received.

Leading up to and during the run-out period, the CONTRACTOR must:

1) Participate in all DEPARTMENT requested meetings.

2) Provide all reports for program close out.

3) Report on performance standards specified in Section 315.

4) Invoice the DEPARTMENT as specified in Section 135A.

5) Transmit program data to the new vendor.

6) Continue grievance, hospital bill audit, subrogation services and overage disabled dependent reviews.

7) Transmit run-out claims data to the DEPARTMENT'S data warehouse as specified in Section 150.

155K Health Underwriting for Statewide/Nationwide Contractor only

LOCAL EMPLOYERS with one or more employees requesting participation in the local HEALTH BENEFIT PROGRAM are subject to underwriting. The CONTRACTOR shall evaluate risk and submit a recommendation back to the DEPARTMENT for final approval by the BOARD'S actuary. The effective date shall be determined by the DEPARTMENT. The fees described in the Cost Proposal, or as agreed upon by the DEPARTMENT, shall be administered per Section 135A.

Employers with fifty-one (51) or more EMPLOYEES shall submit claims and enrollment experience including high cost claims data for the most recent available twenty-four (24) months along with the fees to the DEPARTMENT.

Employers with fifty (50) or less EMPLOYEES shall submit small employer information as required by the CONTRACTOR to the DEPARTMENT along with the fees.

The DEPARTMENT will submit information and appropriate fees to the 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.

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. 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) 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 Eligibility

The 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.

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

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 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 as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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. See Appendix 6, Guidance for DEPARTMENT Initiatives, for additional detail.

The current DEPARTMENT Initiatives 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) High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.

3) Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.

4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.

5) 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.

215C Quality Initiatives

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.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in Uniform Benefits to all PARTICIPANTS with the exception of the statewide/nationwide CONTRACTOR who must provide the BENEFITS and services listed in the IYC Medicare Plus certificate to all Medicare 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 high deductible health plan (HDHP) 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger 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 Preferred Provider Organization (PPO)

The BOARD may offer different copayment and deductible schedules for OUT-OF-NETWORK providers, except in the case of emergency, urgent care or when the services are not reasonably available IN-NETWORK.

If the PARTICIPANT resides in a CONTRACTOR'S service area, the PPO must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty IN-NETWORK provider when determining if that provider is reasonably available.

220G Medicare

The CONTRACTOR will provide BENEFITS and services as described in Uniform Benefits to PARTICIPANTS enrolled in Medicare with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS.

The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare.

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 EMPLOYEE, 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. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payer after this thirty (30)-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty (30) -month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer. No reduction in PREMIUM is available for active EMPLOYEES under this section.

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, change from or to the IYC HDHP).

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:

1) If a PARTICIPANT changes benefit plans.

2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER (or combination of spouse-to-DOMESTIC PARTNER) transfer resulting in a change of SUBSCRIBER, but does not change benefit plans.

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.

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. For HDHPs, medical and pharmacy accumulations are combined.

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.

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 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 audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year, which includes 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 commercially insured adult 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.

c) The results of the survey shall be used for the measurement of PARTICIPANT satisfaction as specified in the performance standards in Section 315G.

4) The DEPARTMENT will monitor health care quality and/or customer satisfaction using performance measures available in the data warehouse and visual business intelligence tool, and will establish performance metrics, baseline results, and target performance levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage performance improvement.

   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.

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 and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how 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.

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.

The 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 their provider network for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150.

The DEPARTMENT will use this data to ensure provider access standards are met. 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 (33%) percent 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 the following minimum requirements:

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 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 the access standards above, including accepting 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. 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 Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in Uniform Benefits with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS. Targets for claims processing performance standards and associated penalties are specified in Section 315C.

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. The CONTRACTOR shall pay claims of providers according to a time standard mutually established by the CONTRACTOR and the DEPARTMENT.

Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR shall provide the total dollar amount of claims paid by the HEALTH BENEFIT PROGRAM.

In accordance with state statute, the CONTRACTOR must maintain individual documentation used for claim adjudication for a minimum of seven (7) years.

240 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 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.

245 Grievances

245A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with the HHS-administered federal external review in accordance with federal law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections 245E, 245F, and 265A.

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 245A – H.

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

4) Notification of DEPARTMENT Administrative Review Rights (not all grievances eligible): Administrative review by DEPARTMENT staff, and/or the DEPARTMENT appeals process including filing an appeal with the BOARD, an administrative appeal hearing, consideration of the appeal by the BOARD, right to appeal the BOARD's final decision to circuit court; or,

5) Federal external review (not all grievances eligible).

245B 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.

245C 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.

245D 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.

245E Notification of Department Administrative Review Rights

In the final grievance decision letters, the CONTRACTOR shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR shall cite the specific Uniform Benefits contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision with the exception of the statewide/nationwide CONTRACTOR who will cite the specific IYC Medicare Plus contractual provision(s) for Medicare PARTICIPANTS.

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 HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

BOARD decisions can only be further reviewed as provided by Wis. Stat. § 40.08 (12) and Wis. Adm. Code ETF 11.15.

245F External Review

The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an 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.

245G 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.

245H 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.

245I 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.

245J 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.

250 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see Section 260D.

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.

255 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt. It is acceptable to credit the collected direct pay PREMIUM amount on the administrative monthly invoice provided that it contains itemized SUBSCRIBER level detail.

Direct pay PREMIUMS may be submitted to the CONTRACTOR via electronic funds transfer or 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.

260 Continuation

260A 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.

260B 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.

260C Conversion / Marketplace

The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment.

260D 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.

265 Miscellaneous Program Requirements

265A 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.

The CONTRACTOR is required to perform and/or manage the following activities by the date indicated:

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Nondiscrimination Testing Plan: The CONTRACTOR works with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.	Within thirty (30) DAYS of execution of this CONTRACT
Transition Plan: The transition plan is established in a mutually agreed upon format and submitted to the DEPARTMENT Program Manager or designee for review.	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2018 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	August 18, 2017
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 1, 2017
Employer Meeting: The CONTRACTOR attends the It's Your Choice EMPLOYER Kick-Off meeting.	Fall 2017 (Date TBD)
Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.	September 30, 2017
Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2017
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	September 2017 (Date TBD)
Employer Health Fairs: The CONTRACTOR shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area.	October – November 2017
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation.	November 16, 2017

Activity	Due Dates
Financial Administration: Financial administration requirements are operational, including but not limited to: • Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. • Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). • Direct pay invoicing process. • ACH mechanism for EFT of claims payments and direct pay PREMIUMS.	November 30, 2017
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2017
ID Cards: The CONTRACTOR issues welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018.	December 15, 2017
Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM are fully operational.	January 1, 2018
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2018
Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly.	January 15, 2018
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2018
Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2018
Claims Data: The claims data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	March 31, 2018

265B Account Management and Staffing

Upon execution of this CONTRACT, the CONTRACTOR shall designate an Account Manager and a backup, assigned to the DEPARTMENT for the life of the CONTRACT, who is accountable for and has the authority to:

1) Manage the entire range of services specified in the CONTRACT;

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

4) Implement the DEPARTMENT changes to benefit plan design and procedures; and,

5) Resolve general administrative problems identified by the DEPARTMENT.

The Account Manager or backup must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the contract. The Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR shall resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR must have a designated Information Technology contact and a backup Information Technology contact who will have overall responsibility for the information technology aspects of the CONTRACT. The Information Technology contact shall be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR shall provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. The CONTRACTOR shall ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT, have the experience and credentials necessary to perform the work required. The CONTRACTOR shall provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS.

The CONTRACTOR shall notify the DEPARTMENT if the Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to deny the CONTRACTOR'S designees.

The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must acknowledge receipt of the inquiry from the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the payroll processing centers and/or other payroll.

The CONTRACTOR shall provide onsite staff attendance at the annual IYC EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the annual IT'S YOUR CHOICE OPEN ENROLLMENT period.

The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR'S operations and policies.

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the 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 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting HEALTH BENEFIT PROGRAM services.

265C Customer Service

The CONTRACTOR shall operate a dedicated 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 315D 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, EMPLOYER group);

5) The representative that handled the inquiry;

6) For phone inquiries, the length of call; and,

7) The resolution of the inquiry (including a resolution code using a coding scheme).

Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request.

At the DEPARTMENT'S request, the CONTRACTOR must provide the policies and procedures related to the operation of the customer service department. The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each 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.

265D 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.).

265E 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.

265F 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR.

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.

265G 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 "personal information", as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;

2) Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,

3) Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record that would violate Wis. Stat. § 40.07 (1) or (2), respectively, if the disclosure was made by the DEPARTMENT.

265H 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.

265I Subrogation and Other Payers

The CONTRACTOR shall correspond with PARTICIPANTS to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other payers such as worker's compensation, insurance contracts, or government-sponsored benefit programs.

The CONTRACTOR shall have authority to retain any attorneys or law firms regarding such subrogation rights and lawsuits involving such rights to represent the BOARD to pursue the BOARD'S subrogation rights in accordance with this AGREEMENT. Any subrogation settlement agreed to by the CONTRACTOR shall be deemed acceptable by the BOARD. The CONTRACTOR may forego subrogation where, at the CONTRACTOR'S discretion, the circumstances in a particular subrogation matter warrant such a decision.

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel or utilize in-house counsel to provide the BOARD with subrogation litigation services on the BOARD'S behalf at a contingency fee not to exceed thirty (30%) percent for outside legal counsel or twenty (20%) percent for in-house counsel of net dollars recovered by such counsel, with those attorneys' fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

For such subrogation matters, the BOARD shall not pay or provide any additional reimbursement for the outside legal counsel's or in-house counsel's legal fees, expenses, costs and disbursements incurred by such counsel while providing subrogation-related legal services and such legal fees, expenses, costs and disbursements are included in, and will be paid out of, the maximum thirty (30%) percent contingency fee that is paid to the outside legal counsel or twenty (20%) percent fee paid to in-house counsel as set forth in this subsection. The CONTRACTOR will not be paid or receive any portion of the contingency fee that is paid to the outside legal counsel if outside legal counsel is hired. The BOARD shall be solely responsible and liable for paying the contingency fee to outside legal counsel for its attorneys' fees, legal costs and disbursements incurred by the outside legal counsel representing the BOARD in subrogation cases, not the CONTRACTOR. The CONTRACTOR is not responsible or liable for paying the contingency fee or any outside counsel attorneys' fees, legal costs and disbursements.

265J 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.

265K Other

The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the HEALTH BENEFIT PROGRAM.

265L 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.

265M Conflict of Interest

During the term of this AGREEMENT, the CONTRACTOR shall have no interest, direct or indirect, that would conflict in any manner or degree with the performance of services required under this AGREEMENT.

Without limiting the generality of the preceding paragraph, the CONTRACTOR agrees that it shall not, during the initial AGREEMENT period and any extension thereof, acquire or hold any business interest that conflicts with the CONTRACTOR'S ability relating to its performance of its services under this AGREEMENT.

The CONTRACTOR shall not engage in any conduct which violates, or induces others to violate, the provision of the Wisconsin statutes regarding the conduct of public employees. If a BOARD member or an organization in which a BOARD member holds at least ten (10%) percent interest is a party to this AGREEMENT, then this AGREEMENT is voidable by the BOARD unless appropriate disclosure has been made to the Wisconsin Ethics Commission.

300 DELIVERABLES

305 Reporting Requirements

As required by the CONTRACT, the CONTRACTOR must submit reports to the DEPARTMENT. Reports must be submitted by SECURE email to the DEPARTMENT, the DEPARTMENT'S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify reporting requirements as deemed necessary to monitor the CONTRACT and programs.

Instructions and specific due dates will be provided by the DEPARTMENT annually.

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the 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 Invoicing	The CONTRACTOR notifies the DEPARTMENT every calendar week during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. *(See Section 135A, 1, a.)*	Weekly
3) Administrative Fee Invoice	The CONTRACTOR submits to the DEPARTMENT an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. *(See Section 135A, 2, a.)*	Monthly
4) 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, 1.)*	Monthly
5) Bank Reconciliation Report	The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. *(See Section 135A, 1, c.)*	Monthly
6) Claims Invoice Reconciliation Report	The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. *(See Section 135A, 1, d.)*	Monthly

Report	Description	Frequency
7) 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 265C.)*	Monthly
8) 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, 2..)*	Monthly
9) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155F, 2.)*	Quarterly
10) Hospital Bill Audit	The CONTRACTOR performs a HOSPITAL bill audit process for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and provides results of material findings to the DEPARTMENT. *(See Section 155C.)*	Quarterly
11) 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
12) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
13) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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, High Tech Radiology, Low Back Surgery, Shared Decision Making, and Advance Care Planning. *(See Section 215B.)*	Semi-annually
14) 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 215C.)*	Semi-annually
15) 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.)*	Semi-annually

Report	Description	Frequency
16) 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
17) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. *(See Section 225, 3, b.)*	Annually
18) 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
19) 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
20) 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.)*	Annually
21) 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
22) 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
23) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year. *(See Section 225, 3, a.)*	Annually
24) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually

Report	Description	Frequency
25) Rate Renewal Reports	To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. *(See Section 130.)*	Annually
26) 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 16 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 DEPARTMENT Program Manager or designee. *(See Section 265A.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. *(See Sections 265A and 265B.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. *(See Section 155F, 2 and Section 265A.)*	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section 205B, 2.)*	Upon identification of issue
5) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section 265B.)*	April August

Deliverable	Description	Frequency
7) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. *(See Section 230A.)*	June
8) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July
9) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
10) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
11) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
12) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. *(See Section 140B, 1.)*	October
13) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
14) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
15) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 265D, 1a and 1p.)*	As directed by the DEPARTMENT
16) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred 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
17) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 265B.)*	As needed
18) Recovery of Overpayments	The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures. *(See Section 135F.)*	As needed
19) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 245K.)*	As needed

Deliverable	Description	Frequency
20) Notification of Legal Action Against PARTICIPANT in Dispute over Charges	If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit's status in a mutually agreeable format. *(See Section 135F.)*	As needed
21) Notification of 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 personal 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 155G.)*	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 245F.)*	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, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. *(See Section 155J.)*	During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • The HEALTH BENEFIT PROGRAM provider directory or directions on how to request a printed copy of the provider directory. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. *(See Section 230C.)*	See description
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. *(See Section 245B.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. *(See Section 245D.)*	See description
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment. *(See Section 260C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed
10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

Performance standards are specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book-of-business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT upon realization that a standard will not be met, prior to the deadline.

The penalties assessed in Section 150B and Section 315 shall not exceed twenty-five (25%) percent of the CONTRACTOR'S total administrative fee in any given quarter. After implementation, all performance standards will be measured by the DEPARTMENT on a QUARTERLY basis and assessed based on PARTICIPANT counts as of the first calendar DAY of the quarter, as determined by DEPARTMENT enrollment records. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

Section	Performance Category	Maximum Penalty
315A	Implementation	Three (3%) percent
315B	Account Management	Three (3%) percent
315C	Claims Processing	Four (4%) percent
315D	Customer Service	Four (4%) percent
315E	Data Management	Four (4%) percent
315F	Enrollment	Four (4%) percent
315G	Other	Three (3%) percent
	TOTAL	Twenty-five (25%) percent

315A Implementation

The CONTRACTOR shall complete the task by the date specified below. If an alternate date is approved by the DEPARTMENT in the implementation plan, the CONTRACTOR shall complete the task by the alternate date. The total penalties for this performance category shall not exceed three (3%) percent of the total estimated administrative fee for year one (1) of the CONTRACT.

Performance Standards – three (3%) percent Penalty	Penalties
1) Program Information: All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards – three (3%) percent Penalty	Penalties
2) Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) Customer Service: The CONTRACTOR's dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained no later than September 30, 2017. (*See Section 265A.)*	
4) Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. *(See Section 265A.)*	
5) Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 265A.)*	
6) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. *(See Section 265A.)*	
7) Financial Administration: Financial administration requirements are operational no later than November 30, 2017. *(See Section 265A.)*	
8) Grievance Procedure: The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT'S review and approval. *(See Section 265A.)*	
9) ID Cards: No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018. *(See Section 265A.)*	
10) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018. *(See Section 265A.)*	

Performance Standards – three (3%) percent Penalty	Penalties
11) Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
12) Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly no later than January 31, 2018. *(See Section 265A.)*	
13) Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than February 28, 2018. *(See Section 265A.)*	
14) Claims Data Transfer: The claims data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than March 31, 2018. *(See Section 265A.)*	

315B Account Management

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(*See *Section 265B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey

Performance Standards	Penalties
2) **Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 265D, 1.)*	Five thousand ($5,000) dollars per incident

315C Claims Processing

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Financial Accuracy:** At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid in the correct amount divided by the total claim dollars paid. *(See Section 235.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
2) **Processing Accuracy:** At least ninety-seven (97%) percent level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section 235.)*	
3) **Claims Processing Time:** At least ninety-five (95%) percent of all claims received must be processed within fifteen (15) BUSINESS DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 235.)*	

315D Customer Service

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Call Answer Timeliness**: At least eighty (80%) percent of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)

Performance Standards	Penalties
2) Call Abandonment Rate: Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
3) Open Call Resolution Turn-Around-Time: At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section 265C.)*	
4) Inquiry Resolution Tracking Document/Log: Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request. *(See Section 265C.)*	
5) Electronic Written Inquiry Response: At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section 265C.)*	

315E Data Management

The DEPARTMENT will specify the timetable and dates for which the claims and provider data transfers must be provided. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Claims Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a and 150B, 1.)*	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, 2.)*	

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 155G.)*	

315F Enrollment

The CONTRACTOR shall report QUARTERLY any DAY for which any of the following standards are not met. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 150A, 4, a and c.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Enrollment Discrepancies: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. *(See Section 150A, 4, a.)*	
3) ID Cards: The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
4) ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID cards by December 15 (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.)*	

Performance Standards	Penalties
5) Direct Pay Terminations: The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section 255.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

315G Other

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155E.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Grievance Resolution: Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. *(See Section 245C.)*	
3) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	
4) PARTICIPANT Satisfaction Surveys: The CONTRACTOR shall achieve at or above a ninety (90%) percent satisfaction rating (defined as “top three-boxes” using a zero (0) to ten (10) rating scale with ten (10) being the highest ranking) on the health plan rating question on the CAHPS survey tool or other survey instrument as approved by the DEPARTMENT. *(See Section 225, 3, c.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
5) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident

Performance Standards	Penalties
6) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

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 2018.

These are the Uniform Benefits or "Summary Plan Description" offered under the Health Benefit Program.

This portion of the Agreement is often excerpted and provided to PARTICIPANTS as their Summary Plan Description.

The contractor shall not alter the language, benefits or exclusions and limitations, herein.

These Uniform Benefits are provided to SUBSCRIBERS via the It's Your Choice materials as their Summary Plan Description. The language in this section is written to the audience of the PARTICIPANT. Included in this section is a set of definitions which is specific to Uniform Benefits. The contractor does not need to recreate the description of benefits nor distribute it to PARTICIPANTS.

These Uniform Benefits are provided to a SUBSCRIBER who is a retired public employee under Wis. Stat. § 40.02 (25) (b) 11, or any DEPENDENT of such an employee, and, if eligible, has acted under Wis. Stat. § 40.51 (10) to elect group health insurance coverage. SUBSCRIBERS or DEPENDENTS who are ineligible and unenrolled in Medicare may join Program Option 16. SUBSCRIBERS or DEPENDENTS who are eligible and enrolled in Medicare may join Program Option 12. Benefits will be provided to SUBSCRIBERS via the Local Annuitant Health Program (LAHP) materials.

I. Schedule of Benefits

All benefits are paid according to the terms of this contract between the THIRD PARTY ADMINISTRATOR(S) (TPA), the PBM, and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the contract. The SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, EMERGENCY services received from an OUT-OF-NETWORK PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE.

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

This Summary Plan Description applies to services received from IN-NETWORK PROVIDERS. If any OUT-OF-NETWORK benefits are available, YOU will be provided with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by OUT-OF-NETWORK PROVIDERS. OUT-OF-NETWORK DEDUCTIBLE amounts do not accumulate to the IN-NETWORK OUT-OF-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 TPA before such services are obtained.

The covered benefits are subject to the following:

1) DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Annual medical DEDUCTIBLE	$250 individual/$500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	None.	$1,500 per individual plan / $3,000 per family plan The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the plan pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).
Annual medical COINSURANCE	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies OOPL except as described below.	BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL.
Annual medical OUT-OF-POCKET LIMIT (OOPL)	$1,250 PARTICIPANT / $2,500 aggregate family limit except as described below.[1]	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]	After DEDUCTIBLE: $2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN pays 100%.	Covered 100%.	BENEFIT PLAN pays 100%.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $75 COPAYMENT (counts towards to OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit).[2]	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. §632.895 (16), covered 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	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 and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). 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 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Prescription Drugs	See below.	See below.	After DEDUCTIBLE: subject to medical DEDUCTIBLE above. After DEDUCTIBLE, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2]Federally required preventive services are covered at 100%.

[3] State of Wisconsin MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the MEDICARE Prime Uniform Benefits SCHEDULE OF BENEFITS.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical DEDUCTIBLE	None.	$250 individual / $500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	$500 individual / $1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). When an individual within a family plan meets the $500 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.	$1,500 per individual plan / $3,000 per family plan. The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the BENEFIT PLAN pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical COINSURANCE	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLEMEDICAL EQUIPMENT, cochlear implants and hearing aids.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visits, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.	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.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / 10% applies to medical services except for office visits, and as described below. COINSURANCE applies to OOPL except as described below.
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]	$1,250 individual / $2,500 aggregate family limit except as described below.[1]	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOPL.[1]	$2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
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	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15 per visit. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.	PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
Cochlear Implants for PARTICIPANTS age 18 and older	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLANS pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), BENEFIT PLANS pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
		treatment per PARTICIPANT per calendar year.		treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.
Prescription Drugs	See below.	See below.	See below.	After DEDUCTIBLE: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2] Federally required preventive services are covered at 100%.

[3] Wisconsin Public Employer MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the PO2 Uniform Benefits SCHEDULE OF BENEFITS.

1) Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE

2) Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.

3) Diagnostic Services Limitations: PRIOR AUTHORIZATION may be required.

4) Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): Covered up to 50 visits per PARTICIPANT for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional MEDICALLY NECESSARY visits may be available when PRIOR AUTHORIZED by the TPA, up to a maximum of 50 additional visits per therapy per PARTICIPANT per calendar year.

5) Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when MEDICALLY NECESSARY and PRIOR AUTHORIZED by the TPA; and HOSPITAL CHARGES. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for PARTICIPANTS under 18 years of age are payable as described in the preceding grid.

6) Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), hearing aids for PARTICIPANTS under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.

7) Home Care Benefits Maximum: 50 visits per PARTICIPANT per calendar year. 50 additional MEDICALLY NECESSARY visits per PARTICIPANT per calendar year may be available when authorized by the TPA.

8) HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the TPA.

9) Transplants: Limited to transplants listed in Benefits and Services Section.

10) Licensed Skilled Nursing Home Maximum: 120 days per BENEFIT PERIOD payable for SKILLED CARE.

11) Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.

12) Vision Services: One routine exam per PARTICIPANT per calendar year. Non-routine eye exams are covered as MEDICALLY NECESSARY. (Contact lens fittings are not part of the routine exam and are not covered.)

13) Oral Surgery: Limited to procedures listed in Benefits and Services Section.

14) Temporomandibular Disorders as required by Wis. Stat. §632.895 (11): The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per PARTICIPANT per calendar year. Intraoral splints are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

15) Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services Section.

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.

b) Preventive Prescription Drugs:

i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.

ii) Under the HDHP, preventive prescription drugs are not subject to the DEDUCTIBLE; however, if the preventive prescription drug is not covered at 100% as required by federal law, a COPAYMENT will be required according to the provisions of this program's benefits.

iii) The PBM will publish a list of prescriptions drugs affected by these provisions.

Prescription Drug Copayments:
Level 1 COPAYMENT: $5.00
The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:
Level 2 COINSURANCE: 20% ($50 max)
The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 COINSURANCE: 40% ($150 max)
The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOPL:
Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $600 per individual or $1,200 per family for all PARTICIPANTS.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): no annual OOPL.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS
Specialty Drug Cost Share:
Level 4 COPAYMENT: $50
The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 COINSURANCE: 40% ($200 max)
The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

3) **Certain grandfathered erectile dysfunction medication as defined by the PBM (Viagra and Caverject Injection):** the 40% Level 4 COINSURANCE ($200 max) applies to these prescription medications. However, the COINSURANCE does not accumulate toward any OOPL. YOU must continue to pay Level 4 COINSURANCE for these drugs even after other annual OOPLs have been met.

4) **Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.

5) **Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits description, are defined and limited to that meaning only:

ADVANCE CARE PLANNING: A process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. ADVANCE CARE PLANNING includes:

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

3) Weighing YOUR options about what kind of care and treatment YOU would want or not want.

4) Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive.

5) Communicating YOUR wishes and any documents with YOUR family, friends, clergy, other advisors and physician and other health care professionals.

BED AND BOARD: Means all usual and customary HOSPITAL CHARGES for: (a) Room and meals; and (b) all general care needed by registered bed patients.

BENEFIT PERIOD: Means the total duration of CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CHARGE: An amount for a health care service from a PROVIDER that is reasonable, as determined by the TPA. The TPA considers, as part of determination of CHARGE:

1) Amounts charged for similar health care services in the same general area under comparable circumstances,

2) the TPA's methodology guidelines,

3) pricing guidelines of any third party responsible for pricing a claim,

4) the negotiated rate determined between the TPA and an IN-NETWORK PROVIDER, and

5) other factors.

The term “area” means a county or other geographical area which the TPA determines is appropriate to obtain a representative cross section of amounts. For example, the “area” may be an entire state.

In some cases the amount the TPA determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the health care service. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: A specified percentage of the CHARGES that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the IN-NETWORK PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

DEPENDENT: Means, as provided herein, the SUBSCRIBER'S:

1) Spouse.[1]

2) DOMESTIC PARTNER, if elected.[2]

3) Child.[3, 4, 5]

4) Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19. [3, 4, 5]

5) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.[3, 4, 5]

6) Stepchild.[1, 3, 4, 5]

7) Child of the DOMESTIC PARTNER insured on the policy.[2, 3, 4, 5]

8) Grandchild if the parent is a DEPENDENT child.[3, 4, 5, 6]

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

[2] A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

[3] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, 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.

[4] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

[5] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

[6] A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

DOMESTIC PARTNER: Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

1) Each individual is at least 18 years old and otherwise competent to enter into a contract.

2) Neither individual is married to, or in a domestic partnership with, another individual.

3) The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.

4) The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY.

5) The two individuals agree to be responsible for each other's basic living expenses.

6) The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

   a) Only one of the individuals has legal ownership of the residence.

   b) One or both of the individuals have one or more additional residences not shared with the other individual.

   c) One of the individuals leaves the common residence with the intent to return.

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 TPA and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

ELIGIBLE EMPLOYEE: As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.

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 TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the TPA and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the TPA and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

GENERIC EQUIVALENT: Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

GRIEVANCE: Means a written complaint filed with the TPA and/or PBM concerning some aspect of the TPA and/or PBM. Some examples would be a rejection of a claim, denial of a formal REFERRAL, etc.

HABILITATION SERVICES: Means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A benefit plan that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OOPL set by the IRS. An HDHP does not pay any health care costs until the annual DEDUCTIBLE has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the TPA.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

2) qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission of Accreditation of HOSPITALS.

The term HOSPITAL does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal HOSPITAL.

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses or DOMESTIC PARTNERS.

INJURY: Means bodily damage that results directly and independently of all other causes from an accident.

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The TPA agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the TPA in advance of the services being provided.

LEVEL "M" DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be on the MEDICARE PRESCRIPTION DRUG PLAN'S MEDICARE Part D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the TPA.

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the TPA after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the TPA:

1) Used primarily to treat an ILLNESS or INJURY, and

2) generally not useful to a person in the absence of an ILLNESS or INJURY, and

3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and

4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the TPA and/or PBM:

1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and

2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and

3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and

4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICARE: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

MEDICAID: Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this TPA.

NATURAL TOOTH: Means a tooth that would not have required restoration in the absence of a PARTICIPANT’S trauma or INJURY, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM’S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

1) Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician.

2) Re-assessment and intervention (individual and group).

3) Diabetes outpatient self-management training services (individual and group sessions).

4) Dietitian visit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-NETWORK PROVIDER: A PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the TPA'S professional directory of providers. Care from an OUT-OF-NETWORK PROVIDER may require PRIOR-AUTHORIZATION from the TPA unless it is EMERGENCY or URGENT CARE.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the allowed amount. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PHARMACY BENEFIT MANAGER (PBM): The PBM is a THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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 TPA before obtaining the services. Unless otherwise indicated by YOUR TPA, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the TPA and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the TPA PRIOR AUTHORIZATION form and approved by the TPA in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each TPA and are described in the It's Your Choice materials. The authorization from the TPA will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED visits and the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the TPA before services are rendered.

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-

language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

SELF-ADMINISTERED 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 TPA to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a TPA or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The TPA or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, DOMESTIC PARTNERS, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

SKILLED NURSING FACILITY: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a SKILLED NURSING FACILITY.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

SUBSCRIBER: An ELIGIBLE EMPLOYEE or annuitant who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits.

THIRD PARTY ADMINISTRATOR (TPA): The THIRD PARTY ADMINISTRATOR who is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the TPA, when taking into consideration, among other factors determined by the TPA, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases the amount the TPA determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. TPA approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits and Services

The benefits and services provided under the Health Benefit Program are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of IN-NETWORK chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the TPA reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see item A, 1 and item A, 2 below).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the TPA's written PRIOR AUTHORIZATION for covered services from an OUT-OF-NETWORK PROVIDER or YOU will be financially responsible for the services. The TPA may also require PRIOR AUTHORIZATION for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached SCHEDULE OF BENEFITS, a PARTICIPANT, in consideration of the employer's payment of the applicable TPA and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the TPA and/or PBM.

A. Medical/Surgical Services

1) EMERGENCY Care

a) Medical care for an EMERGENCY, as defined in Section II. Refer to the SCHEDULE OF BENEFITS for information on the EMERGENCY room COPAYMENT.

b) YOU should use IN-NETWORK HOSPITAL EMERGENCY rooms whenever possible. If YOU are not able to reach YOUR IN-NETWORK PROVIDER, go to the nearest appropriate medical facility. If YOU must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU call the TPA by the next business day or as soon as possible and tell the TPA where YOU received EMERGENCY care. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA. In addition to the cost sharing described in the SCHEDULE OF BENEFITS, EMERGENCY care from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.

c) It is recommended, to expedite claims processing, that YOU (or another individual on YOUR behalf) notify the TPA of EMERGENCY or URGENT CARE OUT-OF-NETWORK HOSPITAL admissions or facility CONFINEMENTS by the next business day after admission or as soon

as reasonably possible. This will help to expedite claims payment. OUT-OF-AREA SERVICE means medical care received outside the defined SERVICE AREA.

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

xiv) Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the EMERGENCY room.

2) URGENT CARE

a) Medical care received in an URGENT CARE situation as defined in Section II. URGENT CARE is not EMERGENCY care. It does not include care that can be safely postponed until the PARTICIPANT can receive care from an IN-NETWORK PROVIDER.

b) YOU must receive URGENT CARE from an IN-NETWORK PROVIDER if YOU are in the SERVICE AREA, unless it is not reasonably possible. If YOU are out of the SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If YOU must go to an

OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU contact YOUR TPA by the next business day or as soon as possible and tell the TPA where YOU received URGENT CARE; this will expedite claims payment. URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA.

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

3) Surgical Services
Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include:

a) PREOPERATIVE and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

This does not include oral surgery procedures, which are covered as described under item 16 of this section.

PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the TPA for any PARTICIPANT who has not completed an optimal regimen of conservative care for low back pain (LBP). PRIOR AUTHORIZATION is not required for a PARTICIPANT who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PARTICIPANTS seeking surgical treatment of LBP must participate in a credible SHARED DECISION MAKING (SDM) program provided by the TPA or its contracted PROVIDERS consistent with the PRIOR AUTHORIZATION requirement.

4) Reproductive Services and Contraceptives
The following services do not require a REFERRAL to an IN-NETWORK PROVIDER who specializes in obstetrics and gynecology, however, the TPA may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

   i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit 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 TPA terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the TPA may request notification of the inpatient stay prior to the delivery or shortly thereafter.

5) Medical Services
MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an IN-NETWORK PROVIDER (or a PROVIDER that was PRIOR AUTHORIZED by YOUR TPA).

a) Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

b) Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

c) Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

d) Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e) MEDICALLY NECESSARY travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the PARTICIPANT by the TPA. It does not apply to travel required for work. (See Exclusions, Section IV, A, 2, e.)

f) Injectable and infusible medications, except for SELF-ADMINISTERED INJECTABLE medications.

g) NUTRITIONAL COUNSELING provided by a participating registered dietician or an IN-NETWORK PROVIDER.

h) A second opinion from an IN-NETWORK PROVIDER or when PRIOR AUTHORIZED by the TPA.

i) Preventive services as required by the federal Patient Protection and Affordable Care Act.

6) Anesthesia Services
Covered when provided in connection with other medical and surgical services covered under these Uniform Benefits. It will also include anesthesia services for dental care as provided under item B, 1, c of this section.

7) Radiation Therapy and Chemotherapy
Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an IN-NETWORK PROVIDER.

8) Detoxification Services
Covers MEDICALLY NECESSARY detoxification services provided by an IN-NETWORK PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an IN-NETWORK PROVIDER.

9) Ambulance Service
Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the TPA) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the TPA'S SERVICE AREA, the TPA or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or urgent transportation is obtained.

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if

correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PRIOR AUTHORIZATIONS are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11) Outpatient Rehabilitation, Physical, Speech and Occupation Therapy
MEDICALLY NECESSARY HABILITATION or REHABILITATION SERVICES and treatment as a result of ILLNESS or INJURY, provided by an IN-NETWORK PROVIDER. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be PRIOR AUTHORIZED by the TPA if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12) Home Care Benefits
Care and treatment of a PARTICIPANT under a plan of care. The IN-NETWORK PROVIDER must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)

d) MEDICAL SUPPLIES, drugs and medicines prescribed by an IN-NETWORK PROVIDER; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.

e) NUTRITIONAL COUNSELING. A registered dietician must give or supervise these services.

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

Home care will not be covered unless the attending physician certifies that:

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A PARTICIPANT may have been CONFINED IN A HOSPITAL just before home care started. If so, the home care plan must be approved, at its start, by the PROVIDER who was the primary PROVIDER of care during the HOSPITAL CONFINEMENT.

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the TPA if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the TPA. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the TPA.

Covers ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

Covers a one-time in-home palliative consult after the PARTICIPANT receives a terminal diagnosis regardless of whether his or her life expectancy is 6 months or less.

HOSPICE CARE is available to a PARTICIPANT who is CONFINED. Inpatient CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a TPA-approved or MEDICARE-certified HOSPICE CARE facility.

When benefits are payable under both this HOSPICE CARE benefit and the Home Care Benefits, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14) Phase II Cardiac Rehabilitation

Services must be approved by the TPA and provided in an outpatient department of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of:

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

15) Extraction of NATURAL TEETH and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/or total replacement (limited to, bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the TPA before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

16) Oral Surgery

PARTICIPANTS should contact the TPA prior to any oral surgery to determine if PRIOR AUTHORIZATION by the TPA is required. When performed by IN-NETWORK PROVIDERS, approved surgical procedures are as follows:

a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

e) Apicoectomy. (Excision of apex of tooth root.)

f) Excision of exostoses of the jaws and hard palate.

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

18) Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the TPA in order to be a covered transplant. Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

a) Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:

i) Aplastic anemia

ii) Acute leukemia

iii) Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the TPA.

h) In addition to the above-listed diagnoses for covered transplants, the TPA may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the TPA determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants 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 TPA.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The TPA may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the TPA.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

   c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
   EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up

care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA.

   a) Outpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "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 TPA within 72 hours after the initial provision of service.

   d) Other
   Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section 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 TPA.

(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 TPA:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the TPA, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the TPA.

k) Other medical equipment and supplies as approved by the TPA. Rental or purchase of equipment/supplies is at the option of the TPA.

l) When PRIOR AUTHORIZED as determined by the TPA, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the TPA will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the TPA. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the TPA. Additional visits may be approved by the TPA. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any TPA under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and

dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for 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 TPA.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The TPA, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED 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 TPA or a contracted PROVIDER administers the injection. If the TPA or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.

d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED 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 TPAs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 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 TPA and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   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 TPA.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, 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 TPA.

c) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

d) All separately billed donor-related services, except for kidney transplants.

e) Non-human organ transplants or artificial organs.

7) Reproductive Services

a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c) Services for storage or processing of semen (sperm); donor sperm.

d) Harvesting of eggs and their cryopreservation.

e) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the TPA.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the TPA.

c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the TPA.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the TPA. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED 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 TPA and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) 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 TPA and/or PBM, or services received after the TPA and/or PBM coverage or eligibility terminates. Except when

a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under TPAs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding TPA will be the responsibility of the succeeding TPA unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding TPA's network. In this instance, the liability will remain with the previous TPA.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the TPA and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

   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 TPA.

v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the TPA. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the TPA.

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 TPA 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 TPA. The treatment of the complication must be a covered benefit of the TPA and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any TPA as part of this program.

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 TPA to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the TPA's and/or PBM's Control: If, due to circumstances not reasonably within the control of the TPA and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the TPA and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the TPA, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other

benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section 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 TPA has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the TPA any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the TPA may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The TPA will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the TPA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1) The persons it has paid or for whom it has paid,

2) Insurance companies, or

3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the TPA and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the TPA and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the TPA, provide any relevant and reasonably available information which the TPA believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the TPA and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the TPA's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The TPA, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the TPA, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The TPA may employ a professional staff to provide case management services. As part of this case management, the TPA or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the TPA agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the TPA's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the TPA. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the TPA or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The TPA and/or PBM might pay more than the TPA and/or PBM owes under the policy. If so, the TPA and/or PBM can recover the excess from YOU. The TPA and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the TPA and/or PBM.

Each PARTICIPANT agrees to reimburse the TPA and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the TPA and/or PBM. At the option of the TPA and/or PBM, benefits for future CHARGES may be reduced by the TPA and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a TPA or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the TPA provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The TPA'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

1) The third party or any liability or other insurance covering the third party.

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the TPA or DEPARTMENT to such extent.

The TPA'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the TPA'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the TPA'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the TPA or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the TPA or DEPARTMENT such additional information as is reasonably requested by the TPA or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the TPA'S or DEPARTMENT'S rights against a third party. The TPA or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the TPA or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the TPA or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the TPA or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the TPA or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the TPA or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the TPA or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in

making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the TPA or DEPARTMENT for all amounts theretofore or thereafter paid by the TPA or DEPARTMENT which would have otherwise been recoverable under such acts and the TPA or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the TPA or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the TPA and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the TPA, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the TPA and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the TPA and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating TPAs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the TPA and/or PBM. Contact the TPA and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the TPA and/or PBM. The TPA and/or PBM will advise YOU of YOUR

right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the TPA and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the TPA and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the TPA's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the TPA and/or PBM breached its contract with the Group Insurance Board.

EXHIBIT 2

Standard Terms And Conditions (Request For Bids / Proposals)

1.0 SPECIFICATIONS: The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid/proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 DEVIATIONS AND EXCEPTIONS: Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 QUALITY: Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 QUANTITIES: The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 DELIVERY: Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 PRICING AND DISCOUNT: The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the contractor which are demonstrated to be industrywide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 UNFAIR SALES ACT: Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 ACCEPTANCE-REJECTION: The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 METHOD OF AWARD: Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 ORDERING: Purchase orders or releases via purchasing cards shall be placed directly to the contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements

are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW AND COMPLIANCE: This contract shall be governed under the laws of the State of Wisconsin. The contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel this contract if the contractor fails to follow the requirements of s. 77.66, Wis. Stats., and related statutes regarding certification for collection of sales and use tax. The State of Wisconsin also reserves the right to cancel this contract with any federally debarred contractor or a contractor that is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

16.0 ANTITRUST ASSIGNMENT: The contractor and the State of Wisconsin recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State of Wisconsin (purchaser). Therefore, the contractor hereby assigns to the State of Wisconsin any and all claims for such overcharges as to goods, materials or services purchased in connection with this contract.

17.0 ASSIGNMENT: No right or duty in whole or in part of the contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION / AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan by the contractor. An exemption occurs from this requirement if the contractor has a workforce of less than fifty (50) employees. Within fifteen (15) working days after the contract is awarded, the contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

19.2 The contractor agrees to post in conspicuous places, available for employees and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the contractor's becoming declared an "ineligible" contractor, termination of the contract, or withholding of payment.

20.0 PATENT INFRINGEMENT: The contractor selling to the State of Wisconsin the articles described herein guarantees the articles were manufactured or produced in accordance with applicable federal labor laws. Further, that the sale or use of the articles described herein will not infringe any United States patent. The contractor covenants that it will at its own expense defend every suit which shall be brought against the State of Wisconsin (provided that such contractor is promptly notified of such suit, and all papers therein are delivered to it) for any alleged infringement of any patent by reason of the sale or use of such articles, and agrees that it will pay all costs, damages, and profits recoverable in any such suit.

21.0 SAFETY REQUIREMENTS: All materials, equipment, and supplies provided to the State of Wisconsin must comply fully with all safety requirements as set forth by the Wisconsin Administrative Code and all applicable OSHA Standards.

22.0 WARRANTY: Unless otherwise specifically stated by the bidder/proposer, equipment purchased as a result of this request shall be warranted against defects by the bidder/proposer for one (1) year from date of receipt. The equipment manufacturer's standard warranty shall apply as a minimum and must be honored by the contractor.

23.0 INSURANCE RESPONSIBILITY: The contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employees engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin public records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot be copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin public records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employees and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

31.0 PROMOTIONAL ADVERTISING / NEWS RELEASES: Reference to or use of the State of Wisconsin, any of its departments, agencies or other subunits, or any state official or employee for commercial promotion is prohibited. News releases pertaining to this procurement shall not be made without prior approval of the State of Wisconsin. Release of broadcast e-mails pertaining to this procurement shall not be made without prior written authorization of the contracting agency.

32.0 HOLD HARMLESS: The contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the contractor, or of any of its contractors, in prosecuting work under this agreement.

33.0 FOREIGN CORPORATION: A foreign corporation (any corporation other than a Wisconsin corporation) which becomes a party to this Agreement is required to conform to all the requirements of Chapter 180, Wis. Stats., relating to a foreign corporation and must possess a certificate of authority from the Wisconsin Department of Financial Institutions, unless the corporation is transacting business in interstate commerce or is otherwise exempt from the requirement of obtaining a certificate of authority. Any foreign corporation which desires to apply for a certificate of authority should contact the Department of Financial Institutions, Division of Corporation, P. O. Box 7846, Madison, WI 53707-7846; telephone (608) 261-7577.

34.0 WORK CENTER PROGRAM: The successful bidder/proposer shall agree to implement processes that allow the State agencies, including the University of Wisconsin System, to satisfy the State's obligation to purchase goods and services produced by work centers certified under the State Use Law, s.16.752, Wis. Stat. This shall result in requiring the successful bidder/proposer to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses.

35.0 FORCE MAJEURE: Neither party shall be in default by reason of any failure in performance of this Agreement in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the party.

State of Wisconsin
Department of Administration
DOA-3681 (01/2001)
ss. 16, 19 and 51, Wis. Stats.

Division of Agency Services
Bureau of Procurement

EXHIBIT 3

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor; and

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential contractor shall certify in writing to the procuring agency that no relationship exists between the potential contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employee or who is retained as a contractor full-time by a State of Wisconsin agency from being retained as a contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.0831 Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

7.0 RECORDKEEPING AND RECORD RETENTION: The contractor shall establish and maintain adequate records of all expenditures incurred under the contract. All records must be kept in accordance with generally accepted accounting procedures. All procedures must be in accordance with federal, state and local ordinances.

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the contractor. The contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

8.0 INDEPENDENT CAPACITY OF CONTRACTOR: The parties hereto agree that the contractor, its officers, agents, and employees, in the performance of this agreement shall act in the capacity of an independent contractor and not as an officer, employee, or agent of the state. The contractor agrees to take such steps as may be necessary to ensure that each subcontractor of the contractor will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the state.

EXHIBIT 4

Department Terms and Conditions

1.0 ENTIRE AGREEMENT: This Contract, its exhibits, subsequent amendments and the documents incorporated by order of precedence contain the entire understanding between the parties on the subject matter hereof, and no representations, inducements, promises, or agreements, oral or otherwise, not embodied herein shall be of any force or effect. This Contract supersedes any other oral or written agreement entered into between the parties on the subject matter hereof.

This Contract may be amended at any time by written mutual agreement, but any such amendment shall be without prejudice to any claim arising prior to the date of the change. No one, except duly authorized officers or agents of the Contractor and the Department, shall alter or amend this Contract. No change in this Contract shall be valid unless evidenced by an amendment that is signed by such officers of the Contractor and the Department.

2.0 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW: In the event of a conflict between this Contract and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state.

The Contractor shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the Department upon request.

The Contractor acknowledges that Wis. Stat. § 40.07 specifically exempts information related to individuals in the records of the Department of Employee Trust Funds from the Wisconsin Public Records Law. Contractor shall treat any such records provided to or accessed by Contractor as non-public records as set forth in Wis. Stat. § 40.07.

Contractor will comply with the provisions of Wis. Stat. § 134.98**.**

3.0 LEGAL RELATIONS: The Contractor shall at all times comply with and observe all federal and State laws, local laws, ordinances, and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct. This includes but is not limited to laws regarding compensation, hours of work, conditions of employment and equal opportunities for employment.

In carrying out any provisions of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters that the Department acts as an agent of the State.

The Contractor accepts full liability and agrees to hold harmless the State, the Department's governing boards, the Department, its employees, agents and contractors for any act or omission of the Contractor, or any of its employees, in connection with this Contract.

No employee of the Contractor may represent himself or herself as an employee of the Department or the State.

4.0 CONTRACTOR: The Contractor will be the sole point of contact with regard to contractual matters, including the performance of Services and the payment of any and all charges resulting from contractual obligations.

None of the Services to be provided by the Contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without prior written notification to, and approval of, the Department.

After execution of the Contract, ETF will provide a designated contact person and commit to a timely approval process for notification of a change in subcontractor(s) and/or delegated services.

The Contractor shall be solely responsible for its actions and those of its agents, employees or subcontractors under this Contract. The Contractor will be responsible for Contract performance when subcontractors are used. Subcontractors must abide by all terms and conditions of this Contract.

Neither the Contractor nor any of the foregoing parties has the authority to act or speak on behalf of the State of Wisconsin.

The Contractor will be responsible for payment of any losses by subcontractors or agents.

Any notice required or permitted to be given shall be deemed to have been given on the date of delivery or three (3) Business Days after mailing by the United States Postal Service, certified or registered mail-receipt requested. In the event the Contractor moves or updates contact information, the Contractor shall inform the Department of such changes in writing within ten (10) Business Days. The Department shall not be held responsible for payments delayed due to the Contractor's failure to provide such notice.

5.0 **CONTRACTOR PERFORMANCE:** Work under this Contract shall be performed in a timely, professional and diligent matter by qualified and efficient personnel and in conformity with the strictest quality standards mandated or recommended by all generally-recognized organizations establishing quality standards for the work of the type to be performed hereunder. The Contractor shall be solely responsible for controlling the manner and means by which it and its employees or its subcontractors perform the Services, and the Contractor shall observe, abide by, and perform all of its obligations in accordance with all legal and Contract requirements.

Without limiting the foregoing, the Contractor shall control the manner and means of the Services so as to perform the work in a reasonably safe manner and comply fully with all applicable codes, regulations and requirements imposed or enforced by any government agencies. Notwithstanding the foregoing, any stricter standard provided in plans, specifications or other documents incorporated as part of this Contract shall govern.

The Contractor shall provide the Services with all due skill, care, and diligence, in accordance with accepted industry practices and legal requirements, and to the Department's satisfaction; the Department's decision in that regard shall be final and conclusive.

All Contractor's Services under this Contract shall be performed in material compliance with the applicable federal and state laws and regulations in effect at the time of performance, except when imposition of a newly enacted or revised law or regulation would result in an unconstitutional impairment of this Contract.

The Contractor will make commercially reasonable efforts to ensure that Contractor's professional and managerial staff maintain a working knowledge and understanding of all federal and state laws, regulations, and administrative code appropriate for the performance of their respective duties, as well as contemplated changes in such law which affect or may affect the Service under this Contract.

The Contractor shall maintain a written contingency plan describing in detail how it will continue operations and Services under the Contract in certain events including, but not limited to, strike and disaster, and shall submit it to the Department upon request.

6.0 **AUDIT PROVISION:** The Contractor and its authorized subcontractors are subject to audits by the State of Wisconsin, the Legislative Audit Bureau (LAB), an independent Certified Public Accountant (CPA), or other representatives as authorized by the State of Wisconsin. The Contractor will cooperate with such efforts and provide all requested information permitted under the law.

Authorized personnel shall have access to interview any Contractor's or subcontractor's employee or authorized agent involved with this Contract in conjunction with any audit, review, or investigation deemed necessary by the State of Wisconsin.

7.0 **CRIMINAL BACKGROUND VERIFICATION:** The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://oser.state.wi.us/docview.asp?docid=6658). The Contractor is expected to perform background checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

8.0 **COMPLIANCE WITH ON-SITE PARTY RULES AND REGULATIONS:** Contractor and the State of Wisconsin agree that their employees, while working at or visiting the premises of the other party, shall comply with all internal rules and regulations of the other party, including security procedures, and all applicable federal, state, and local laws and regulations applicable to the location where said employees are working or visiting.

The Department is responsible for allocating building and equipment access, as well as any other necessary Services available from the Department that may be used by the Contractor. Any use of the Department facilities, equipment, internet access, and/or services shall only be for project purposes as authorized by the Department. The Contractor will provide its own personal computers, which must comply with the Department security policies before connection

to the Department's local computer network.

9.0 SECURITY OF PREMISES, EQUIPMENT, DATA AND PERSONNEL: The State of Wisconsin shall have the right, acting by itself or through its authorized representatives, to enter the premises of the Contractor at mutually agreeable times to inspect and copy the records of the Contractor and the Contractor's compliance with this section. In the course of performing Services under this Contract, the Contractor may have access to the personnel, premises, equipment, and other property, including data files, information, or materials (collectively referred to as "data") belonging to the State.

The Contractor shall be responsible for damage to the State's equipment, workplace, and its contents, or for the loss of data, when such damage or loss is caused by the Contractor, contracted personnel, or subcontractors, and shall reimburse the State accordingly upon demand. This remedy shall be in addition to any other remedies available to the State by law or in equity.

10.0 BREACH NOT WAIVER: A failure to exercise any right, or a delay in exercising any right, power or remedy hereunder on the part of either party shall not operate as a waiver thereof. Any express waiver shall be in writing and shall not affect any event or default other than the event or default specified in such waiver. A waiver of any covenant, term or condition contained herein shall not be construed as a waiver of any subsequent breach of the same covenant, term or condition. The making of any payment to the Contractor under this Contract shall not constitute a waiver of default, evidence of proper Contractor performance, or acceptance of any defective item or Services furnished by the Contractor.

11.0 SEVERABILITY: The provisions of this Contract shall be deemed severable and the unenforceability of any one or more provisions shall not affect the enforceability of any of the other provisions. If any provision of this Contract, for any reason, is declared to be invalid, unenforceable, or illegal, the parties shall substitute an enforceable provision that, to the maximum extent possible in accordance with applicable law, preserves the original intentions and economic positions of the parties.

12.0 LIQUIDATED DAMAGES: The Contractor and Department acknowledge that it can be difficult to ascertain actual damages when a Contractor fails to carry out the responsibilities of this Contract. Because of that, the Contractor and Department will negotiate liquidated damages, as required by the State of Wisconsin, for this Contract. The Contractor agrees that the Department shall have the right to liquidate such damages, through deduction from the Contractor's invoices, in the amount equal to the damages incurred, or by direct billing to the Contractor.

The Department shall notify the Contractor in writing of any claim for liquidated damages pursuant to this section within thirty (30) Calendar Days after the Contractor's failure to perform in accordance with the terms and conditions of this Contract.

Notwithstanding the foregoing language, when necessary the Department will identify in the RFP specific financial penalties for failure of the Contractor to meet performance standards and guarantees that may be set forth in the RFP.

13.0 CONTRACT DISPUTE RESOLUTION: In the event of any dispute or disagreement between the parties under this Contract, whether with respect to the interpretation of any provision of this Contract, or with respect to the performance of either party hereto, except for breach of Contractor's intellectual property rights, each party shall appoint a representative to meet for the purpose of endeavoring to resolve such dispute or negotiate for and adjustment to such provision.

No legal action of any kind, except for the seeking of equitable relief in the case of the public's health, safety or welfare, may begin in regard to the dispute until this dispute resolution procedure has been elevated to the Contractor's highest executive authority and the equivalent executive authority within the Department, and either of the representatives in good faith concludes, after a good faith attempt to resolve the dispute, that amicable resolution through continued negotiation of the matter at issue does not appear likely.

The party believing itself aggrieved (the "Invoking Party") shall call for progressive management involvement in the dispute negotiation by delivering written notice to the other party. Such notice shall be without prejudice to the Invoking Party's right to any other remedy permitted by this Contract. After such notice, the parties shall use all reasonable efforts to arrange personal meetings and/or telephone conferences as needed, at mutually convenient times and places, between authorized negotiators for the parties at the following successive management levels, each of which shall have a period of allotted time as specified below which to attempt to resolve the dispute:

Level	Contractor	The Department	Allotted Time
First Second	Level 1 entity	Deputy Office Director Office	10 Business Days
	Level 2 entity	Director	20 Business Days
Third	Level 3 entity	Secretary	30 Business Days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is days from the date that the Invoking Party's notice was originally received by the other party. If the Third Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's

original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the section below. The time periods herein are in addition to those periods for a party to cure provided elsewhere in this Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

14.0 **CONTROLLING LAW:** All questions as to the execution, validity, interpretation, construction and performance of this Contract shall be construed in accordance with the laws of the State of Wisconsin, without regard to any conflicts of laws or choice of law principles. Any court proceeding arising or related to this Contract or a party's obligations hereunder shall be exclusively brought and exclusively maintained in the State of Wisconsin, Dane County Circuit Court, or in the District Court of the United States Western District (if jurisdiction is proper in federal court), or upon appeal to the appellate courts of corresponding jurisdiction, and Contractor hereby consents to the exclusive jurisdiction and exclusive venue therein and waives any right to object to such jurisdiction or venue. To the extent that in any jurisdiction Contractor may now or hereafter be entitled to claim for itself or its assets immunity from suit, execution, attachment (before or after judgment) or other legal process, Contractor, to the extent it may effectively do so, irrevocably agrees not to claim, and it hereby waives, the same.

15.0 **RIGHT TO SUSPEND OPERATIONS:** If, at any time during the period of this Contract, the Department determines that the best interest of the Department or its governing boards would be best served by the Contractor's temporarily holding of all Services, the Department will promptly notify the Contractor. Upon receipt of such notice, the Contractor shall suspend all Services.

16.0 **TERMINATION OF THIS CONTRACT:** The Department may terminate this Contract at any time at its sole discretion by delivering one-hundred eighty (180) Calendar Days written notice to the Contractor.

Upon termination, the Department's liability shall be limited to the prorated cost of the Services performed as of the date of termination plus expenses incurred with the prior written approval of the Department.

If the Contractor terminates this Contract, it shall refund all payments made hereunder by the Department to the Contractor for work not completed or not accepted by the Department. Such termination shall require written notice to that effect to be delivered by the Contractor to the Department not less than one-hundred eighty (180) Calendar Days prior to said termination.

Upon any termination of this Contract, the Contractor shall perform the Services specified in a transition plan if so requested by the Department; provided, however, that except as expressly set forth otherwise herein, the Contractor shall not be obligated to perform such Services unless all amounts due to the Contractor under this Contract, including payment for the transition Services, have been paid. Failure of the Contractor to comply with a transition plan upon request and upon payment shall constitute a separate breach for which the Contractor shall be liable.

Upon the expiration or termination for any reason, each party shall be released from all obligations to the other arising after the expiration date or termination date, except for those that by their terms survive such termination or expiration.

17.0 **TERMINATION FOR CAUSE:** If the Contractor fails to perform any material requirement of this Contract, breaches any material requirement of this Contract, or if the Contractor's full and satisfactory performance of this Contract is substantially endangered, the Department may terminate this Contract. Before terminating this Contract, the Department shall give written notice of its intent to terminate to Contractor after a thirty (30) Day written notice and cure period.

The State of Wisconsin reserves the right to cancel this Contract in whole or in part without penalty in one (1) or more of the following occurrences:

- **(a)** If the Contractor intentionally furnished any statement, representation, warranty, or certification in connection with its Proposal which is materially false, incorrect, or incomplete;
- **(b)** If applicable, fails to follow the sales and use tax certification requirements of Wis. Stat. § 77.66;
- **(c)** Incurs a delinquent Wisconsin tax liability;
- **(d)** Fails to submit a non-discrimination or affirmative action plan per the requirements of Wis. Stat. § 16.765 and Wisconsin's Fair Employment Law, subch. II, Chapter 111 of the Wisconsin Statutes as required herein;
- **(e)** Is presently identified on the list of parties excluded from State of Wisconsin procurement and non-procurement Contracts;
- **(f)** Becomes a state or federal debarred Contractor, or becomes excluded from state Contracts, or;
- **(g)** Fails to maintain and keep in force all required insurance, permits and licenses as required per this Contract;
- **(h)** Fails to maintain the confidentiality of the State of Wisconsin's information that is considered to be Confidential Information or Protected Health Information;
- **(i)** Files a petition in bankruptcy, become insolvent, or otherwise takes action to dissolve as a legal entity; or,
- **(j)** If at any time the Contractor's performance threatens the health or safety of a State of Wisconsin employee, citizen, or customer.
- **(k)** Violation of any requirements in Section 22 regarding Confidential Information.

In the event of a termination for cause by the State of Wisconsin, the State of Wisconsin shall be liable for payments for

any work accepted by the State of Wisconsin prior to the date of termination.

18.0 **REMEDIES OF THE STATE:** The State of Wisconsin shall be free to invoke any and all remedies permitted under Wisconsin law. In particular, if the Contractor fails to perform as specified in this Contract, the State of Wisconsin may issue a written notice of default providing for at least a seven (7) Business Day period in which the Contractor shall have an opportunity to cure, provided that cure is possible, feasible, and approved in writing by the State of Wisconsin. Time allowed for cure of a default shall not diminish or eliminate the Contractor's liability. If the default remains, after opportunity to cure, then the State of Wisconsin may: (1) exercise any remedy provided in law or in equity or (2) terminate Contractor's Services.

If the Contractor fails to remedy any delay or other problem in its performance of this Contract after receiving reasonable notice from the State of Wisconsin to do so, the Contractor shall reimburse the State of Wisconsin for all reasonable costs incurred as a direct consequence of the Contractor's delay, action, or inaction.

In case of failure to deliver Services in accordance with or Services from other sources as necessary, Contractor shall be responsible for the additional cost, including purchase price and administrative fees. This remedy shall be in addition to any other legal remedies available to the State of Wisconsin.

19.0 **TRANSITIONAL SERVICES:** Upon cancellation, termination, or expiration of this Contract for any reason, the Contractor shall provide reasonable cooperation, assistance and Services, and shall assist the State of Wisconsin to facilitate the orderly transition of the work hereunder to the State of Wisconsin and or to an alternative Contractor selected for the transition upon written notice to the Contractor at least thirty (30) business days prior to termination or cancellation, and subject to the terms and conditions set forth herein.

20.0 **ADDITIONAL INSURANCE RESPONSIBILITY:** The Contractor shall exercise due diligence in providing Services under this Contract. In order to protect the Board's governing the Department and any Department employee against liability, cost, or expenses (including reasonable attorney fees) which may be incurred or sustained as a result of Contractors errors or other failure to comply with the terms of this Contract, the selected Contractor shall maintain errors and omissions insurance including coverage for network and privacy risks, breach of privacy and wrongful disclosure of information in an amount acceptable to the Department with a minimum of **$1,000,000** and **$5,000,000** aggregate per claim in force during this Contract period and for a period of three (3) years thereafter for Services completed. Contractor shall furnish the Department with a certificate of insurance for such amount. Further, this certificate shall designate the State of Wisconsin Employee Trust Funds and its affiliated boards as additional insured parties. The Department reserves the right to require higher or lower limits where warranted.

21.0 **OWNERSHIP OF MATERIALS:** Except as otherwise provided in subsection (t) of Section 22, all information, data, reports and other materials as are existing and available from the Department and which the Department determines to be necessary to carry out the scope of Services under this Contract shall be furnished to the Contractor and shall be returned to the Department upon completion of this Contract. The Contractor shall not use it for any purpose other than carrying out the work described in this Contract.

The Department will be furnished without additional charge all data, models, information, reports, and other materials associated with and generated under this Contract by the Contractor.

The Department shall solely own all customized software, documents, and other materials developed under this Contract. Use of such software, documents, and materials by the Contractor shall only be with the prior written approval of the Department.

This Contract shall in no way affect or limit the Department's rights to use, disclose or duplicate, for any purpose whatsoever, all information and data pertaining to the Department or covered individuals and generated by the claims administration and other Services provided by Contractor under this Contract.

All files (paper or electronic) containing any Wisconsin claimant or employee information and all records created and maintained in the course of the work specified by this Contract are the sole and exclusive property of the Department. Contractor may maintain copies of such files during the term of this Contract as may be necessary or appropriate for its performance of this Contract. Moreover, Contractor may maintain copies of such files after the term of this Contract (i) for one hundred twenty (120) days after termination, after which all such files shall be transferred to the Department or destroyed by Contractor, except for any files as to which a claim has been made, and (ii) for an unlimited period of time after termination for Contractor's use for statistical purposes, if Contractor first deletes all information in the records from which the identity of a claimant or employee could be determined and certifies to the Department that all personal identifiers have been removed from the retained files.

22.0 **CONFIDENTIAL INFORMATION AND HIPAA BUSINESS ASSOCIATE AGREEMENT:** This Section is intended to cover handling of Confidential Information under state and federal law, and specifically to comply with the requirements of HIPAA, HITECH, and the Genetic Information Nondiscrimination Act (GINA) and the federal implementing regulations for those statutes requiring a written agreement with business associates.

(a) DEFINITIONS: As used in this Section, unless the context otherwise requires:

(1) Business Associate. "Business Associate" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Contractor (insert name of Contractor).

(2) Confidential Information has the meaning ascribed to it in Section 1.5 of the RFP.

(3) Covered Entity. "Covered Entity" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Department of Employee Trust Funds.

(4) HIPAA Rules. "HIPAA Rules" mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(5) Individual Personal Information "Individual Personal Information" has the meaning ascribed to it at Wis. Admin. Code ETF § 10.70 (1).

(6) Medical Record. "Medical Record" has the meaning ascribed to it at Wis. Admin. Code ETF 10.01 (3m).

(b) PROVISION OF CONFIDENTIAL INFORMATION FOR CONTRACTED SERVICES: ETF, a different business associate of ETF or a contractor performing Services for ETF may provide Confidential Information to the Contractor under this Contract as the Department determines is necessary for the proper administration of this Contract, as provided by Wis. Stat. § 40.07 (1m) (d) and (3).

(c) DUTY TO SAFEGUARD CONFIDENTIAL INFORMATION: The Contractor shall safeguard Confidential Information supplied to the Contractor or its employees under this Contract. In addition, the Contractor will only share Confidential Information with its employees on a need-to-know basis. Should the Contractor fail to properly protect Confidential Information, any cost the Department pays to mitigate the failure will be subtracted from the Contractor's invoice(s).

(d) USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor shall:

(1) Not use or disclose Confidential Information for any purpose other than as permitted or required by this Contract or as required by law. Contractor shall not use or disclose member names, addresses, or other data for any purpose other than specifically provided for in this Contract;

(2) Make uses and disclosures and requests for any Confidential Information following the minimum necessary standard in the HIPAA Rules;

(3) Use appropriate safeguards to prevent use or disclosure of Confidential Information other than as provided for by this Contract, and with respect to Protected Health Information, comply with Subpart C of 45 CFR Part 164;

(4) Not use or disclose Confidential Information in a manner that would violate Subpart E of 45 CFR Part 164 or Wis. Stat. § 40.07 if done by ETF; and

(5) If applicable, be allowed to use or disclose Confidential Information for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided the disclosures are required by law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been or is suspected of being breached.

(e) COMPLIANCE WITH ELECTRONIC TRANSACTIONS AND CODE SET STANDARDS: The Contractor shall comply with each applicable requirements of 45 C.F.R. Part 162 if the Contractor conducts standard transactions, as that term is defined in HIPAA, for or on behalf of ETF.

(f) MANDATORY REPORTING: Contractor shall report to ETF in the manner set forth in Subsection (l) any use or disclosure or suspected use or disclosure of Confidential Information not provided for by this Contract, of which it becomes aware, including breaches or suspected breaches of unsecured Protected Health Information as required at 45 CFR 164.410.

(g) DESIGNATED RECORD SET: Contractor shall make available Protected Health Information in a designated record set to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.524.

(h) AMENDMENT IN DESIGNATED RECORD SET: Contractor shall make any amendment to Protected Health Information in a designated record set as directed or agreed to by ETF pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy ETF's obligations under 45 CFR 164.526.

(i) ACCOUNTING OF DISCLOSURES: Contractor shall maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.528.

(j) COMPLIANCE WITH SUBPART E OF 45 CFR 164: To the extent Contractor is to carry out one or more of ETF's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to a covered entity in the performance of such obligation; and

(k) INTERNAL PRACTICES: Contractor shall make its internal practices, books, and records available to the Secretary of the United States Department of Labor for purposes of determining compliance with the HIPAA Rules.

(l) CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** A list of any affected members (if available);
- **b.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **c.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **d.** The date of the discovery by Contractor;
- **e.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **f.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than one (1) business day before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

(m) CLASSIFICATION LABELS: Contractor shall ensure that all data classification labels contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed by the Department.

(n) SUBCONTRACTORS: If applicable, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit Confidential Information on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information.

(o) NOTICE OF LEGAL PROCEEDINGS: If Contractor or any of its employees, agents, or subcontractors is legally required in any administrative, regulatory or judicial proceeding to disclose any Confidential Information, contractor shall give the Department prompt notice (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

(p) MITIGATION: The Contractor shall take immediate steps to mitigate any harmful effects of the suspected or actual unauthorized use, disclosure, or loss of any Confidential Information provided to Contractor under this Contract. The Contractor shall reasonably cooperate with the Department's efforts to comply with the breach notification requirements of HIPAA, to seek appropriate injunctive relief or otherwise prevent or curtail such suspected or actual unauthorized use, disclosure or loss, or to recover its Confidential Information, including complying with a

reasonable corrective action plan, as directed by the Department.

(q) COMPLIANCE REVIEWS: The Department may conduct a compliance review of the Contractor's security procedures before and during this Contract term to protect Confidential Information.

(r) AMENDMENT: The Parties agree to take such action as is necessary to amend the Contract as necessary for compliance with the HIPAA Rules and other applicable law.

(s) SURVIVAL: The obligations of Contractor under this Section survive the termination of the underlying Contract.

(t) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION: Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

1. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to ETF or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;
4. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;
5. Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and
6. If required by ETF, transmit the Confidential Information to another contractor of ETF.

23.0 INDEMNIFICATION:

23.1 SCOPE OF INDEMNIFICATION FOR INTELLECTUAL PROPERTY RIGHTS INFRINGEMENT: In the event of a claim against the Parties for Intellectual Property Rights Infringement associated with a claim for benefits, Contractor agrees to defend, indemnify and hold harmless Board and Department ("Indemnified Parties") from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Board, Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section.

23.2 SCOPE OF OTHER INDEMNIFICATION: In addition to the foregoing Section, Contractor shall defend, indemnify and hold harmless the Indemnified Parties from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section, or liability arising from or in connection with the following: (a) Contractor's performance of or failure to perform any duties or obligations under any agreement between Contractor and any third party; (b) injury to persons (including death or illness) or damage to property caused by the act or omission of Contractor or Contractor Personnel; (c) any claims or losses for Services rendered by any subcontractor, person, or firm performing or supplying Services, materials, or supplies in connection with the Contractor's performance of this Contract; (d) any claims or losses resulting to any person or third party entity injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under this Contract in a manner not authorized by this Contract, or by Federal or State statutes or regulations; and (e) any failure of the Contractor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

23.3 INDEMNIFICATION NOTICE: Department shall give Contractor prompt written notice of such claim, suit, demand, or action (provided that a failure to give such prompt notice will not relieve Contractor of its indemnification obligations hereunder except to the extent Contractor can demonstrate actual, material prejudice to its ability to mount a defense as a result of such failure). Department will cooperate, assist, and consult with Contractor in the defense or investigation of any claim made or suit filed against Department resulting from Contractor's performance under the Contract.

23.4 NO INDEMNIFICATION OBLIGATIONS: Contractor shall as soon as practicable, notify Department of any claim made or suit filed against Contractor resulting from Contractor's obligations under this Contract if such claim may involve the Department. Department has no obligation to provide legal counsel or defense to Contractor if a suit, claim, or action is brought against Contractor or its subcontractors as a result of Contractor's performance of its obligations under this Contract. In addition, Department has no obligation for the payment of any judgments or the settlement of any claims against Contractor arising from or related to this Contract. Department has not waived any right or entitlement to claim sovereign immunity under this Contract.

23.5 CONTRACTOR'S DUTY TO INDEMNIFY: Contractor shall comply with its obligations to indemnify, defend and hold the Indemnified Parties harmless with regard to claims, damages, losses and/or expenses arising from a claim for benefits under the Plan as provided herein. Contractor shall be entitled to control the defense of any such claim and to defend or settle any such claim, in its sole discretion, with counsel of its own choosing; however, Contractor shall consult with Department regarding its defense of any claim and not settle or compromise any claim or action in a manner that imposes restrictions or obligations on Department, requires any financial payment by Department, or grants rights or concessions to a third party without first obtaining Department's prior written consent. Contractor shall have the right to assert any and all defenses on behalf of the Indemnified parties, including sovereign immunity.

In carrying out any provision of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters the Department acts as an agent of the State.

The Contractor shall at all times comply with and observe all federal and state laws and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct.

24.0 EQUITABLE RELIEF: The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury shall not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Contract or under applicable law.

25.0 RIGHT TO PUBLISH OR DISCLOSE: Throughout the term of this Contract, the Contractor must secure the Department's written approval prior to the release of any information which pertains to work or activities covered by this Contract.

The parties agree that it is a breach of this Contract to disclose any information to any person that the Department or its governing boards may not disclose under Wis. Stat. § 40.07. Contractor acknowledges that it will be liable for damage or injury to persons whose Confidential Information is disclosed by any officer, employee, agent, or subcontractor of the Contractor without proper authorization.

26.0 TIME IS OF THE ESSENCE: Timely provision of the Services required under this Contract shall be of the essence of the Contract, including the provisions of the Services within the time agreed or on a date specified herein.

27.0 IDENTIFICATION OF KEY PERSONNEL AND PERSONNEL CHANGES: The Department will designate a contract administrator, who shall have oversight for performance of the Department's obligations under this Contract. The Department shall not change the person designated without prior written notification to the Contractor.

The State of Wisconsin reserves the right to approve all individuals assigned to this project. The Contractor agrees to use its best effort to minimize personnel changes during the Contract term.

At the time of contract negotiations, the Contractor shall furnish the Department with names of all key personnel assigned to perform work under this Contract and furnish the Department with criminal background checks.

The Contractor will designate a contract administrator who shall have executive and administrative oversight for performance of the Contractor's obligations under this Contract. The Contractor shall not change this designation without prior written notice to the Department.

The Contractor may not divert key personnel for any period of time except in accordance with the procedure identified in this section. The Contractor shall provide a notice of proposed diversion or replacement to the single person of contact (SPOC) at least sixty (60) days in advance, together with the name and qualifications of the person(s) who will take the place of the diverted or replaced staff. At least thirty (30) days before the proposed diversion or replacement, the Department shall notify the SPOC whether the proposed diversion or replacement is approved or rejected, and if rejected shall provide reasons for the rejection. Such approval by the Department shall not be unreasonably withheld or delayed.

Replacement staff shall be on-site within two (2) weeks of the departure date of the person being replaced. The Contractor shall provide the Department with reasonable access to any staff diverted by the Contractor.

Replacement of key personnel shall be with persons of equal ability and qualifications. The Department has the right to conduct separate interviews of proposed replacements for key personnel. The Department shall have the right to approve, in writing, the replacement of key personnel. Such approval shall not be unreasonably withheld. Failure of the Contractor to promptly replace key personnel within thirty (30) Calendar Days after departure shall entitle the Department to terminate this Contract. The notice and justification must include identification of proposed substitute key personnel and must provide sufficient detail to permit evaluation of the impact of the change on the project and/or maintenance.

Any of the Contractor's staff that the Department deems unacceptable shall be promptly and without delay removed by the Contractor from the project and replaced by the Contractor within thirty (30) Calendar Days by another employee with acceptable experience and skills subject to the prior approval of the Department. Such approval by the Department will not be unreasonably withheld or delayed.

An unauthorized change by the Contractor of any Contracted Personnel designed as key personnel will result in the imposition of liquidated damages, as defined in this Contract.

28.0 DATA SECURITY AND PRIVACY AGREEMENT

(a) PURPOSE AND SCOPE OF APPLICATION: This Data Security and Privacy Agreement (Agreement) is designed to protect the Department of Employee Trust Fund's (ETF) Confidential Information and ETF Information Resources (defined below). This Agreement describes the data security and privacy obligations of Contractor and its sub-contractors that connect to ETF Information Resources and/or gain access to Confidential Information.

(b) DEFINED TERMS:

(1) **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) Individual Personal 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); or (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 by Contractor on FORM D –Designation of Confidential and Proprietary Information (DOA-3027). Pricing information cannot be held confidential.

(2) **ETF Information Resources** means those devices, networks and related infrastructure that ETF has obtained for use to conduct ETF business. Devices include but are not limited to, ETF-owned, managed, used through service agreements storage, processing, communications devices and related infrastructure on which ETF data is accessed, processed, stored, or communicated, and may include personally owned devices. Data includes, but is not limited to, Confidential Information, other ETF created or managed business and research data, metadata, and credentials created by or issued on behalf of ETF.

(c) ACCESS TO ETF INFORMATION RESOURCES: In any circumstance when Contractor is provided access to ETF Information Resources, it is solely Contractor's responsibility to ensure that its access does not result in any access by unauthorized individuals to ETF Information Resources. Contractors who access ETF's systems from any ETF location must at a minimum conform with ETF security standards that are in effect at the ETF location(s) where the access is provided. Any Contractor technology and/or systems that gain access to ETF Information Resources must comply with, at a minimum, the elements in the Computer System Security Requirements set forth in this Agreement.

(d) COMPLIANCE WITH APPLICABLE LAWS: Contractor agrees to comply with all applicable state and federal laws, as well as industry best practices, governing the collection, access, use, disclosure, safeguarding and destruction of Confidential Information.

(e) PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor agrees to hold ETF's Confidential Information, and any information derived from such information, in strictest confidence. Contractor will not access, use or disclose Confidential Information other than to carry out the purposes for which ETF disclosed the Confidential Information to Contractor, except as permitted or required by applicable law, or as otherwise authorized in writing by ETF. For avoidance of doubt, this provision prohibits Contractor from using for its own benefit Confidential Information or any information derived from such information. If required by a court of competent jurisdiction or an administrative body to disclose Confidential Information, Contractor will notify ETF in writing immediately upon receiving notice of such requirement and prior to any such disclosure, to give ETF an opportunity to oppose or otherwise respond to such disclosure (unless prohibited by law from doing so).

(f) REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES: The Contractor's transmission, transportation or storage of Confidential Information outside the United States, or access of Confidential Information from outside the United States, is prohibited except on prior written authorization by ETF.

(g) SAFEGUARD STANDARD: Contractor agrees to protect the privacy and security of Confidential Information according to all applicable laws and regulations, including HIPAA, by commercially-acceptable frameworks or standards such as the ISO/IEC 27000-series, NIST, 800-53, RFC 2196, IEC 62443, and SANS CIS Top 20. ISO 270001, etc. Security Controls, and no less rigorously than it protects its own confidential information, but in no case less than reasonable care. Contractor will implement, maintain and use appropriate administrative, technical and physical security measures to preserve the confidentiality, integrity and availability of the Confidential Information. All Confidential Information stored on portable devices or media must be encrypted in accordance with the Federal Information Processing Standards (FIPS) Publication 140-2. Contractor will ensure that all security measures are regularly reviewed including ongoing monitoring, an annual penetration and vulnerability test, and an annual security incident response test, and revised, no less than annually, to address evolving threats and vulnerabilities while Contractor has responsibility for the Confidential Information under the terms of this Agreement. Prior to agreeing to the terms of this Agreement, and periodically thereafter (no more frequently than annually) at ETF's request, Contractor will provide assurance, in the form of a third-party audit report or other documentation acceptable to ETF, such as SOC2 Type II, demonstrating that appropriate information security safeguards and controls are in place.

(h) INFORMATION SECURITY PLAN:

(1) Contractor acknowledges that ETF is required to comply with information security standards for the protection of Confidential Information as required by law, regulation and regulatory guidance, as well as ETF's internal security program for information and systems protection.

(2) Contractor will establish, maintain and comply with an information security plan (Information Security Plan), which will contain, at a minimum, such elements as those set forth in this Agreement.

(3) Contractor's Information Security Plan will be designed to:

- **a.** Ensure the privacy, security, integrity, availability, and confidentiality of Confidential Information;
- **b.** Protect against any anticipated threats or hazards to the security or integrity of such information;
- **c.** Protect against unauthorized access to or use of such information that could result in harm or inconvenience to the person that is the subject of such information;
- **d.** Reduce risks associated with Contractor having access to ETF Information Resources; and
- **e.** Comply with all applicable legal and regulatory requirements for data protection.

(4) On at least an annual basis, Contractor will review its Information Security Plan, update and revise it as needed, and submit it to ETF upon request. At ETF's request, Contractor will make modifications to its Information Security Plan or to the procedures and practices thereunder to conform to ETF's security requirements as they exist from time to time. If there are any significant

modifications to Contractor's Information Security Plan, Contractor will notify ETF within a reasonable period of time, not to exceed two weeks. Any significant modification must include the same or a higher framework or information security standard maturity level than what currently exists in the Plan.

(i) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION:

Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

(1) Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

(2) Where feasible, return to ETF, or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;

(3) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;

(4) Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;

(5) Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and

(6) If required by ETF, transmit the Confidential Information to another contractor of ETF.

(j) NOTIFICATION OF CORRESPONDENCE CONCERNING CONFIDENTIAL INFORMATION: Contractor agrees to notify ETF immediately, both orally and in writing, but in no event more than twenty-four (24) hours after Contractor receives correspondence or a complaint regarding Confidential Information, including but not limited to, correspondence or a complaint that originates from a regulatory agency or an individual.

(k) BREACHES OF CONFIDENTIAL INFORMATION:

CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure of ETF's Confidential Information, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** The nature of the unauthorized access, use or disclosure;
- **b.** A list of any affected members (if available);
- **c.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **d.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **e.** The date of the discovery by Contractor;
- **f.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **g.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than twenty-four (24) hours before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons

potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

COORDINATION OF BREACH RESPONSE ACTIVITIES:

(4) Contractor will fully cooperate with ETF's investigation of any breach involving Contractor, including but not limited to making witnesses, documents, HIPAA logs, systems logs, video recordings, or other pertinent or useful information available immediately upon Contractor's reporting of the breach and throughout the investigation. Contractor's full cooperation will include but not be limited to Contractor:

- **a.** Immediately preserving any potential forensic evidence relating to the breach, and remedying the breach as quickly as circumstances permit
- **b.** Within forty-eight (48) hours designating a contact person to whom ETF will direct inquiries, and who will communicate Contractor responses to ETF inquiries; Contractor will designate a Privacy Officer and Security Officer to serve as contacts for ETF.
- **c.** As rapidly as circumstances permit, applying appropriate resources to remedy the breach condition, investigate, document, restore ETF service(s) as directed by ETF, and undertake appropriate response activities such as working with ETF, its representative, and law enforcement to identify the breach, identify the perpetrator(s), and take appropriate actions to remediate the security vulnerability;
- **d.** Providing status reports at least every two (2) hours until the root cause of the breach is identified and a plan is devised to fully remediate the breach;
- **e.** Once the root cause of the breach is identified and a plan is devised to fully remediate the breach, providing status reports daily or at mutually agreed upon timeframes, to ETF on breach response activities, findings, analyses, and conclusions;
- **f.** Coordinating all media, law enforcement, or other breach notifications with ETF in advance of such notification(s), unless expressly prohibited by law; and
- **g.** Ensuring that knowledgeable Contractor staff is available on short notice, if needed, to participate in ETF-initiated meetings and/or conference calls regarding the breach.

ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS:

(5) Contractor will make itself and any employees, subcontractors, or agents assisting Contractor in the performance of its obligations available to ETF at no cost to ETF to testify as witnesses, or otherwise, in the event of a breach or other unauthorized disclosure of Confidential Information caused by Contractor that results in litigation, governmental investigations, or administrative proceedings against ETF, its directors, officers, agents or employees based upon a claimed violation of laws relating to security and privacy or arising out of this Agreement or the Contract.

(l) RETENTION OF LOGS:

(1) HIPAA logs (logs of any systems that have information relating to HIPAA) must be kept for six (6) years.

(2) Firewall logs must be kept for twelve (12) months.

(m) ADDITIONAL INSURANCE: In addition to the insurance required under the Agreement, Contractor at its sole cost and expense will obtain, keep in force, and maintain an insurance policy (or policies) that provides coverage for privacy and data security breaches. This specific type of insurance is typically referred to as Privacy, Technology and Data Security Liability, Cyber Liability, or Technology Professional Liability. In some cases, Professional Liability policies may include some coverage for privacy and/or data breaches. Regardless of the type of policy in place, it needs to include coverage for reasonable costs in investigating and responding to privacy and/or data breaches with the following minimum limits unless ETF specifies otherwise: $1,000,000 Each Occurrence and $5,000,000 Aggregate.

(n) INFORMATION SECURITY PLAN REQUIREMENTS:

(1) Contractor will develop, implement, and maintain a comprehensive Information Security Plan that is written in one or more readily accessible parts and contains administrative, technical, and physical safeguards. The safeguards contained in such program must be consistent with the safeguards for protection of Confidential Information and information of a similar character set forth in any state or federal regulations by which the person who owns or licenses such information may be regulated.

(2) Without limiting the generality of the foregoing, every comprehensive Information Security Plan will include, but not be limited to:

a. Designating one or more employees to maintain the comprehensive Information Security Plan;

b. Identifying and assessing internal and external risks to the security, confidentiality, and/or integrity of any electronic, paper or other records containing Confidential Information and of ETF Information Resources, and evaluating and improving, where necessary, the effectiveness of the current safeguards for limiting such risks, including but not limited to:

c. Ongoing employee (including temporary and contract employee) training;

d. Employee compliance with policies and procedures; and

e. Means, including Contractor staff, processes, and technology, for detecting information system intrusions, data breaches, and anomalous system behavior or activity, and for preventing security breaches, intrusions, or unauthorized access to information systems or networks.

f. Developing security policies for employees relating to the storage, access and transportation of records containing Confidential Information outside of business premises.

g. Imposing disciplinary measures for violations of the comprehensive Information Security Plan rules.

h. Preventing terminated employees from accessing records containing Confidential Information and/or ETF Information Resources.

i. Overseeing service providers, by:

--Taking reasonable steps to select and retain third-party service providers that are capable of maintaining appropriate security measures to protect such Confidential Information and ETF Information Resources consistent with all applicable laws and regulations; and

-- Requiring such third-party service providers by contract to implement and maintain such appropriate security measures for Confidential Information.

j. Placing reasonable restrictions upon physical access to records containing Confidential Information and ETF Information Resources and requiring storage of such records and data in locked facilities, storage areas or containers.

k. Restrict physical access to any network or data centers that may have access to Confidential Information or ETF Information Resources.

l. Requiring regular monitoring to ensure that the comprehensive Information Security Plan is operating in a manner reasonably calculated to prevent unauthorized access to or

unauthorized use of Confidential Information and ETF Information Resources; and upgrading information safeguards as necessary to limit risks.

m. Reviewing the scope of the security measures at least annually or whenever there is a material change in business practices that may reasonably implicate the security or integrity of records containing Confidential Information and of ETF Information Resources.

n. Documenting responsive actions taken in connection with any incident involving a breach, and mandating post-incident review of events and actions taken, if any, to make changes in business practices relating to protection of Confidential Information and ETF Information Resources.

(o) COMPUTER SYSTEM SECURITY REQUIREMENTS: To the extent that Contractor electronically stores or transmits Confidential Information or has access to any ETF Information Resources, it will include in its written, comprehensive Information Security Plan the establishment and maintenance of a security system covering its computers, including any wireless system, that, at a minimum, and to the extent technically feasible, will have the following elements:

(1) Secure user authentication protocols including:

a. Control of user IDs and other identifiers;
b. A secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;
c. Multi-Factor Authentication (MFA);
c. Control of data security passwords to ensure that such passwords are kept in a location and/or format that does not compromise the security of the data they protect;
d. Multi-factor authentication for system administrators and others with 'super-user' access rights;
e. Restricting access to active users and active user accounts only;
f. Blocking access to user identification after multiple unsuccessful attempts to gain access or the limitation placed on access for the particular system; and
g. Periodic review of user access, access rights and audit of user accounts.

(2) Secure access control measures that:

a. Restrict access to records and files containing Confidential Information and systems that may have access to ETF Information Resources to those who need such information to perform their job duties; and
b. Assign unique identifications plus passwords, which are not vendor supplied default passwords, to each person with computer access, which are reasonably designed to maintain the integrity of the security of the access controls.

(3) Encryption of all transmitted records and files containing Confidential Information.

(4) Adequate security of all networks that connect to ETF Information Resources or access Confidential Information, including wireless networks.

(5) Reasonable monitoring of systems, for unauthorized use of or access to Confidential Information and ETF Information Resources.

(6) Encryption of all Confidential Information stored on Contractor devices, including laptops or other portable storage devices.

(7) For files containing Confidential Information on a system that is connected to the Internet or that may have access to ETF Information Resources, reasonably up-to-date firewall, router and switch protection and operating system security patches, reasonably designed to maintain the integrity of the Confidential Information.

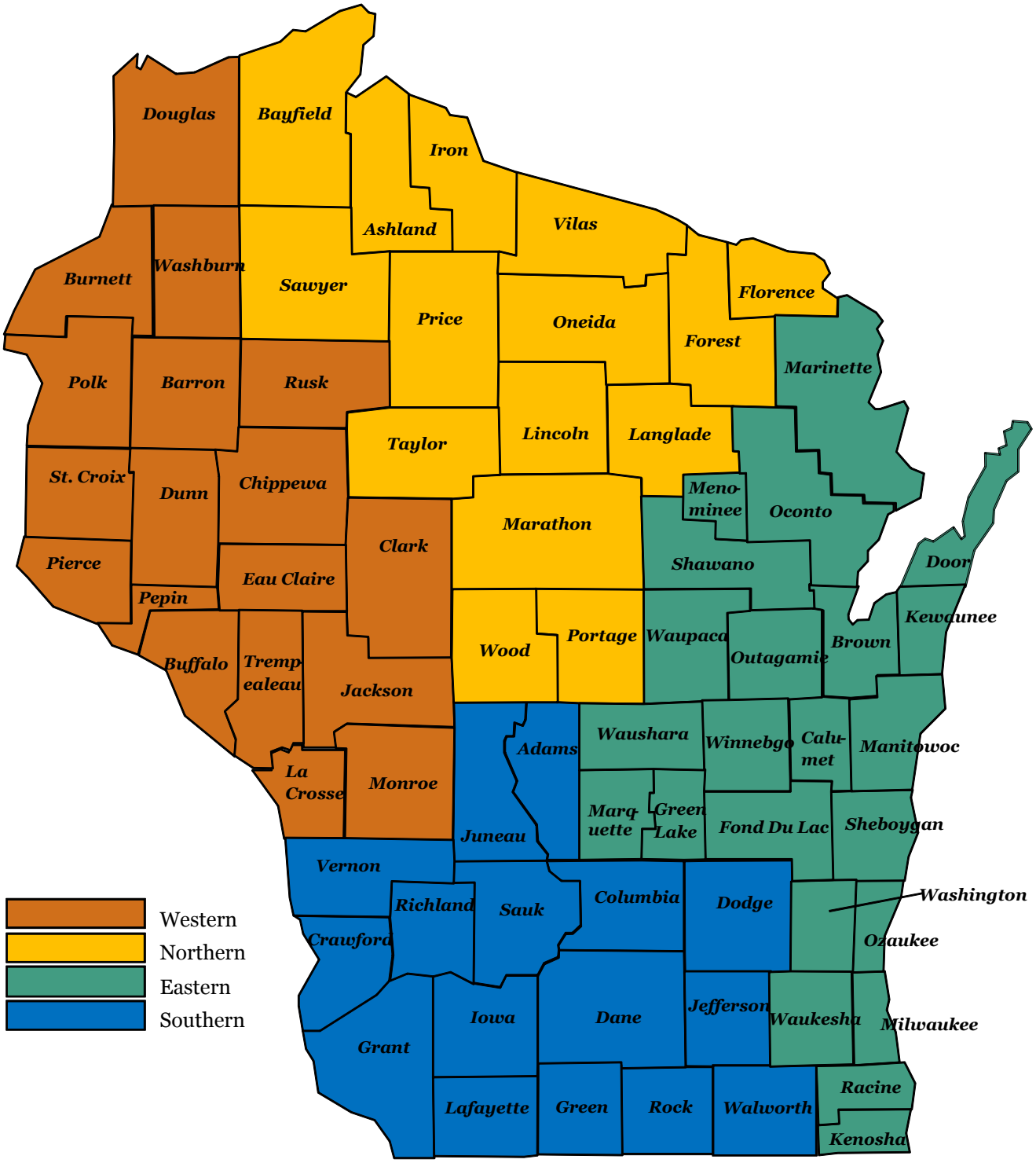
(8) Reasonably up-to-date versions of system security agent software, including intrusion detection systems, which must include malware protection and reasonably up-to-date patches and virus definitions, or a version of such software that can still be supported with up-to-date patches and virus definitions, and is set to receive the most current security updates on a regular basis.

(9) Education and training of employees on the proper use of the computer security system and the importance of Confidential Information and network security.

With reasonable notice to Contractor, ETF may require additional security measures which may be identified in additional guidance, contracts, communications or requirements.

State of Wisconsin
Department of Employee Trust Funds
Regional Map

RFP ETG0003
Exhibit 5: Map
Issued July 22, 2016



State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R07/2016)
§ 51.01(5) Wis. Stats. § 111.32(13m) Wis. Stats.

Department of Employee Trust Funds
801 W. Badger Road
P. O. Box 7931
Madison, WI 53707-7931

Contract

Commodity or Service:

Administrative Services for the State of Wisconsin Health Benefit Program

Contract No./Request for Bid/Proposal No:

ETG0003(D)
Authorized Board: Group Insurance Board

Contract Period: June 1, 2017 through December 31, 2020 with the optional renewal of three (3) two (2) year periods

1. This Contract is entered into by the State of Wisconsin, Department of Employee Trust Funds (Department), the State of Wisconsin Group Insurance Board (Board) and between Dean Health Plan. hereinafter referred to as the "Contractor", whose address and principal officer appears on page 2. The Department is the sole point of contact for this Contract.

2. Whereby the Department of Employee Trust Funds agrees to direct the purchase and the Contractor agrees to supply the Contract requirements cited in accordance with the State of Wisconsin standard terms and conditions and in accordance with the Contractor's proposal dated September 16, 2016, hereby made a part of this Contract by reference.

3. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employees or applicants for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s.51.01(5), Wis. Stats., sexual orientation as defined in s.111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

4. Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan. Contractors with an annual work force of less than fifty (50) employees are exempted from this requirement. Within fifteen (15) business days after the award of the Contract, the plan shall be submitted for approval to the Department. Technical assistance regarding this clause is provided by the Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931, 608.261.7952, or via e-mail at ETFProcurement@etf.wi.gov.

5. Contractor agrees to the Discount Guarantees and Gain Sharing Agreement in Exhibit B.

6. For purposes of administering this Contract, the order of precedence is:
   a) This Contract (Form DOA-3049) with Dean Health Plan;
   b) Exhibit A, Contract clarifications from ETF;
   c) Exhibit B, Discount Guarantees and Gain Sharing Agreement;
   d) RFP Exhibit 1 – State of Wisconsin Health Benefit Program Agreement, dated May 1, 2017;
   e) RFP Exhibit 4 – Department Terms and Conditions, dated April 26, 2017;
   f) Appendix 4a Claims Data Specifications – Medical, dated March 29, 2017;
   g) Appendix 5 Provider Data Specifications, dated March 29, 2017;
   h) Request for Proposal (RFP) ETG0003 dated July 22, 2016, including all appendices, attachments, and amendments thereto; and
   i) Contractor's proposal dated September 16, 2016.

Contract Number & Service: ETG0003(D) - Administrative Services for the State of Wisconsin Health Benefit Program

State of Wisconsin Department of Employee Trust Funds	Contractor to Complete
By Authorized Board *(Name)* **Group Insurance Board**	Legal Company Name Dean Health Plan, Inc.
By *(Name)* **Michael Farrell**	Trade Name Dean Health Plan
Signature	Taxpayer Identification Number 39-1535024
Title **Chair** Group Insurance Board	Company Address *(City, State, Zip)* 1277 Deming Way Madison, WI 53717
Phone 608.266.9854 (A. John Voelker, Deputy Secretary)	By *(print Name)* Frank Lucia
Date *(MM/DD/CCYY)*	Signature
	Title President & Chief Executive Officer
	Phone 608-827-4107
	Date *(MM/DD/CCYY)* 05/03/2017

Exhibit A

Contract ETG0003(D): Clarifications and changes agreed to by the parties to the July 22, 2016 Request for Proposal (RFP) ETG0003 Administrative Services for the State of Wisconsin Health Benefit Program to be provided by Dean Health Plan to the State of Wisconsin Department of Employee Trust Funds for the Health Insurance Programs Offered by the State of Wisconsin Group Insurance Board.

The following are clarifications to Contract terms:

#	Document / Section	Section Description	Clarification
1	n/a	n/a	Any dispute, disagreement or question of interpretation of Exhibits 2, 3, or 4 (the Terms and Conditions) and the application of those Exhibits to the terms of this contract is subject to discussion and resolution under Exhibit 4, Section 13.0 (Contract Dispute Resolution) of the Department Terms and Conditions."
2	Exhibit 1 Section 130	Premiums	The language in this section is not intended to hold a Contractor liable for payment of actuarial services related to a review of claims experience, trends and other factors covered by the rate renewal reports submitted by a Contractor pursuant to this section.
3	Exhibit 1 Section 135B	Administrative Fee Adjustments	Language as shown was drafted with the intention to allow for administrative fee increases, as recommended by ETF's actuary. Should an administrative fee change be implemented for which the TPA disagrees, the process on contract dispute resolution is provided in Exhibit 4.0, Section 13.0.
4	Exhibit 1 Section 215A	Disease Management / Prior Authorizations / Utilization Review	The contract requires prior authorizations to include member out-of-pocket cost sharing information. The intent is to base the authorization on the provider status at time of the authorization review with disclosure about any anticipated provider status change for the length of the approval period and disclosure that the member's deductible, coinsurance and/or copayment applies. Member out-of-pocket costs do not need to be amount specific and instruction should be provided on how members can obtain specific cost-sharing information. The contract also states the Contractor is responsible for the cost of services not covered under the contract when the member has received a prior authorization. The intent is to hold the Contractor accountable if it errors by prior authorizing a service that is not covered under the contract.

#	Document / Section	Section Description	Clarification
5	Exhibit 1 Sections 230 and 230D	Provider Contracts Provider Contracts Shall Include Compliance Plans	Including the provider agreement requirements outlined in Section 230 and the compliance plans outlined in Section 230D in a policy, program or process for which the provider contract requires compliance, even though the provider contract does not specifically identify such items, is deemed to meet this contractual requirement.
6	Exhibit 4 Section 28.0 (i)(2)	Data Security and Privacy Agreement	1) The data should be destroyed; 2) unless Contractor can definitely prove to ETF that the data was de-identified; and 3) that Contractor confirms to ETF in writing that no crosswalk exists to re-identify the data.
7	n/a	n/a	Based on the contract negotiations that ETF has conducted over the last several weeks with each of the six contractors, ETF now believes it is appropriate to delete references in the RFP and Section 135B of RFP Exhibit 1 specifically stating that the contractors are fiduciaries. The duties that contractors will perform are delineated throughout the RFP and Exhibit 1. Case law confirms that whether or not a contract specifically states that a contractor is a fiduciary, courts have issued decisions finding that the duties and facts in a particular situation demonstrate that a contractor is a fiduciary.
8	Exhibit 4 Section 12.0	Liquidated Damages	It is the Department's intent that the Contractor will be able to utilize the process described in Exhibit 4, Section 13.0 (Contract Dispute Resolution) prior to the Department imposing any Liquidated Damages.

Wisconsin Department of Employee Trust Funds
Discount Guarantees for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Dean Health Plan**
Region **Southern**

Vendor will provide 2018 expected overall level of discount.
ETF and Vendor will mutually agree on final starting point.

2018 Discount Target*

* A supplemental worksheet allows vendors to calculate this discount with enrollment and regional assumptions. Upon open enrollment these will be re-based accordingly.

Annual improvement - Spread between Eligible Charge Increase and Vendor Allowed Increase. Expectations on Discount improvement decrease with higher baseline discounts. Improvement is calculated as Assumed Spread x (1-Discount).

Assumed Spread

		Annual Improvement
2019 overall level of discount is expected to improve over 2018	**2019 Discount Target**	
2020 overall level of discount is expected to improve over 2019	**2020 Discount Target**	

Fees at Risk will vary by percentage below target for each of the 3 years based on the following Scale:

% of Actual Discount below Target	% of Total Admin Fees at Risk
	0%
	5%
	10%

Notes:
Actual Performance against Target Discounts will be calculated 6 months after the end of the Calendar Year with runout data available in the data warehouse at that time.
Large claims over $100,000, and any out-of-network claims, will be removed from the calculation.
Discount Percent is calculated as Total Submitted Eligible Charge less Total Allowed (state & member) divided by Total Submitted Eligible Charge.
Discount Guarantee is null and void if Gain-Sharing Actual PMPM is less than Target PMPM.

ETG0003

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Exhibit B

Vendor **Dean Health Plan**
Region **Southern**

Annual Shared Savings will be calculated based on two factors:
(1) Performance of Actual versus Target PMPM
(2) Performance of Actual versus Target Clinical Performance Measures

Performance of Actual versus Target PMPM **Illustrative Calculation**

Prior Calendar Year allowed claims for those members who select vendor during open enrollment will be used as a starting point to determine a base aggregate PMPM. The data will be normalized to the vendor's network pricing. It is anticipated that this will include 12 months of incurred allowed claims. (TBD)

A claims completion factor will be applied to the allowed claims. This will be updated with runout during the settlement process with claims paid through June of the following Calendar Year. (TBD)

Total Calendar Year Incurred Claims

Apply Industry and Market Specific Trend (TBD) - Trend assumptions will be uniform across all vendors

Calendar Year Allowed PMPM Target

Amount of savings to be shared with vendor will vary by percentage of actual PMPM below Target PMPM based on the following Scale:

	CY 2018	CY 2019	CY 2020
% of Actual PMPM below Target	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**
< 3.00%	0%	0%	0%
3.00% - 6.00%	5%	7.5%	10%
> 6.00%	10%	17.5%	25%

Notes on PMPM:
1) Target PMPM will be set by March 1st of the current CY based on prior CY incurred claims with current year enrollment, adjustment for network pricing, completion factors and trend.
2) Performance of Actual versus Target PMPM will be calculated at the end of the CY when 6 months of runout is available in the data warehouse. This results in 18 months of runout for the Target PMPM and 6 months of runout for the Actual PMPM. Note that the Actual PMPM will have a completion factor applied.

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Dean Health Plan**
Region **Southern**

Performance of Actual versus Target Clinical Performance Measures

In addition to the shared savings amounts based on Actual versus Target PMPM Calculations, payments will be reduced based on the percentage of clinical targets met by the vendor for the Calendar Year. If all clinical targets are met, payouts will be 100% of the PMPM calculations described above. If, for example, 75% of the clinical targets are met, payouts will be 75% of the PMPM calculations described above.

Clinical Targets for each year of the contract will be determined for each vendor individually by comparing actual baseline for each vendor to an ultimate target for each measure. The difference between the vendor's baseline and target will be the gap that should be closed over 3 years with equal improvement in each of the 3 years to reach the target. Examples are shown below:

	Baseline	Target	Gap	2018 Target	2019 Target	2020 Target
Vendor A	50%	90%	40%	63%	77%	90%
Vendor B	80%	90%	10%	83%	87%	90%
Vendor C	95%	90%	-5%	90%	90%	90%

ETG0003

Wisconsin Department of Employee Trust Funds
Discount Guarantee Development Worksheet

Exhibit B

Vendor **Dean Health Plan**
Region **Southern**

		Preliminary Discount Guarantee			Final Discount Guarantee		
Region	Total Members	Expected Enrollment	Expected Distribution	Discount Guarantee	Open Enrollment	Final Distribution	Discount Guarantee
Eastern	63,766						
Northern	8,151						
Southern	113,299						
Western	21,024						
In-State	206,240						
Out-of-State	3,379						
Total Membership	209,619						

After open enrollment, a final discount guarantee will be developed based on vendor's actual enrollment.
Discount guarantees by region may not be altered during this process.

ETG0003

RFP ETG0003

Exhibit 1: State of Wisconsin Health Benefit Program Agreement

Issued May 1, 2017

State of Wisconsin Health Benefit Program Agreement

Issued by the State of Wisconsin

Department of Employee Trust Funds

On behalf of the Group Insurance Board

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000 DEFINITIONS

Unless otherwise defined herein, any term needing definition shall have the definition found in Uniform Benefits (of this AGREEMENT), the RFP, the PROPOSAL or in applicable Wisconsin law. These terms, when used and capitalized in this AGREEMENT are defined and limited to that meaning only:

AGREEMENT means the State of Wisconsin Health Benefit Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

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).

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).

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 attachments, supplements, endorsements riders and the CONTRACTOR'S PROPOSAL.

CONTRACTOR means the legal signatory to this AGREEMENT.

DAY means calendar DAY unless otherwise indicated.

DEPARTMENT means the State of Wisconsin Department of Employee Trust Funds.

DEPENDENT as defined in Uniform Benefits.

DOMESTIC PARTNER as defined in Uniform Benefits.

EFFECTIVE DATE means the date, as certified by the DEPARTMENT and shown on the records of the CONTRACTOR in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

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 program that provides group health BENEFITS to eligible State of Wisconsin and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

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.

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.

PBM means the Pharmacy Benefit Manager (PBM) which is a third party administrator that is contracted with the BOARD to administer the prescription drug benefits under this HEALTH BENEFIT PROGRAM. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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.

PROPOSAL means the complete response of a proposer submitted and setting forth the proposer's pricing for providing the services described in the Request for Proposal (RFP).

QUARTERLY means a period consisting of every consecutive three (3) months beginning January 2018.

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.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the CONTRACTOR for enrollment and who is entitled to BENEFITS.

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).

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETG0003 and in the PROPOSAL.

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 (forms 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).

110 Objectives

The BOARD's objectives of the HEALTH BENEFIT PROGRAM include, but are not limited to the following:

1) Management and delivery of health care services to PARTICIPANTS through contracted networks that provide for high-quality, cost-effective care.

2) To provide excellent customer service to PARTICIPANTS.

3) To offer networks of high value providers, and to incent PARTICIPANTS to choose benefit plan designs with high value providers.

4) To provide high-quality services at a competitive price.

5) Accurate, timely and responsive administration of health care claims.

6) 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.

7) To offer tools for PARTICIPANTS to increase engagement, including:

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

8) To ensure quality population health programs, including case management and disease management, which promote proactive management of PARTICIPANT health concerns.

9) 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 to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

3) Cooperate with the DEPARTMENT to develop procedures and protocols for sharing information as necessary.

4) Provide, in a format acceptable to the DEPARTMENT, at no cost and in a timely manner, all data and written or recorded material pertaining to this AGREEMENT.

5) Provide the specified level of services as indicated in this AGREEMENT to PARTICIPANTS.

6) Assist the DEPARTMENT with the administration of this AGREEMENT, including PARTICIPANT enrollment, record keeping, and general operations.

7) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT, including but not limited to, initial determination of eligibility for DEPENDENTS for disabled and full-time student status.

8) 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.

9) Have a mechanism, as approved by the DEPARTMENT, for handling complaints and grievances made by PARTICIPANTS.

   a) This includes a formal grievance procedure, which at a minimum complies with federal law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the 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.

10) Submit to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information.

11) Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in care from OUT-OF-NETWORK providers.

12) Comply with state and federal regulations pertaining to mandated or minimum BENEFITS which may be applicable to the CONTRACTOR under insurance statutes or as directed by the BOARD.

13) Provide DEPARTMENT approved materials to PARTICIPANTS as required under this AGREEMENT.

14) Provide notification of all significant events:

a) 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 (15%) percent 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 (51%) percent) interest in the CONTRACTOR or any transfer of ten (10%) percent or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the 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."

15) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT.

16) Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32.

17) Provide coverage for PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

18) 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.

19) Shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT.

20) 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, per Wis. Stat. § 40.02 (25) (b), eligible EMPLOYEES include:

1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS).

2) Elected state officials.

3) Members or EMPLOYEES of the legislature.

4) Any blind EMPLOYEES of the Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3.

5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance.

6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave (Wis. Stat. § 40.05 (4) (bm)).

7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority:

    a) Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

b) Any teacher who is a participating EMPLOYEE and who is employed by the UW System for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

c) Certain visiting faculty members in the UW System.

d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.

e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one (1) semester for academic year (nine (9) month) or six (6) months for annual (twelve (12) month) appointments.

f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of twenty-eight (28%) percent or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one (21%) percent or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.

g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.

h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospital and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.

8) ANNUITANTS and CONTINUANTS:

a) Any covered EMPLOYEE who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

b) The surviving spouse or DOMESTIC PARTNER of a SUBSCRIBER.

c) Covered EMPLOYEES who terminate employment, have attained minimum retirement age (fifty (50) for protective services or fifty-five (55) for all other categories), have twenty (20) years of WRS creditable service and defer their annuity are eligible to continue in the HEALTH BENEFIT PROGRAM if a timely application is submitted.

d) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll 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.

e) Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for coverage through the EMPLOYER.

f) Any retired public employee under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

125B Dependent Coverage Eligibility

Individual coverage covers only the SUBSCRIBER. All eligible DEPENDENTS listed on the application are covered under a family contract. A SUBSCRIBER cannot choose to exclude any eligible DEPENDENT from family coverage, unless that DEPENDENT is already covered under the HEALTH BENEFIT PROGRAM.

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

Notwithstanding the paragraph above, the birth or adoption of a child to a SUBSCRIBER under an individual benefit plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within sixty (60) DAYS of the birth, adoption, or placement for adoption.

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the 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.

125E Local Annuitants

LOCAL ANNUITANTS who cancel coverage for any reason are not eligible to reenroll in the program as a SUBSCRIBER.

125F Medicare Participants

ANNUITANTS and their DEPENDENTS, or surviving DEPENDENTS, who become enrolled in Medicare may continue to be covered at reduced PREMIUM rates, as specified by the BOARD.

Enrollment in Medicare by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the STATE or participating LOCAL EMPLOYER. Enrollment in Medicare Parts A and B is required for the EMPLOYEE and/or Medicare-eligible DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active EMPLOYEE'S group health benefit policy with another employer and that policy is the primary payer for Medicare Parts A and B charges, the ANNUITANT and/or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare reduced PREMIUM for coverage under this program.

As required by Medicare rules, Medicare is the primary payer for DOMESTIC PARTNERS age sixty-five (65) and older who are enrolled in Medicare, regardless of the work status of the SUBSCRIBER. The reduction in PREMIUM is available only when the coverage is provided under a non-employer group number.

Enrollment in Medicare by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the covered EMPLOYEE, ANNUITANT or DEPENDENT is required to pay a premium to enroll in the HOSPITAL portion of Medicare (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

130 Premiums

The BOARD determines the PREMIUM for its self-insured benefit plans as part of the HEALTH BENEFIT PROGRAM. This PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to:

1) Projection of incurred claims costs for the renewal benefit period.

2) The most recent thirty-six (36) months of incurred/paid triangular reports for the current benefit period.

3) Complete documentation of the methodology and assumptions utilized to develop the projected costs.

4) Disclosure of supporting data used in the calculation, including monthly paid claims and enrollment, network provider fee-structure analysis, provider negotiations updates, utilization analysis to report on unusual patterns, large claims analysis, trend analysis, and demographic analysis.

5) Substantiation of any proposed increase in fixed costs, such as administrative costs, via a thorough analysis of activities and costs covered by those fees.

6) Explanations for any unusual trend results (high or low relative to the market).

The CONTRACTOR will work with the BOARD'S consulting actuary independently to agree on a format, and the frequency of providing this data.

SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255.

The State of Wisconsin's current contribution toward the total health benefit for EMPLOYEES (non-retired) for both individual and family contracts is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The tiered structure is based on recommendations from the BOARD'S consulting actuary.

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 the Medicare HOSPTIAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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 coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. 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.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see Sections 125F and 220H.

135 Administrative Fee and Financial Administration

135A Invoicing and Banking

1) Claims Invoicing:

   a) The CONTRACTOR shall notify the DEPARTMENT every calendar week during the term of this AGREEMENT and inform the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. The amount due every week shall be the total amount of BENEFIT payments issued by the CONTRACTOR for the claims processed during the immediately prior calendar week (Saturday through Friday).

   b) The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT by the first Friday immediately following the DEPARTMENT'S receipt of the request for payment by the CONTRACTOR. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.

   c) The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within twenty (20) BUSINESS DAYS following month-end.

   d) The CONTRACTOR shall submit a claims invoice reconciliation report each month for the prior month. The report will reconcile the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. The weekly claims invoice must show claims by the benefit period in which they were incurred and by state and local subgroups.

2) Administrative Fee Invoicing:

   a) The CONTRACTOR must submit to the DEPARTMENT on the twentieth (20th) DAY of each calendar month (or the first BUSINESS DAY following the twentieth (20th) DAY of the calendar month), an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The monthly invoice must show the total amount of administration

fees, other approved fees and expenses due for the immediately following calendar month. The DEPARTMENT shall deposit funds into the bank account designated by the CONTRACTOR on the first BUSINESS DAY of the calendar month following the DEPARTMENT'S receipt of the invoice from the CONTRACTOR.

b) The CONTRACTOR shall be paid the administrative fee per month per PARTICIPANT as detailed in the CONTRACT. All administrative plan arrangement-related fees are included in the CONTRACTOR's administrative fee.

   The statewide/nationwide CONTRACTOR shall be paid for underwriting services to evaluate risk and submit recommendations for LOCAL EMPLOYERS requesting participation in the local HEALTH BENEFIT PROGRAM. The LOCAL EMPLOYER shall send payments for underwriting services to the DEPARTMENT. The DEPARTMENT shall forward one check for the appropriate amount shown in the Cost Proposal to the CONTRACTOR for their services.

3) Direct Pay SUBSCRIBER Invoicing:

   The CONTRACTOR shall not process any PREMIUM transactions related to enrollment, except for those direct pay SUBSCRIBERS.

135B Administrative Fee Adjustments

Administrative fee adjustments, if any, required as recommended by the BOARD's consulting actuary for BENEFIT changes, mandated BENEFIT payments, and/or operational changes, will occur on January 1 after the next contract period begins unless otherwise approved by the BOARD. The CONTRACTOR shall supply an administrative monthly invoice that must be based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The CONTRACTOR shall be paid the following administrative charge per month per PARTICIPANT for the AGREEMENT periods stated as follows:

Medical administration fee per individual and family contract. The medical administration fee includes, but is not limited to, the following:

1) Claims administration (including adjudication, payment, reprocessing, coordination of BENEFITS (excluding vendor recoveries), and overpayment collection).

2) Utilization review fees.

3) Network access fees.

4) MHSA claims administration.

5) Medical management (including medical review).

6) Disease management.

7) Customer service (to meet all requirements of this AGREEMENT, including all key personnel).

8) PARTICIPANT materials (including explanations of BENEFITS, summary of BENEFITS and coverage, web tools, ID cards, printing and mailing costs).

9) All required reports (including federally required reports and tax related forms).

10) Claims data extracts.

11) Administration, collection of, and passing through to the DEPARTMENT, premiums for direct pay SUBSCRIBERS (including reporting non-payment terminations).

12) IT services (including hardware and software).

13) Telecom (other program resource links, reporting, special usage or access requirements).

14) Required reviews (including fraud and abuse, and HOSPITAL bill).

15) Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing).

16) Telehealth services.

17) Twenty-four (24)-hour nurse line services.

18) Underwriting services (applies to a CONTRACTOR providing statewide/nationwide services under this AGREEMENT only).

135C Prohibited Fees

1) The CONTRACTOR is prohibited from including in their administrative fee:

   a) The cost to handle any claims paid outside of Uniform Benefits or IYC Medicare Plus administered by the statewide/nationwide CONTRACTOR.

   b) The cost to administer any optional health and wellness benefit(s) beyond Uniform Benefits, IYC Medicare Plus that is administered by the statewide/nationwide CONTRACTOR or the Well Wisconsin program.

2) The CONTRACTOR is prohibited from billing separate fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

135D Recovery of Overpayments

1) Overpayments:
   If it is determined that any payment has been made under this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or

shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.

If any overpayments made to ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments. Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR'S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments. Any overpayment caused by the CONTRACTOR'S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.

The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures.

2) The BOARD shall hold the CONTRACTOR and its directors, officers, and employees harmless from any liability for any overpayments and/or underpayments made to any ineligible former PARTICIPANT when payments result from a failure of the BOARD, the DEPARTMENT or any other State department or agency to make a timely report to the CONTRACTOR of any PARTICIPANT'S loss of eligibility.

   The DEPARTMENT shall not hold the CONTRACTOR responsible for any overpayments caused by DEPARTMENT or EMPLOYER errors or fraud by a person other than an employee of the CONTRACTOR.

   The CONTRACTOR shall assist the DEPARTMENT in identifying overpayments caused by such error or fraud.

3) The BOARD reserves the sole right to institute litigation for the purpose of recovering any overpayment. The BOARD reserves the right to join in any litigation instituted by the CONTRACTOR for the purpose of recovering any overpayment which is the responsibility of the CONTRACTOR.

4) The CONTRACTOR shall be given full credit for all refunds that result from recovery of any overpayment to the extent that the CONTRACTOR is held financially responsible for such overpayment within this AGREEMENT.

5) Disputes over Charges:

   Notwithstanding any other terms, conditions, and provisions of this AGREEMENT, the CONTRACTOR shall pay CHARGES as determined by the CONTRACTOR. Disputes as to CHARGES will be referred, on a timely basis, to the CONTRACTOR who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

   If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT shall contact the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR shall notify the DEPARTMENT about the lawsuit.

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 administrative fees or other 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:

1) Providers to request and receive electronic funds transfer (EFT) of claims payments for BENEFITS.

2) SUBSCRIBERS to submit EFT of direct pay PREMIUM payments. The CONTRACTOR must support other mechanisms for payment of direct pay PREMIUMS.

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.

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.

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. 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. The next roll-out for the new system is currently scheduled for 2018.

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.

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 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.

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 Claims Data Specifications document, all claims processed for PARTICIPANTS. At least ninety-five (95%) percent of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred (100%) percent of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

b) 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, 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. 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 and integrate the data as required under Section 240. 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 provided by the DEPARTMENT with 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 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 RFP, 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. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file. 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 and are the direct result of the CONTRACTOR's failure to meet the

DEPARTMENT'S data submission requirements or timelines and which the DEPARTMENT will deduct from any payment owed the CONTRACTOR in the payment period.

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.

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 Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits. All amounts recovered under this program shall be paid forty-five (45%) percent to the CONTRACTOR and fifty-five (55%) percent to the BOARD.

155D 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.

155E 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) 16 and provide a copy of the CPA's report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.) The audit report must be submitted annually.

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.

155F 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. For information see Section 135D.

2) Contractor Provider 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; and,

n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. 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 personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

4) The actual impact list (as soon as known).

5) A copy of any correspondence sent to affected PARTICIPANTS (this must be pre-approved by the DEPARTMENT).

6) A description of the steps taken to ensure a similar incident will not be repeated.

This notification requirement shall apply only to PHI or PII received or maintained by the CONTRACTOR pursuant to this AGREEMENT. The CONTRACTOR shall make good faith efforts to communicate with the DEPARTMENT about breaches by major provider groups if the CONTRACTOR knows those breaches affect PARTICIPANTS.

The CONTRACT shall notify the DEPARTMENT Program Manager and Privacy Officer no less than one (1) BUSINESS DAY before any external communications are made regarding a data breach.

155H 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.

155I 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 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) In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.

4) Membership changes and corrections not processed during the term of the contract will continue to be processed by the CONTRACTOR during the entire run-out period. During the entire run-out period, all performance standards and penalties remain in force.

5) The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT'S approval.

155J Transition Plan

During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. In the event that the CONTRACTOR terminates the CONTRACT, an updated

transition plan must accompany the notice of termination. In the event the BOARD terminates the CONTRACT, the CONTRACTOR must send an updated transition plan to the DEPARTMENT within thirty (30) DAYS of the written notice of termination to the CONTRACTOR. The transition plan must be approved by the DEPARTMENT prior to the transition begin date and must include the CONTRACTOR'S cooperation and participation in planning calls or meetings with the succeeding vendor.

The CONTRACTOR must administer a program run-out period to process claims and to handle related customer service inquiries. The run-out period begins on the CONTRACT termination date and will be no longer than one (1) year. The CONTRACTOR shall be paid three (3) months of administrative expenses based on the membership census as of November 1 of the last year of the contract. The administrative fee shall be the fee in effect during the last year the contract. The fee shall be paid in three (3) installments. The first installment shall be paid in December of the last year of the contact. The second installment shall be paid in January of the year of run-out. The final payment will be made no later than December of the year of run-out unless issues arise with data submission to the DEPARTMENT'S data warehouse. In the event of issues receiving run-out claims per the DEPARTMENT'S timeline, the DEPARTMENT will withhold the final fee payment until all run-out claims are received.

Leading up to and during the run-out period, the CONTRACTOR must:

1) Participate in all DEPARTMENT requested meetings.

2) Provide all reports for program close out.

3) Report on performance standards specified in Section 315.

4) Invoice the DEPARTMENT as specified in Section 135A.

5) Transmit program data to the new vendor.

6) Continue grievance, hospital bill audit, subrogation services and overage disabled dependent reviews.

7) Transmit run-out claims data to the DEPARTMENT'S data warehouse as specified in Section 150.

155K Health Underwriting for Statewide/Nationwide Contractor only

LOCAL EMPLOYERS with one or more employees requesting participation in the local HEALTH BENEFIT PROGRAM are subject to underwriting. The CONTRACTOR shall evaluate risk and submit a recommendation back to the DEPARTMENT for final approval by the BOARD'S actuary. The effective date shall be determined by the DEPARTMENT. The fees described in the Cost Proposal, or as agreed upon by the DEPARTMENT, shall be administered per Section 135A.

Employers with fifty-one (51) or more EMPLOYEES shall submit claims and enrollment experience including high cost claims data for the most recent available twenty-four (24) months along with the fees to the DEPARTMENT.

Employers with fifty (50) or less EMPLOYEES shall submit small employer information as required by the CONTRACTOR to the DEPARTMENT along with the fees.

The DEPARTMENT will submit information and appropriate fees to the 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.

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. 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) 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 Eligibility

The 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.

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

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 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 as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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. See Appendix 6, Guidance for DEPARTMENT Initiatives, for additional detail.

The current DEPARTMENT Initiatives 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) High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.

3) Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.

4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.

5) 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.

215C Quality Initiatives

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.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in Uniform Benefits to all PARTICIPANTS with the exception of the statewide/nationwide CONTRACTOR who must provide the BENEFITS and services listed in the IYC Medicare Plus certificate to all Medicare 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 high deductible health plan (HDHP) 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger 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 Preferred Provider Organization (PPO)

The BOARD may offer different copayment and deductible schedules for OUT-OF-NETWORK providers, except in the case of emergency, urgent care or when the services are not reasonably available IN-NETWORK.

If the PARTICIPANT resides in a CONTRACTOR'S service area, the PPO must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty IN-NETWORK provider when determining if that provider is reasonably available.

220G Medicare

The CONTRACTOR will provide BENEFITS and services as described in Uniform Benefits to PARTICIPANTS enrolled in Medicare with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS.

The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare.

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 EMPLOYEE, 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. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payer after this thirty (30)-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty (30) -month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer. No reduction in PREMIUM is available for active EMPLOYEES under this section.

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, change from or to the IYC HDHP).

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:

1) If a PARTICIPANT changes benefit plans.

2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER (or combination of spouse-to-DOMESTIC PARTNER) transfer resulting in a change of SUBSCRIBER, but does not change benefit plans.

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.

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. For HDHPs, medical and pharmacy accumulations are combined.

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.

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 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 audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year, which includes 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 commercially insured adult 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.

c) The results of the survey shall be used for the measurement of PARTICIPANT satisfaction as specified in the performance standards in Section 315G.

4) The DEPARTMENT will monitor health care quality and/or customer satisfaction using performance measures available in the data warehouse and visual business intelligence tool, and will establish performance metrics, baseline results, and target performance levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage performance improvement.

   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.

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 and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how 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.

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.

The 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 their provider network for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150.

The DEPARTMENT will use this data to ensure provider access standards are met. 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 (33%) percent 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 the following minimum requirements:

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 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 the access standards above, including accepting 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. 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 Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in Uniform Benefits with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS. Targets for claims processing performance standards and associated penalties are specified in Section 315C.

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. The CONTRACTOR shall pay claims of providers according to a time standard mutually established by the CONTRACTOR and the DEPARTMENT.

Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR shall provide the total dollar amount of claims paid by the HEALTH BENEFIT PROGRAM.

In accordance with state statute, the CONTRACTOR must maintain individual documentation used for claim adjudication for a minimum of seven (7) years.

240 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 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.

245 Grievances

245A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with the HHS-administered federal external review in accordance with federal law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections 245E, 245F, and 265A.

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 245A – H.

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

4) Notification of DEPARTMENT Administrative Review Rights (not all grievances eligible): Administrative review by DEPARTMENT staff, and/or the DEPARTMENT appeals process including filing an appeal with the BOARD, an administrative appeal hearing, consideration of the appeal by the BOARD, right to appeal the BOARD's final decision to circuit court; or,

5) Federal external review (not all grievances eligible).

245B 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.

245C 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.

245D 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.

245E Notification of Department Administrative Review Rights

In the final grievance decision letters, the CONTRACTOR shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR shall cite the specific Uniform Benefits contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision with the exception of the statewide/nationwide CONTRACTOR who will cite the specific IYC Medicare Plus contractual provision(s) for Medicare PARTICIPANTS.

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 HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

BOARD decisions can only be further reviewed as provided by Wis. Stat. § 40.08 (12) and Wis. Adm. Code ETF 11.15.

245F External Review

The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an 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.

245G 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.

245H 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.

245I 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.

245J 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.

250 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see Section 260D.

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.

255 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt. It is acceptable to credit the collected direct pay PREMIUM amount on the administrative monthly invoice provided that it contains itemized SUBSCRIBER level detail.

Direct pay PREMIUMS may be submitted to the CONTRACTOR via electronic funds transfer or 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.

260 Continuation

260A 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.

260B 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.

260C Conversion / Marketplace

The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment.

260D 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.

265 Miscellaneous Program Requirements

265A 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.

The CONTRACTOR is required to perform and/or manage the following activities by the date indicated:

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Nondiscrimination Testing Plan: The CONTRACTOR works with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.	Within thirty (30) DAYS of execution of this CONTRACT
Transition Plan: The transition plan is established in a mutually agreed upon format and submitted to the DEPARTMENT Program Manager or designee for review.	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2018 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	August 18, 2017
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 1, 2017
Employer Meeting: The CONTRACTOR attends the It's Your Choice EMPLOYER Kick-Off meeting.	Fall 2017 (Date TBD)
Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.	September 30, 2017
Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2017
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	September 2017 (Date TBD)
Employer Health Fairs: The CONTRACTOR shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area.	October – November 2017
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation.	November 16, 2017

Activity	Due Dates
Financial Administration: Financial administration requirements are operational, including but not limited to: • Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. • Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). • Direct pay invoicing process. • ACH mechanism for EFT of claims payments and direct pay PREMIUMS.	November 30, 2017
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2017
ID Cards: The CONTRACTOR issues welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018.	December 15, 2017
Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM are fully operational.	January 1, 2018
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2018
Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly.	January 15, 2018
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2018
Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2018
Claims Data: The claims data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	March 31, 2018

265B Account Management and Staffing

Upon execution of this CONTRACT, the CONTRACTOR shall designate an Account Manager and a backup, assigned to the DEPARTMENT for the life of the CONTRACT, who is accountable for and has the authority to:

1) Manage the entire range of services specified in the CONTRACT;

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

4) Implement the DEPARTMENT changes to benefit plan design and procedures; and,

5) Resolve general administrative problems identified by the DEPARTMENT.

The Account Manager or backup must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the contract. The Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR shall resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR must have a designated Information Technology contact and a backup Information Technology contact who will have overall responsibility for the information technology aspects of the CONTRACT. The Information Technology contact shall be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR shall provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. The CONTRACTOR shall ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT, have the experience and credentials necessary to perform the work required. The CONTRACTOR shall provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS.

The CONTRACTOR shall notify the DEPARTMENT if the Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to deny the CONTRACTOR'S designees.

The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must acknowledge receipt of the inquiry from the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the payroll processing centers and/or other payroll.

The CONTRACTOR shall provide onsite staff attendance at the annual IYC EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the annual IT'S YOUR CHOICE OPEN ENROLLMENT period.

The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR'S operations and policies.

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the 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 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting HEALTH BENEFIT PROGRAM services.

265C Customer Service

The CONTRACTOR shall operate a dedicated 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 315D 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, EMPLOYER group);

5) The representative that handled the inquiry;

6) For phone inquiries, the length of call; and,

7) The resolution of the inquiry (including a resolution code using a coding scheme).

Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request.

At the DEPARTMENT'S request, the CONTRACTOR must provide the policies and procedures related to the operation of the customer service department. The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each 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.

265D 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.).

265E 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.

265F 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR.

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.

265G 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 "personal information", as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;

2) Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,

3) Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record that would violate Wis. Stat. § 40.07 (1) or (2), respectively, if the disclosure was made by the DEPARTMENT.

265H 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.

265I Subrogation and Other Payers

The CONTRACTOR shall correspond with PARTICIPANTS to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other payers such as worker's compensation, insurance contracts, or government-sponsored benefit programs.

The CONTRACTOR shall have authority to retain any attorneys or law firms regarding such subrogation rights and lawsuits involving such rights to represent the BOARD to pursue the BOARD'S subrogation rights in accordance with this AGREEMENT. Any subrogation settlement agreed to by the CONTRACTOR shall be deemed acceptable by the BOARD. The CONTRACTOR may forego subrogation where, at the CONTRACTOR'S discretion, the circumstances in a particular subrogation matter warrant such a decision.

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel or utilize in-house counsel to provide the BOARD with subrogation litigation services on the BOARD'S behalf at a contingency fee not to exceed thirty (30%) percent for outside legal counsel or twenty (20%) percent for in-house counsel of net dollars recovered by such counsel, with those attorneys' fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

For such subrogation matters, the BOARD shall not pay or provide any additional reimbursement for the outside legal counsel's or in-house counsel's legal fees, expenses, costs and disbursements incurred by such counsel while providing subrogation-related legal services and such legal fees, expenses, costs and disbursements are included in, and will be paid out of, the maximum thirty (30%) percent contingency fee that is paid to the outside legal counsel or twenty (20%) percent fee paid to in-house counsel as set forth in this subsection. The CONTRACTOR will not be paid or receive any portion of the contingency fee that is paid to the outside legal counsel if outside legal counsel is hired. The BOARD shall be solely responsible and liable for paying the contingency fee to outside legal counsel for its attorneys' fees, legal costs and disbursements incurred by the outside legal counsel representing the BOARD in subrogation cases, not the CONTRACTOR. The CONTRACTOR is not responsible or liable for paying the contingency fee or any outside counsel attorneys' fees, legal costs and disbursements.

265J 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.

265K Other

The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the HEALTH BENEFIT PROGRAM.

265L 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.

265M Conflict of Interest

During the term of this AGREEMENT, the CONTRACTOR shall have no interest, direct or indirect, that would conflict in any manner or degree with the performance of services required under this AGREEMENT.

Without limiting the generality of the preceding paragraph, the CONTRACTOR agrees that it shall not, during the initial AGREEMENT period and any extension thereof, acquire or hold any business interest that conflicts with the CONTRACTOR'S ability relating to its performance of its services under this AGREEMENT.

The CONTRACTOR shall not engage in any conduct which violates, or induces others to violate, the provision of the Wisconsin statutes regarding the conduct of public employees. If a BOARD member or an organization in which a BOARD member holds at least ten (10%) percent interest is a party to this AGREEMENT, then this AGREEMENT is voidable by the BOARD unless appropriate disclosure has been made to the Wisconsin Ethics Commission.

300 DELIVERABLES

305 Reporting Requirements

As required by the CONTRACT, the CONTRACTOR must submit reports to the DEPARTMENT. Reports must be submitted by SECURE email to the DEPARTMENT, the DEPARTMENT'S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify reporting requirements as deemed necessary to monitor the CONTRACT and programs.

Instructions and specific due dates will be provided by the DEPARTMENT annually.

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the 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 Invoicing	The CONTRACTOR notifies the DEPARTMENT every calendar week during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. *(See Section 135A, 1, a.)*	Weekly
3) Administrative Fee Invoice	The CONTRACTOR submits to the DEPARTMENT an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. *(See Section 135A, 2, a.)*	Monthly
4) 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, 1.)*	Monthly
5) Bank Reconciliation Report	The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. *(See Section 135A, 1, c.)*	Monthly
6) Claims Invoice Reconciliation Report	The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. *(See Section 135A, 1, d.)*	Monthly

Report	Description	Frequency
7) 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 265C.)*	Monthly
8) 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, 2..)*	Monthly
9) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155F, 2.)*	Quarterly
10) Hospital Bill Audit	The CONTRACTOR performs a HOSPITAL bill audit process for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and provides results of material findings to the DEPARTMENT. *(See Section 155C.)*	Quarterly
11) 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
12) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
13) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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, High Tech Radiology, Low Back Surgery, Shared Decision Making, and Advance Care Planning. *(See Section 215B.)*	Semi-annually
14) 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 215C.)*	Semi-annually
15) 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.)*	Semi-annually

Report	Description	Frequency
16) 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
17) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. *(See Section 225, 3, b.)*	Annually
18) 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
19) 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
20) 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.)*	Annually
21) 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
22) 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
23) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year. *(See Section 225, 3, a.)*	Annually
24) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually

Report	Description	Frequency
25) Rate Renewal Reports	To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. *(See Section 130.)*	Annually
26) 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 16 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 DEPARTMENT Program Manager or designee. *(See Section 265A.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. *(See Sections 265A and 265B.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. *(See Section 155F, 2 and Section 265A.)*	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section 205B, 2.)*	Upon identification of issue
5) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section 265B.)*	April August

Deliverable	Description	Frequency
7) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. *(See Section 230A.)*	June
8) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July
9) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
10) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
11) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
12) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. *(See Section 140B, 1.)*	October
13) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
14) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
15) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 265D, 1a and 1p.)*	As directed by the DEPARTMENT
16) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred 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
17) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 265B.)*	As needed
18) Recovery of Overpayments	The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures. *(See Section 135F.)*	As needed
19) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 245K.)*	As needed

Deliverable	Description	Frequency
20) Notification of Legal Action Against PARTICIPANT in Dispute over Charges	If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit's status in a mutually agreeable format. *(See Section 135F.)*	As needed
21) Notification of 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 personal 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 155G.)*	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 245F.)*	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, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. *(See Section 155J.)*	During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • The HEALTH BENEFIT PROGRAM provider directory or directions on how to request a printed copy of the provider directory. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. *(See Section 230C.)*	See description
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. *(See Section 245B.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. *(See Section 245D.)*	See description
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment. *(See Section 260C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed
10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

Performance standards are specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book-of-business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT upon realization that a standard will not be met, prior to the deadline.

The penalties assessed in Section 150B and Section 315 shall not exceed twenty-five (25%) percent of the CONTRACTOR'S total administrative fee in any given quarter. After implementation, all performance standards will be measured by the DEPARTMENT on a QUARTERLY basis and assessed based on PARTICIPANT counts as of the first calendar DAY of the quarter, as determined by DEPARTMENT enrollment records. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

Section	Performance Category	Maximum Penalty
315A	Implementation	Three (3%) percent
315B	Account Management	Three (3%) percent
315C	Claims Processing	Four (4%) percent
315D	Customer Service	Four (4%) percent
315E	Data Management	Four (4%) percent
315F	Enrollment	Four (4%) percent
315G	Other	Three (3%) percent
	TOTAL	Twenty-five (25%) percent

315A Implementation

The CONTRACTOR shall complete the task by the date specified below. If an alternate date is approved by the DEPARTMENT in the implementation plan, the CONTRACTOR shall complete the task by the alternate date. The total penalties for this performance category shall not exceed three (3%) percent of the total estimated administrative fee for year one (1) of the CONTRACT.

Performance Standards – three (3%) percent Penalty	Penalties
1) Program Information: All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards – three (3%) percent Penalty	Penalties
2) Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) Customer Service: The CONTRACTOR's dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained no later than September 30, 2017. (*See Section 265A.)*	
4) Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. *(See Section 265A.)*	
5) Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 265A.)*	
6) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. *(See Section 265A.)*	
7) Financial Administration: Financial administration requirements are operational no later than November 30, 2017. *(See Section 265A.)*	
8) Grievance Procedure: The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT'S review and approval. *(See Section 265A.)*	
9) ID Cards: No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018. *(See Section 265A.)*	
10) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018. *(See Section 265A.)*	

Performance Standards – three (3%) percent Penalty	Penalties
11) Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
12) Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly no later than January 31, 2018. *(See Section 265A.)*	
13) Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than February 28, 2018. *(See Section 265A.)*	
14) Claims Data Transfer: The claims data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than March 31, 2018. *(See Section 265A.)*	

315B Account Management

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(*See *Section 265B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey

Performance Standards	Penalties
2) **Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 265D, 1.)*	Five thousand ($5,000) dollars per incident

315C Claims Processing

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Financial Accuracy:** At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid in the correct amount divided by the total claim dollars paid. *(See Section 235.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
2) **Processing Accuracy:** At least ninety-seven (97%) percent level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section 235.)*	
3) **Claims Processing Time:** At least ninety-five (95%) percent of all claims received must be processed within fifteen (15) BUSINESS DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 235.)*	

315D Customer Service

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Call Answer Timeliness**: At least eighty (80%) percent of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)

Performance Standards	Penalties
2) Call Abandonment Rate: Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
3) Open Call Resolution Turn-Around-Time: At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section 265C.)*	
4) Inquiry Resolution Tracking Document/Log: Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request. *(See Section 265C.)*	
5) Electronic Written Inquiry Response: At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section 265C.)*	

315E Data Management

The DEPARTMENT will specify the timetable and dates for which the claims and provider data transfers must be provided. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Claims Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a and 150B, 1.)*	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, 2.)*	

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 155G.)*	

315F Enrollment

The CONTRACTOR shall report QUARTERLY any DAY for which any of the following standards are not met. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 150A, 4, a and c.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Enrollment Discrepancies: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. *(See Section 150A, 4, a.)*	
3) ID Cards: The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
4) ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID cards by December 15 (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.)*	

Performance Standards	Penalties
5) Direct Pay Terminations: The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section 255.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

315G Other

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155E.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Grievance Resolution: Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. *(See Section 245C.)*	
3) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	
4) PARTICIPANT Satisfaction Surveys: The CONTRACTOR shall achieve at or above a ninety (90%) percent satisfaction rating (defined as “top three-boxes” using a zero (0) to ten (10) rating scale with ten (10) being the highest ranking) on the health plan rating question on the CAHPS survey tool or other survey instrument as approved by the DEPARTMENT. *(See Section 225, 3, c.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
5) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident

Performance Standards	Penalties
6) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

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 2018.

These are the Uniform Benefits or "Summary Plan Description" offered under the Health Benefit Program.

This portion of the Agreement is often excerpted and provided to PARTICIPANTS as their Summary Plan Description.

The contractor shall not alter the language, benefits or exclusions and limitations, herein.

These Uniform Benefits are provided to SUBSCRIBERS via the It's Your Choice materials as their Summary Plan Description. The language in this section is written to the audience of the PARTICIPANT. Included in this section is a set of definitions which is specific to Uniform Benefits. The contractor does not need to recreate the description of benefits nor distribute it to PARTICIPANTS.

These Uniform Benefits are provided to a SUBSCRIBER who is a retired public employee under Wis. Stat. § 40.02 (25) (b) 11, or any DEPENDENT of such an employee, and, if eligible, has acted under Wis. Stat. § 40.51 (10) to elect group health insurance coverage. SUBSCRIBERS or DEPENDENTS who are ineligible and unenrolled in Medicare may join Program Option 16. SUBSCRIBERS or DEPENDENTS who are eligible and enrolled in Medicare may join Program Option 12. Benefits will be provided to SUBSCRIBERS via the Local Annuitant Health Program (LAHP) materials.

I. Schedule of Benefits

All benefits are paid according to the terms of this contract between the THIRD PARTY ADMINISTRATOR(S) (TPA), the PBM, and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the contract. The SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, EMERGENCY services received from an OUT-OF-NETWORK PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE.

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

This Summary Plan Description applies to services received from IN-NETWORK PROVIDERS. If any OUT-OF-NETWORK benefits are available, YOU will be provided with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by OUT-OF-NETWORK PROVIDERS. OUT-OF-NETWORK DEDUCTIBLE amounts do not accumulate to the IN-NETWORK OUT-OF-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 TPA before such services are obtained.

The covered benefits are subject to the following:

1) DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Annual medical DEDUCTIBLE	$250 individual/$500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	None.	$1,500 per individual plan / $3,000 per family plan The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the plan pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).
Annual medical COINSURANCE	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies OOPL except as described below.	BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL.
Annual medical OUT-OF-POCKET LIMIT (OOPL)	$1,250 PARTICIPANT / $2,500 aggregate family limit except as described below.[1]	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]	After DEDUCTIBLE: $2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN pays 100%.	Covered 100%.	BENEFIT PLAN pays 100%.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $75 COPAYMENT (counts towards to OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit).[2]	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. §632.895 (16), covered 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	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 and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). 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 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Prescription Drugs	See below.	See below.	After DEDUCTIBLE: subject to medical DEDUCTIBLE above. After DEDUCTIBLE, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2]Federally required preventive services are covered at 100%.

[3] State of Wisconsin MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the MEDICARE Prime Uniform Benefits SCHEDULE OF BENEFITS.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical DEDUCTIBLE	None.	$250 individual / $500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	$500 individual / $1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). When an individual within a family plan meets the $500 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.	$1,500 per individual plan / $3,000 per family plan. The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the BENEFIT PLAN pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical COINSURANCE	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLEMEDICAL EQUIPMENT, cochlear implants and hearing aids.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visits, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.	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.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / 10% applies to medical services except for office visits, and as described below. COINSURANCE applies to OOPL except as described below.
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]	$1,250 individual / $2,500 aggregate family limit except as described below.[1]	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOPL.[1]	$2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
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	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15 per visit. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.	PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
Cochlear Implants for PARTICIPANTS age 18 and older	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLANS pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), BENEFIT PLANS pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
		treatment per PARTICIPANT per calendar year.		treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.
Prescription Drugs	See below.	See below.	See below.	After DEDUCTIBLE: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2] Federally required preventive services are covered at 100%.

[3] Wisconsin Public Employer MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the PO2 Uniform Benefits SCHEDULE OF BENEFITS.

1) Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE

2) Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.

3) Diagnostic Services Limitations: PRIOR AUTHORIZATION may be required.

4) Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): Covered up to 50 visits per PARTICIPANT for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional MEDICALLY NECESSARY visits may be available when PRIOR AUTHORIZED by the TPA, up to a maximum of 50 additional visits per therapy per PARTICIPANT per calendar year.

5) Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when MEDICALLY NECESSARY and PRIOR AUTHORIZED by the TPA; and HOSPITAL CHARGES. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for PARTICIPANTS under 18 years of age are payable as described in the preceding grid.

6) Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), hearing aids for PARTICIPANTS under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.

7) Home Care Benefits Maximum: 50 visits per PARTICIPANT per calendar year. 50 additional MEDICALLY NECESSARY visits per PARTICIPANT per calendar year may be available when authorized by the TPA.

8) HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the TPA.

9) Transplants: Limited to transplants listed in Benefits and Services Section.

10) Licensed Skilled Nursing Home Maximum: 120 days per BENEFIT PERIOD payable for SKILLED CARE.

11) Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.

12) Vision Services: One routine exam per PARTICIPANT per calendar year. Non-routine eye exams are covered as MEDICALLY NECESSARY. (Contact lens fittings are not part of the routine exam and are not covered.)

13) Oral Surgery: Limited to procedures listed in Benefits and Services Section.

14) Temporomandibular Disorders as required by Wis. Stat. §632.895 (11): The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per PARTICIPANT per calendar year. Intraoral splints are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

15) Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services Section.

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.

b) Preventive Prescription Drugs:

i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.

ii) Under the HDHP, preventive prescription drugs are not subject to the DEDUCTIBLE; however, if the preventive prescription drug is not covered at 100% as required by federal law, a COPAYMENT will be required according to the provisions of this program's benefits.

iii) The PBM will publish a list of prescriptions drugs affected by these provisions.

Prescription Drug Copayments:
Level 1 COPAYMENT: $5.00
The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:
Level 2 COINSURANCE: 20% ($50 max)
The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 COINSURANCE: 40% ($150 max)
The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOPL:
Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $600 per individual or $1,200 per family for all PARTICIPANTS.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): no annual OOPL.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS
Specialty Drug Cost Share:
Level 4 COPAYMENT: $50
The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 COINSURANCE: 40% ($200 max)
The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

3) **Certain grandfathered erectile dysfunction medication as defined by the PBM (Viagra and Caverject Injection):** the 40% Level 4 COINSURANCE ($200 max) applies to these prescription medications. However, the COINSURANCE does not accumulate toward any OOPL. YOU must continue to pay Level 4 COINSURANCE for these drugs even after other annual OOPLs have been met.

4) **Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.

5) **Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits description, are defined and limited to that meaning only:

ADVANCE CARE PLANNING: A process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. ADVANCE CARE PLANNING includes:

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

3) Weighing YOUR options about what kind of care and treatment YOU would want or not want.

4) Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive.

5) Communicating YOUR wishes and any documents with YOUR family, friends, clergy, other advisors and physician and other health care professionals.

BED AND BOARD: Means all usual and customary HOSPITAL CHARGES for: (a) Room and meals; and (b) all general care needed by registered bed patients.

BENEFIT PERIOD: Means the total duration of CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CHARGE: An amount for a health care service from a PROVIDER that is reasonable, as determined by the TPA. The TPA considers, as part of determination of CHARGE:

1) Amounts charged for similar health care services in the same general area under comparable circumstances,

2) the TPA's methodology guidelines,

3) pricing guidelines of any third party responsible for pricing a claim,

4) the negotiated rate determined between the TPA and an IN-NETWORK PROVIDER, and

5) other factors.

The term “area” means a county or other geographical area which the TPA determines is appropriate to obtain a representative cross section of amounts. For example, the “area” may be an entire state.

In some cases the amount the TPA determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the health care service. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: A specified percentage of the CHARGES that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the IN-NETWORK PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

DEPENDENT: Means, as provided herein, the SUBSCRIBER'S:

1) Spouse.[1]

2) DOMESTIC PARTNER, if elected.[2]

3) Child.[3, 4, 5]

4) Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19. [3, 4, 5]

5) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.[3, 4, 5]

6) Stepchild.[1, 3, 4, 5]

7) Child of the DOMESTIC PARTNER insured on the policy.[2, 3, 4, 5]

8) Grandchild if the parent is a DEPENDENT child.[3, 4, 5, 6]

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

[2] A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

[3] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, 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.

[4] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

[5] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

[6] A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

DOMESTIC PARTNER: Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

1) Each individual is at least 18 years old and otherwise competent to enter into a contract.

2) Neither individual is married to, or in a domestic partnership with, another individual.

3) The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.

4) The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY.

5) The two individuals agree to be responsible for each other's basic living expenses.

6) The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

   a) Only one of the individuals has legal ownership of the residence.

   b) One or both of the individuals have one or more additional residences not shared with the other individual.

   c) One of the individuals leaves the common residence with the intent to return.

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 TPA and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

ELIGIBLE EMPLOYEE: As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.

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 TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the TPA and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the TPA and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

GENERIC EQUIVALENT: Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

GRIEVANCE: Means a written complaint filed with the TPA and/or PBM concerning some aspect of the TPA and/or PBM. Some examples would be a rejection of a claim, denial of a formal REFERRAL, etc.

HABILITATION SERVICES: Means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A benefit plan that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OOPL set by the IRS. An HDHP does not pay any health care costs until the annual DEDUCTIBLE has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the TPA.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

2) qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission of Accreditation of HOSPITALS.

The term HOSPITAL does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal HOSPITAL.

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses or DOMESTIC PARTNERS.

INJURY: Means bodily damage that results directly and independently of all other causes from an accident.

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The TPA agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the TPA in advance of the services being provided.

LEVEL "M" DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be on the MEDICARE PRESCRIPTION DRUG PLAN'S MEDICARE Part D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the TPA.

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the TPA after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the TPA:

1) Used primarily to treat an ILLNESS or INJURY, and

2) generally not useful to a person in the absence of an ILLNESS or INJURY, and

3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and

4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the TPA and/or PBM:

1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and

2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and

3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and

4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICARE: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

MEDICAID: Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this TPA.

NATURAL TOOTH: Means a tooth that would not have required restoration in the absence of a PARTICIPANT’S trauma or INJURY, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM’S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

1) Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician.

2) Re-assessment and intervention (individual and group).

3) Diabetes outpatient self-management training services (individual and group sessions).

4) Dietitian visit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-NETWORK PROVIDER: A PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the TPA'S professional directory of providers. Care from an OUT-OF-NETWORK PROVIDER may require PRIOR-AUTHORIZATION from the TPA unless it is EMERGENCY or URGENT CARE.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the allowed amount. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PHARMACY BENEFIT MANAGER (PBM): The PBM is a THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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 TPA before obtaining the services. Unless otherwise indicated by YOUR TPA, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the TPA and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the TPA PRIOR AUTHORIZATION form and approved by the TPA in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each TPA and are described in the It's Your Choice materials. The authorization from the TPA will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED visits and the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the TPA before services are rendered.

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-

language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

SELF-ADMINISTERED 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 TPA to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a TPA or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The TPA or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, DOMESTIC PARTNERS, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

SKILLED NURSING FACILITY: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a SKILLED NURSING FACILITY.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

SUBSCRIBER: An ELIGIBLE EMPLOYEE or annuitant who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits.

THIRD PARTY ADMINISTRATOR (TPA): The THIRD PARTY ADMINISTRATOR who is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the TPA, when taking into consideration, among other factors determined by the TPA, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases the amount the TPA determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. TPA approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits and Services

The benefits and services provided under the Health Benefit Program are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of IN-NETWORK chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the TPA reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see item A, 1 and item A, 2 below).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the TPA's written PRIOR AUTHORIZATION for covered services from an OUT-OF-NETWORK PROVIDER or YOU will be financially responsible for the services. The TPA may also require PRIOR AUTHORIZATION for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached SCHEDULE OF BENEFITS, a PARTICIPANT, in consideration of the employer's payment of the applicable TPA and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the TPA and/or PBM.

A. Medical/Surgical Services

1) EMERGENCY Care

a) Medical care for an EMERGENCY, as defined in Section II. Refer to the SCHEDULE OF BENEFITS for information on the EMERGENCY room COPAYMENT.

b) YOU should use IN-NETWORK HOSPITAL EMERGENCY rooms whenever possible. If YOU are not able to reach YOUR IN-NETWORK PROVIDER, go to the nearest appropriate medical facility. If YOU must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU call the TPA by the next business day or as soon as possible and tell the TPA where YOU received EMERGENCY care. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA. In addition to the cost sharing described in the SCHEDULE OF BENEFITS, EMERGENCY care from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.

c) It is recommended, to expedite claims processing, that YOU (or another individual on YOUR behalf) notify the TPA of EMERGENCY or URGENT CARE OUT-OF-NETWORK HOSPITAL admissions or facility CONFINEMENTS by the next business day after admission or as soon

as reasonably possible. This will help to expedite claims payment. OUT-OF-AREA SERVICE means medical care received outside the defined SERVICE AREA.

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

xiv) Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the EMERGENCY room.

2) URGENT CARE

a) Medical care received in an URGENT CARE situation as defined in Section II. URGENT CARE is not EMERGENCY care. It does not include care that can be safely postponed until the PARTICIPANT can receive care from an IN-NETWORK PROVIDER.

b) YOU must receive URGENT CARE from an IN-NETWORK PROVIDER if YOU are in the SERVICE AREA, unless it is not reasonably possible. If YOU are out of the SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If YOU must go to an

OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU contact YOUR TPA by the next business day or as soon as possible and tell the TPA where YOU received URGENT CARE; this will expedite claims payment. URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA.

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

3) Surgical Services
Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include:

a) PREOPERATIVE and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

This does not include oral surgery procedures, which are covered as described under item 16 of this section.

PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the TPA for any PARTICIPANT who has not completed an optimal regimen of conservative care for low back pain (LBP). PRIOR AUTHORIZATION is not required for a PARTICIPANT who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PARTICIPANTS seeking surgical treatment of LBP must participate in a credible SHARED DECISION MAKING (SDM) program provided by the TPA or its contracted PROVIDERS consistent with the PRIOR AUTHORIZATION requirement.

4) Reproductive Services and Contraceptives
The following services do not require a REFERRAL to an IN-NETWORK PROVIDER who specializes in obstetrics and gynecology, however, the TPA may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

   i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit 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 TPA terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the TPA may request notification of the inpatient stay prior to the delivery or shortly thereafter.

5) Medical Services
MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an IN-NETWORK PROVIDER (or a PROVIDER that was PRIOR AUTHORIZED by YOUR TPA).

a) Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

b) Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

c) Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

d) Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e) MEDICALLY NECESSARY travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the PARTICIPANT by the TPA. It does not apply to travel required for work. (See Exclusions, Section IV, A, 2, e.)

f) Injectable and infusible medications, except for SELF-ADMINISTERED INJECTABLE medications.

g) NUTRITIONAL COUNSELING provided by a participating registered dietician or an IN-NETWORK PROVIDER.

h) A second opinion from an IN-NETWORK PROVIDER or when PRIOR AUTHORIZED by the TPA.

i) Preventive services as required by the federal Patient Protection and Affordable Care Act.

6) Anesthesia Services
Covered when provided in connection with other medical and surgical services covered under these Uniform Benefits. It will also include anesthesia services for dental care as provided under item B, 1, c of this section.

7) Radiation Therapy and Chemotherapy
Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an IN-NETWORK PROVIDER.

8) Detoxification Services
Covers MEDICALLY NECESSARY detoxification services provided by an IN-NETWORK PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an IN-NETWORK PROVIDER.

9) Ambulance Service
Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the TPA) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the TPA'S SERVICE AREA, the TPA or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or urgent transportation is obtained.

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if

correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PRIOR AUTHORIZATIONS are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11) Outpatient Rehabilitation, Physical, Speech and Occupation Therapy
MEDICALLY NECESSARY HABILITATION or REHABILITATION SERVICES and treatment as a result of ILLNESS or INJURY, provided by an IN-NETWORK PROVIDER. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be PRIOR AUTHORIZED by the TPA if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12) Home Care Benefits
Care and treatment of a PARTICIPANT under a plan of care. The IN-NETWORK PROVIDER must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)

d) MEDICAL SUPPLIES, drugs and medicines prescribed by an IN-NETWORK PROVIDER; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.

e) NUTRITIONAL COUNSELING. A registered dietician must give or supervise these services.

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

Home care will not be covered unless the attending physician certifies that:

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A PARTICIPANT may have been CONFINED IN A HOSPITAL just before home care started. If so, the home care plan must be approved, at its start, by the PROVIDER who was the primary PROVIDER of care during the HOSPITAL CONFINEMENT.

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the TPA if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the TPA. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the TPA.

Covers ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

Covers a one-time in-home palliative consult after the PARTICIPANT receives a terminal diagnosis regardless of whether his or her life expectancy is 6 months or less.

HOSPICE CARE is available to a PARTICIPANT who is CONFINED. Inpatient CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a TPA-approved or MEDICARE-certified HOSPICE CARE facility.

When benefits are payable under both this HOSPICE CARE benefit and the Home Care Benefits, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14) Phase II Cardiac Rehabilitation

Services must be approved by the TPA and provided in an outpatient department of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of:

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

15) Extraction of NATURAL TEETH and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/or total replacement (limited to, bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the TPA before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

16) Oral Surgery

PARTICIPANTS should contact the TPA prior to any oral surgery to determine if PRIOR AUTHORIZATION by the TPA is required. When performed by IN-NETWORK PROVIDERS, approved surgical procedures are as follows:

a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

e) Apicoectomy. (Excision of apex of tooth root.)

f) Excision of exostoses of the jaws and hard palate.

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

18) Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the TPA in order to be a covered transplant. Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

a) Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:

i) Aplastic anemia

ii) Acute leukemia

iii) Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the TPA.

h) In addition to the above-listed diagnoses for covered transplants, the TPA may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the TPA determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants 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 TPA.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The TPA may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the TPA.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

   c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
   EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up

care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA.

   a) Outpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "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 TPA within 72 hours after the initial provision of service.

   d) Other
   Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section 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 TPA.

(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 TPA:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the TPA, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the TPA.

k) Other medical equipment and supplies as approved by the TPA. Rental or purchase of equipment/supplies is at the option of the TPA.

l) When PRIOR AUTHORIZED as determined by the TPA, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the TPA will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the TPA. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the TPA. Additional visits may be approved by the TPA. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any TPA under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and

dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for 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 TPA.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The TPA, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED 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 TPA or a contracted PROVIDER administers the injection. If the TPA or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.

d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED 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 TPAs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 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 TPA and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   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 TPA.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, 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 TPA.

c) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

d) All separately billed donor-related services, except for kidney transplants.

e) Non-human organ transplants or artificial organs.

7) Reproductive Services

a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c) Services for storage or processing of semen (sperm); donor sperm.

d) Harvesting of eggs and their cryopreservation.

e) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the TPA.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the TPA.

c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the TPA.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the TPA. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED 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 TPA and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) 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 TPA and/or PBM, or services received after the TPA and/or PBM coverage or eligibility terminates. Except when

a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under TPAs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding TPA will be the responsibility of the succeeding TPA unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding TPA's network. In this instance, the liability will remain with the previous TPA.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the TPA and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

   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 TPA.

v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the TPA. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the TPA.

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 TPA 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 TPA. The treatment of the complication must be a covered benefit of the TPA and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any TPA as part of this program.

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 TPA to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the TPA's and/or PBM's Control: If, due to circumstances not reasonably within the control of the TPA and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the TPA and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the TPA, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other

benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section 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 TPA has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the TPA any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the TPA may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The TPA will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the TPA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1) The persons it has paid or for whom it has paid,

2) Insurance companies, or

3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the TPA and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the TPA and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the TPA, provide any relevant and reasonably available information which the TPA believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the TPA and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the TPA's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The TPA, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the TPA, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The TPA may employ a professional staff to provide case management services. As part of this case management, the TPA or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the TPA agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the TPA's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the TPA. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the TPA or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The TPA and/or PBM might pay more than the TPA and/or PBM owes under the policy. If so, the TPA and/or PBM can recover the excess from YOU. The TPA and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the TPA and/or PBM.

Each PARTICIPANT agrees to reimburse the TPA and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the TPA and/or PBM. At the option of the TPA and/or PBM, benefits for future CHARGES may be reduced by the TPA and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a TPA or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the TPA provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The TPA'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

1) The third party or any liability or other insurance covering the third party.

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the TPA or DEPARTMENT to such extent.

The TPA'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the TPA'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the TPA'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the TPA or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the TPA or DEPARTMENT such additional information as is reasonably requested by the TPA or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the TPA'S or DEPARTMENT'S rights against a third party. The TPA or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the TPA or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the TPA or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the TPA or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the TPA or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the TPA or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the TPA or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in

making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the TPA or DEPARTMENT for all amounts theretofore or thereafter paid by the TPA or DEPARTMENT which would have otherwise been recoverable under such acts and the TPA or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the TPA or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the TPA and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the TPA, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the TPA and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the TPA and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating TPAs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the TPA and/or PBM. Contact the TPA and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the TPA and/or PBM. The TPA and/or PBM will advise YOU of YOUR

right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the TPA and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the TPA and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the TPA's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the TPA and/or PBM breached its contract with the Group Insurance Board.

EXHIBIT 2

Standard Terms And Conditions (Request For Bids / Proposals)

1.0 SPECIFICATIONS: The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid/proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 DEVIATIONS AND EXCEPTIONS: Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 QUALITY: Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 QUANTITIES: The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 DELIVERY: Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 PRICING AND DISCOUNT: The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the contractor which are demonstrated to be industrywide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 UNFAIR SALES ACT: Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 ACCEPTANCE-REJECTION: The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 METHOD OF AWARD: Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 ORDERING: Purchase orders or releases via purchasing cards shall be placed directly to the contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements

are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW AND COMPLIANCE: This contract shall be governed under the laws of the State of Wisconsin. The contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel this contract if the contractor fails to follow the requirements of s. 77.66, Wis. Stats., and related statutes regarding certification for collection of sales and use tax. The State of Wisconsin also reserves the right to cancel this contract with any federally debarred contractor or a contractor that is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

16.0 ANTITRUST ASSIGNMENT: The contractor and the State of Wisconsin recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State of Wisconsin (purchaser). Therefore, the contractor hereby assigns to the State of Wisconsin any and all claims for such overcharges as to goods, materials or services purchased in connection with this contract.

17.0 ASSIGNMENT: No right or duty in whole or in part of the contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION / AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan by the contractor. An exemption occurs from this requirement if the contractor has a workforce of less than fifty (50) employees. Within fifteen (15) working days after the contract is awarded, the contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

19.2 The contractor agrees to post in conspicuous places, available for employees and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the contractor's becoming declared an "ineligible" contractor, termination of the contract, or withholding of payment.

20.0 PATENT INFRINGEMENT: The contractor selling to the State of Wisconsin the articles described herein guarantees the articles were manufactured or produced in accordance with applicable federal labor laws. Further, that the sale or use of the articles described herein will not infringe any United States patent. The contractor covenants that it will at its own expense defend every suit which shall be brought against the State of Wisconsin (provided that such contractor is promptly notified of such suit, and all papers therein are delivered to it) for any alleged infringement of any patent by reason of the sale or use of such articles, and agrees that it will pay all costs, damages, and profits recoverable in any such suit.

21.0 SAFETY REQUIREMENTS: All materials, equipment, and supplies provided to the State of Wisconsin must comply fully with all safety requirements as set forth by the Wisconsin Administrative Code and all applicable OSHA Standards.

22.0 WARRANTY: Unless otherwise specifically stated by the bidder/proposer, equipment purchased as a result of this request shall be warranted against defects by the bidder/proposer for one (1) year from date of receipt. The equipment manufacturer's standard warranty shall apply as a minimum and must be honored by the contractor.

23.0 INSURANCE RESPONSIBILITY: The contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employees engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin public records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot be copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin public records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employees and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

31.0 PROMOTIONAL ADVERTISING / NEWS RELEASES: Reference to or use of the State of Wisconsin, any of its departments, agencies or other subunits, or any state official or employee for commercial promotion is prohibited. News releases pertaining to this procurement shall not be made without prior approval of the State of Wisconsin. Release of broadcast e-mails pertaining to this procurement shall not be made without prior written authorization of the contracting agency.

32.0 HOLD HARMLESS: The contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the contractor, or of any of its contractors, in prosecuting work under this agreement.

33.0 FOREIGN CORPORATION: A foreign corporation (any corporation other than a Wisconsin corporation) which becomes a party to this Agreement is required to conform to all the requirements of Chapter 180, Wis. Stats., relating to a foreign corporation and must possess a certificate of authority from the Wisconsin Department of Financial Institutions, unless the corporation is transacting business in interstate commerce or is otherwise exempt from the requirement of obtaining a certificate of authority. Any foreign corporation which desires to apply for a certificate of authority should contact the Department of Financial Institutions, Division of Corporation, P. O. Box 7846, Madison, WI 53707-7846; telephone (608) 261-7577.

34.0 WORK CENTER PROGRAM: The successful bidder/proposer shall agree to implement processes that allow the State agencies, including the University of Wisconsin System, to satisfy the State's obligation to purchase goods and services produced by work centers certified under the State Use Law, s.16.752, Wis. Stat. This shall result in requiring the successful bidder/proposer to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses.

35.0 FORCE MAJEURE: Neither party shall be in default by reason of any failure in performance of this Agreement in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the party.

State of Wisconsin
Department of Administration
DOA-3681 (01/2001)
ss. 16, 19 and 51, Wis. Stats.

Division of Agency Services
Bureau of Procurement

EXHIBIT 3

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor; and

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential contractor shall certify in writing to the procuring agency that no relationship exists between the potential contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employee or who is retained as a contractor full-time by a State of Wisconsin agency from being retained as a contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.0831 Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

7.0 RECORDKEEPING AND RECORD RETENTION: The contractor shall establish and maintain adequate records of all expenditures incurred under the contract. All records must be kept in accordance with generally accepted accounting procedures. All procedures must be in accordance with federal, state and local ordinances.

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the contractor. The contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

8.0 INDEPENDENT CAPACITY OF CONTRACTOR: The parties hereto agree that the contractor, its officers, agents, and employees, in the performance of this agreement shall act in the capacity of an independent contractor and not as an officer, employee, or agent of the state. The contractor agrees to take such steps as may be necessary to ensure that each subcontractor of the contractor will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the state.

EXHIBIT 4

Department Terms and Conditions

1.0 ENTIRE AGREEMENT: This Contract, its exhibits, subsequent amendments and the documents incorporated by order of precedence contain the entire understanding between the parties on the subject matter hereof, and no representations, inducements, promises, or agreements, oral or otherwise, not embodied herein shall be of any force or effect. This Contract supersedes any other oral or written agreement entered into between the parties on the subject matter hereof.

This Contract may be amended at any time by written mutual agreement, but any such amendment shall be without prejudice to any claim arising prior to the date of the change. No one, except duly authorized officers or agents of the Contractor and the Department, shall alter or amend this Contract. No change in this Contract shall be valid unless evidenced by an amendment that is signed by such officers of the Contractor and the Department.

2.0 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW: In the event of a conflict between this Contract and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state.

The Contractor shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the Department upon request.

The Contractor acknowledges that Wis. Stat. § 40.07 specifically exempts information related to individuals in the records of the Department of Employee Trust Funds from the Wisconsin Public Records Law. Contractor shall treat any such records provided to or accessed by Contractor as non-public records as set forth in Wis. Stat. § 40.07.

Contractor will comply with the provisions of Wis. Stat. § 134.98**.**

3.0 LEGAL RELATIONS: The Contractor shall at all times comply with and observe all federal and State laws, local laws, ordinances, and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct. This includes but is not limited to laws regarding compensation, hours of work, conditions of employment and equal opportunities for employment.

In carrying out any provisions of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters that the Department acts as an agent of the State.

The Contractor accepts full liability and agrees to hold harmless the State, the Department's governing boards, the Department, its employees, agents and contractors for any act or omission of the Contractor, or any of its employees, in connection with this Contract.

No employee of the Contractor may represent himself or herself as an employee of the Department or the State.

4.0 CONTRACTOR: The Contractor will be the sole point of contact with regard to contractual matters, including the performance of Services and the payment of any and all charges resulting from contractual obligations.

None of the Services to be provided by the Contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without prior written notification to, and approval of, the Department.

After execution of the Contract, ETF will provide a designated contact person and commit to a timely approval process for notification of a change in subcontractor(s) and/or delegated services.

The Contractor shall be solely responsible for its actions and those of its agents, employees or subcontractors under this Contract. The Contractor will be responsible for Contract performance when subcontractors are used. Subcontractors must abide by all terms and conditions of this Contract.

Neither the Contractor nor any of the foregoing parties has the authority to act or speak on behalf of the State of Wisconsin.

The Contractor will be responsible for payment of any losses by subcontractors or agents.

Any notice required or permitted to be given shall be deemed to have been given on the date of delivery or three (3) Business Days after mailing by the United States Postal Service, certified or registered mail-receipt requested. In the event the Contractor moves or updates contact information, the Contractor shall inform the Department of such changes in writing within ten (10) Business Days. The Department shall not be held responsible for payments delayed due to the Contractor's failure to provide such notice.

5.0 **CONTRACTOR PERFORMANCE:** Work under this Contract shall be performed in a timely, professional and diligent matter by qualified and efficient personnel and in conformity with the strictest quality standards mandated or recommended by all generally-recognized organizations establishing quality standards for the work of the type to be performed hereunder. The Contractor shall be solely responsible for controlling the manner and means by which it and its employees or its subcontractors perform the Services, and the Contractor shall observe, abide by, and perform all of its obligations in accordance with all legal and Contract requirements.

Without limiting the foregoing, the Contractor shall control the manner and means of the Services so as to perform the work in a reasonably safe manner and comply fully with all applicable codes, regulations and requirements imposed or enforced by any government agencies. Notwithstanding the foregoing, any stricter standard provided in plans, specifications or other documents incorporated as part of this Contract shall govern.

The Contractor shall provide the Services with all due skill, care, and diligence, in accordance with accepted industry practices and legal requirements, and to the Department's satisfaction; the Department's decision in that regard shall be final and conclusive.

All Contractor's Services under this Contract shall be performed in material compliance with the applicable federal and state laws and regulations in effect at the time of performance, except when imposition of a newly enacted or revised law or regulation would result in an unconstitutional impairment of this Contract.

The Contractor will make commercially reasonable efforts to ensure that Contractor's professional and managerial staff maintain a working knowledge and understanding of all federal and state laws, regulations, and administrative code appropriate for the performance of their respective duties, as well as contemplated changes in such law which affect or may affect the Service under this Contract.

The Contractor shall maintain a written contingency plan describing in detail how it will continue operations and Services under the Contract in certain events including, but not limited to, strike and disaster, and shall submit it to the Department upon request.

6.0 **AUDIT PROVISION:** The Contractor and its authorized subcontractors are subject to audits by the State of Wisconsin, the Legislative Audit Bureau (LAB), an independent Certified Public Accountant (CPA), or other representatives as authorized by the State of Wisconsin. The Contractor will cooperate with such efforts and provide all requested information permitted under the law.

Authorized personnel shall have access to interview any Contractor's or subcontractor's employee or authorized agent involved with this Contract in conjunction with any audit, review, or investigation deemed necessary by the State of Wisconsin.

7.0 **CRIMINAL BACKGROUND VERIFICATION:** The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://oser.state.wi.us/docview.asp?docid=6658). The Contractor is expected to perform background checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

8.0 **COMPLIANCE WITH ON-SITE PARTY RULES AND REGULATIONS:** Contractor and the State of Wisconsin agree that their employees, while working at or visiting the premises of the other party, shall comply with all internal rules and regulations of the other party, including security procedures, and all applicable federal, state, and local laws and regulations applicable to the location where said employees are working or visiting.

The Department is responsible for allocating building and equipment access, as well as any other necessary Services available from the Department that may be used by the Contractor. Any use of the Department facilities, equipment, internet access, and/or services shall only be for project purposes as authorized by the Department. The Contractor will provide its own personal computers, which must comply with the Department security policies before connection

to the Department's local computer network.

9.0 SECURITY OF PREMISES, EQUIPMENT, DATA AND PERSONNEL: The State of Wisconsin shall have the right, acting by itself or through its authorized representatives, to enter the premises of the Contractor at mutually agreeable times to inspect and copy the records of the Contractor and the Contractor's compliance with this section. In the course of performing Services under this Contract, the Contractor may have access to the personnel, premises, equipment, and other property, including data files, information, or materials (collectively referred to as "data") belonging to the State.

The Contractor shall be responsible for damage to the State's equipment, workplace, and its contents, or for the loss of data, when such damage or loss is caused by the Contractor, contracted personnel, or subcontractors, and shall reimburse the State accordingly upon demand. This remedy shall be in addition to any other remedies available to the State by law or in equity.

10.0 BREACH NOT WAIVER: A failure to exercise any right, or a delay in exercising any right, power or remedy hereunder on the part of either party shall not operate as a waiver thereof. Any express waiver shall be in writing and shall not affect any event or default other than the event or default specified in such waiver. A waiver of any covenant, term or condition contained herein shall not be construed as a waiver of any subsequent breach of the same covenant, term or condition. The making of any payment to the Contractor under this Contract shall not constitute a waiver of default, evidence of proper Contractor performance, or acceptance of any defective item or Services furnished by the Contractor.

11.0 SEVERABILITY: The provisions of this Contract shall be deemed severable and the unenforceability of any one or more provisions shall not affect the enforceability of any of the other provisions. If any provision of this Contract, for any reason, is declared to be invalid, unenforceable, or illegal, the parties shall substitute an enforceable provision that, to the maximum extent possible in accordance with applicable law, preserves the original intentions and economic positions of the parties.

12.0 LIQUIDATED DAMAGES: The Contractor and Department acknowledge that it can be difficult to ascertain actual damages when a Contractor fails to carry out the responsibilities of this Contract. Because of that, the Contractor and Department will negotiate liquidated damages, as required by the State of Wisconsin, for this Contract. The Contractor agrees that the Department shall have the right to liquidate such damages, through deduction from the Contractor's invoices, in the amount equal to the damages incurred, or by direct billing to the Contractor.

The Department shall notify the Contractor in writing of any claim for liquidated damages pursuant to this section within thirty (30) Calendar Days after the Contractor's failure to perform in accordance with the terms and conditions of this Contract.

Notwithstanding the foregoing language, when necessary the Department will identify in the RFP specific financial penalties for failure of the Contractor to meet performance standards and guarantees that may be set forth in the RFP.

13.0 CONTRACT DISPUTE RESOLUTION: In the event of any dispute or disagreement between the parties under this Contract, whether with respect to the interpretation of any provision of this Contract, or with respect to the performance of either party hereto, except for breach of Contractor's intellectual property rights, each party shall appoint a representative to meet for the purpose of endeavoring to resolve such dispute or negotiate for and adjustment to such provision.

No legal action of any kind, except for the seeking of equitable relief in the case of the public's health, safety or welfare, may begin in regard to the dispute until this dispute resolution procedure has been elevated to the Contractor's highest executive authority and the equivalent executive authority within the Department, and either of the representatives in good faith concludes, after a good faith attempt to resolve the dispute, that amicable resolution through continued negotiation of the matter at issue does not appear likely.

The party believing itself aggrieved (the "Invoking Party") shall call for progressive management involvement in the dispute negotiation by delivering written notice to the other party. Such notice shall be without prejudice to the Invoking Party's right to any other remedy permitted by this Contract. After such notice, the parties shall use all reasonable efforts to arrange personal meetings and/or telephone conferences as needed, at mutually convenient times and places, between authorized negotiators for the parties at the following successive management levels, each of which shall have a period of allotted time as specified below which to attempt to resolve the dispute:

Level	Contractor	The Department	Allotted Time
First Second	Level 1 entity	Deputy Office Director Office	10 Business Days
	Level 2 entity	Director	20 Business Days
Third	Level 3 entity	Secretary	30 Business Days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is days from the date that the Invoking Party's notice was originally received by the other party. If the Third Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's

original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the section below. The time periods herein are in addition to those periods for a party to cure provided elsewhere in this Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

14.0 **CONTROLLING LAW:** All questions as to the execution, validity, interpretation, construction and performance of this Contract shall be construed in accordance with the laws of the State of Wisconsin, without regard to any conflicts of laws or choice of law principles. Any court proceeding arising or related to this Contract or a party's obligations hereunder shall be exclusively brought and exclusively maintained in the State of Wisconsin, Dane County Circuit Court, or in the District Court of the United States Western District (if jurisdiction is proper in federal court), or upon appeal to the appellate courts of corresponding jurisdiction, and Contractor hereby consents to the exclusive jurisdiction and exclusive venue therein and waives any right to object to such jurisdiction or venue. To the extent that in any jurisdiction Contractor may now or hereafter be entitled to claim for itself or its assets immunity from suit, execution, attachment (before or after judgment) or other legal process, Contractor, to the extent it may effectively do so, irrevocably agrees not to claim, and it hereby waives, the same.

15.0 **RIGHT TO SUSPEND OPERATIONS:** If, at any time during the period of this Contract, the Department determines that the best interest of the Department or its governing boards would be best served by the Contractor's temporarily holding of all Services, the Department will promptly notify the Contractor. Upon receipt of such notice, the Contractor shall suspend all Services.

16.0 **TERMINATION OF THIS CONTRACT:** The Department may terminate this Contract at any time at its sole discretion by delivering one-hundred eighty (180) Calendar Days written notice to the Contractor.

Upon termination, the Department's liability shall be limited to the prorated cost of the Services performed as of the date of termination plus expenses incurred with the prior written approval of the Department.

If the Contractor terminates this Contract, it shall refund all payments made hereunder by the Department to the Contractor for work not completed or not accepted by the Department. Such termination shall require written notice to that effect to be delivered by the Contractor to the Department not less than one-hundred eighty (180) Calendar Days prior to said termination.

Upon any termination of this Contract, the Contractor shall perform the Services specified in a transition plan if so requested by the Department; provided, however, that except as expressly set forth otherwise herein, the Contractor shall not be obligated to perform such Services unless all amounts due to the Contractor under this Contract, including payment for the transition Services, have been paid. Failure of the Contractor to comply with a transition plan upon request and upon payment shall constitute a separate breach for which the Contractor shall be liable.

Upon the expiration or termination for any reason, each party shall be released from all obligations to the other arising after the expiration date or termination date, except for those that by their terms survive such termination or expiration.

17.0 **TERMINATION FOR CAUSE:** If the Contractor fails to perform any material requirement of this Contract, breaches any material requirement of this Contract, or if the Contractor's full and satisfactory performance of this Contract is substantially endangered, the Department may terminate this Contract. Before terminating this Contract, the Department shall give written notice of its intent to terminate to Contractor after a thirty (30) Day written notice and cure period.

The State of Wisconsin reserves the right to cancel this Contract in whole or in part without penalty in one (1) or more of the following occurrences:

- **(a)** If the Contractor intentionally furnished any statement, representation, warranty, or certification in connection with its Proposal which is materially false, incorrect, or incomplete;
- **(b)** If applicable, fails to follow the sales and use tax certification requirements of Wis. Stat. § 77.66;
- **(c)** Incurs a delinquent Wisconsin tax liability;
- **(d)** Fails to submit a non-discrimination or affirmative action plan per the requirements of Wis. Stat. § 16.765 and Wisconsin's Fair Employment Law, subch. II, Chapter 111 of the Wisconsin Statutes as required herein;
- **(e)** Is presently identified on the list of parties excluded from State of Wisconsin procurement and non-procurement Contracts;
- **(f)** Becomes a state or federal debarred Contractor, or becomes excluded from state Contracts, or;
- **(g)** Fails to maintain and keep in force all required insurance, permits and licenses as required per this Contract;
- **(h)** Fails to maintain the confidentiality of the State of Wisconsin's information that is considered to be Confidential Information or Protected Health Information;
- **(i)** Files a petition in bankruptcy, become insolvent, or otherwise takes action to dissolve as a legal entity; or,
- **(j)** If at any time the Contractor's performance threatens the health or safety of a State of Wisconsin employee, citizen, or customer.
- **(k)** Violation of any requirements in Section 22 regarding Confidential Information.

In the event of a termination for cause by the State of Wisconsin, the State of Wisconsin shall be liable for payments for

any work accepted by the State of Wisconsin prior to the date of termination.

18.0 **REMEDIES OF THE STATE:** The State of Wisconsin shall be free to invoke any and all remedies permitted under Wisconsin law. In particular, if the Contractor fails to perform as specified in this Contract, the State of Wisconsin may issue a written notice of default providing for at least a seven (7) Business Day period in which the Contractor shall have an opportunity to cure, provided that cure is possible, feasible, and approved in writing by the State of Wisconsin. Time allowed for cure of a default shall not diminish or eliminate the Contractor's liability. If the default remains, after opportunity to cure, then the State of Wisconsin may: (1) exercise any remedy provided in law or in equity or (2) terminate Contractor's Services.

If the Contractor fails to remedy any delay or other problem in its performance of this Contract after receiving reasonable notice from the State of Wisconsin to do so, the Contractor shall reimburse the State of Wisconsin for all reasonable costs incurred as a direct consequence of the Contractor's delay, action, or inaction.

In case of failure to deliver Services in accordance with or Services from other sources as necessary, Contractor shall be responsible for the additional cost, including purchase price and administrative fees. This remedy shall be in addition to any other legal remedies available to the State of Wisconsin.

19.0 **TRANSITIONAL SERVICES:** Upon cancellation, termination, or expiration of this Contract for any reason, the Contractor shall provide reasonable cooperation, assistance and Services, and shall assist the State of Wisconsin to facilitate the orderly transition of the work hereunder to the State of Wisconsin and or to an alternative Contractor selected for the transition upon written notice to the Contractor at least thirty (30) business days prior to termination or cancellation, and subject to the terms and conditions set forth herein.

20.0 **ADDITIONAL INSURANCE RESPONSIBILITY:** The Contractor shall exercise due diligence in providing Services under this Contract. In order to protect the Board's governing the Department and any Department employee against liability, cost, or expenses (including reasonable attorney fees) which may be incurred or sustained as a result of Contractors errors or other failure to comply with the terms of this Contract, the selected Contractor shall maintain errors and omissions insurance including coverage for network and privacy risks, breach of privacy and wrongful disclosure of information in an amount acceptable to the Department with a minimum of **$1,000,000** and **$5,000,000** aggregate per claim in force during this Contract period and for a period of three (3) years thereafter for Services completed. Contractor shall furnish the Department with a certificate of insurance for such amount. Further, this certificate shall designate the State of Wisconsin Employee Trust Funds and its affiliated boards as additional insured parties. The Department reserves the right to require higher or lower limits where warranted.

21.0 **OWNERSHIP OF MATERIALS:** Except as otherwise provided in subsection (t) of Section 22, all information, data, reports and other materials as are existing and available from the Department and which the Department determines to be necessary to carry out the scope of Services under this Contract shall be furnished to the Contractor and shall be returned to the Department upon completion of this Contract. The Contractor shall not use it for any purpose other than carrying out the work described in this Contract.

The Department will be furnished without additional charge all data, models, information, reports, and other materials associated with and generated under this Contract by the Contractor.

The Department shall solely own all customized software, documents, and other materials developed under this Contract. Use of such software, documents, and materials by the Contractor shall only be with the prior written approval of the Department.

This Contract shall in no way affect or limit the Department's rights to use, disclose or duplicate, for any purpose whatsoever, all information and data pertaining to the Department or covered individuals and generated by the claims administration and other Services provided by Contractor under this Contract.

All files (paper or electronic) containing any Wisconsin claimant or employee information and all records created and maintained in the course of the work specified by this Contract are the sole and exclusive property of the Department. Contractor may maintain copies of such files during the term of this Contract as may be necessary or appropriate for its performance of this Contract. Moreover, Contractor may maintain copies of such files after the term of this Contract (i) for one hundred twenty (120) days after termination, after which all such files shall be transferred to the Department or destroyed by Contractor, except for any files as to which a claim has been made, and (ii) for an unlimited period of time after termination for Contractor's use for statistical purposes, if Contractor first deletes all information in the records from which the identity of a claimant or employee could be determined and certifies to the Department that all personal identifiers have been removed from the retained files.

22.0 **CONFIDENTIAL INFORMATION AND HIPAA BUSINESS ASSOCIATE AGREEMENT:** This Section is intended to cover handling of Confidential Information under state and federal law, and specifically to comply with the requirements of HIPAA, HITECH, and the Genetic Information Nondiscrimination Act (GINA) and the federal implementing regulations for those statutes requiring a written agreement with business associates.

(a) DEFINITIONS: As used in this Section, unless the context otherwise requires:

(1) Business Associate. "Business Associate" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Contractor (insert name of Contractor).

(2) Confidential Information has the meaning ascribed to it in Section 1.5 of the RFP.

(3) Covered Entity. "Covered Entity" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Department of Employee Trust Funds.

(4) HIPAA Rules. "HIPAA Rules" mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(5) Individual Personal Information "Individual Personal Information" has the meaning ascribed to it at Wis. Admin. Code ETF § 10.70 (1).

(6) Medical Record. "Medical Record" has the meaning ascribed to it at Wis. Admin. Code ETF 10.01 (3m).

(b) PROVISION OF CONFIDENTIAL INFORMATION FOR CONTRACTED SERVICES: ETF, a different business associate of ETF or a contractor performing Services for ETF may provide Confidential Information to the Contractor under this Contract as the Department determines is necessary for the proper administration of this Contract, as provided by Wis. Stat. § 40.07 (1m) (d) and (3).

(c) DUTY TO SAFEGUARD CONFIDENTIAL INFORMATION: The Contractor shall safeguard Confidential Information supplied to the Contractor or its employees under this Contract. In addition, the Contractor will only share Confidential Information with its employees on a need-to-know basis. Should the Contractor fail to properly protect Confidential Information, any cost the Department pays to mitigate the failure will be subtracted from the Contractor's invoice(s).

(d) USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor shall:

(1) Not use or disclose Confidential Information for any purpose other than as permitted or required by this Contract or as required by law. Contractor shall not use or disclose member names, addresses, or other data for any purpose other than specifically provided for in this Contract;

(2) Make uses and disclosures and requests for any Confidential Information following the minimum necessary standard in the HIPAA Rules;

(3) Use appropriate safeguards to prevent use or disclosure of Confidential Information other than as provided for by this Contract, and with respect to Protected Health Information, comply with Subpart C of 45 CFR Part 164;

(4) Not use or disclose Confidential Information in a manner that would violate Subpart E of 45 CFR Part 164 or Wis. Stat. § 40.07 if done by ETF; and

(5) If applicable, be allowed to use or disclose Confidential Information for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided the disclosures are required by law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been or is suspected of being breached.

(e) COMPLIANCE WITH ELECTRONIC TRANSACTIONS AND CODE SET STANDARDS: The Contractor shall comply with each applicable requirements of 45 C.F.R. Part 162 if the Contractor conducts standard transactions, as that term is defined in HIPAA, for or on behalf of ETF.

(f) MANDATORY REPORTING: Contractor shall report to ETF in the manner set forth in Subsection (l) any use or disclosure or suspected use or disclosure of Confidential Information not provided for by this Contract, of which it becomes aware, including breaches or suspected breaches of unsecured Protected Health Information as required at 45 CFR 164.410.

(g) DESIGNATED RECORD SET: Contractor shall make available Protected Health Information in a designated record set to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.524.

(h) AMENDMENT IN DESIGNATED RECORD SET: Contractor shall make any amendment to Protected Health Information in a designated record set as directed or agreed to by ETF pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy ETF's obligations under 45 CFR 164.526.

(i) ACCOUNTING OF DISCLOSURES: Contractor shall maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.528.

(j) COMPLIANCE WITH SUBPART E OF 45 CFR 164: To the extent Contractor is to carry out one or more of ETF's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to a covered entity in the performance of such obligation; and

(k) INTERNAL PRACTICES: Contractor shall make its internal practices, books, and records available to the Secretary of the United States Department of Labor for purposes of determining compliance with the HIPAA Rules.

(l) CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** A list of any affected members (if available);
- **b.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **c.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **d.** The date of the discovery by Contractor;
- **e.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **f.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than one (1) business day before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

(m) CLASSIFICATION LABELS: Contractor shall ensure that all data classification labels contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed by the Department.

(n) SUBCONTRACTORS: If applicable, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit Confidential Information on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information.

(o) NOTICE OF LEGAL PROCEEDINGS: If Contractor or any of its employees, agents, or subcontractors is legally required in any administrative, regulatory or judicial proceeding to disclose any Confidential Information, contractor shall give the Department prompt notice (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

(p) MITIGATION: The Contractor shall take immediate steps to mitigate any harmful effects of the suspected or actual unauthorized use, disclosure, or loss of any Confidential Information provided to Contractor under this Contract. The Contractor shall reasonably cooperate with the Department's efforts to comply with the breach notification requirements of HIPAA, to seek appropriate injunctive relief or otherwise prevent or curtail such suspected or actual unauthorized use, disclosure or loss, or to recover its Confidential Information, including complying with a

reasonable corrective action plan, as directed by the Department.

(q) COMPLIANCE REVIEWS: The Department may conduct a compliance review of the Contractor's security procedures before and during this Contract term to protect Confidential Information.

(r) AMENDMENT: The Parties agree to take such action as is necessary to amend the Contract as necessary for compliance with the HIPAA Rules and other applicable law.

(s) SURVIVAL: The obligations of Contractor under this Section survive the termination of the underlying Contract.

(t) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION: Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

1. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to ETF or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;
4. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;
5. Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and
6. If required by ETF, transmit the Confidential Information to another contractor of ETF.

23.0 INDEMNIFICATION:

23.1 SCOPE OF INDEMNIFICATION FOR INTELLECTUAL PROPERTY RIGHTS INFRINGEMENT: In the event of a claim against the Parties for Intellectual Property Rights Infringement associated with a claim for benefits, Contractor agrees to defend, indemnify and hold harmless Board and Department ("Indemnified Parties") from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Board, Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section.

23.2 SCOPE OF OTHER INDEMNIFICATION: In addition to the foregoing Section, Contractor shall defend, indemnify and hold harmless the Indemnified Parties from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section, or liability arising from or in connection with the following: (a) Contractor's performance of or failure to perform any duties or obligations under any agreement between Contractor and any third party; (b) injury to persons (including death or illness) or damage to property caused by the act or omission of Contractor or Contractor Personnel; (c) any claims or losses for Services rendered by any subcontractor, person, or firm performing or supplying Services, materials, or supplies in connection with the Contractor's performance of this Contract; (d) any claims or losses resulting to any person or third party entity injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under this Contract in a manner not authorized by this Contract, or by Federal or State statutes or regulations; and (e) any failure of the Contractor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

23.3 INDEMNIFICATION NOTICE: Department shall give Contractor prompt written notice of such claim, suit, demand, or action (provided that a failure to give such prompt notice will not relieve Contractor of its indemnification obligations hereunder except to the extent Contractor can demonstrate actual, material prejudice to its ability to mount a defense as a result of such failure). Department will cooperate, assist, and consult with Contractor in the defense or investigation of any claim made or suit filed against Department resulting from Contractor's performance under the Contract.

23.4 NO INDEMNIFICATION OBLIGATIONS: Contractor shall as soon as practicable, notify Department of any claim made or suit filed against Contractor resulting from Contractor's obligations under this Contract if such claim may involve the Department. Department has no obligation to provide legal counsel or defense to Contractor if a suit, claim, or action is brought against Contractor or its subcontractors as a result of Contractor's performance of its obligations under this Contract. In addition, Department has no obligation for the payment of any judgments or the settlement of any claims against Contractor arising from or related to this Contract. Department has not waived any right or entitlement to claim sovereign immunity under this Contract.

23.5 CONTRACTOR'S DUTY TO INDEMNIFY: Contractor shall comply with its obligations to indemnify, defend and hold the Indemnified Parties harmless with regard to claims, damages, losses and/or expenses arising from a claim for benefits under the Plan as provided herein. Contractor shall be entitled to control the defense of any such claim and to defend or settle any such claim, in its sole discretion, with counsel of its own choosing; however, Contractor shall consult with Department regarding its defense of any claim and not settle or compromise any claim or action in a manner that imposes restrictions or obligations on Department, requires any financial payment by Department, or grants rights or concessions to a third party without first obtaining Department's prior written consent. Contractor shall have the right to assert any and all defenses on behalf of the Indemnified parties, including sovereign immunity.

In carrying out any provision of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters the Department acts as an agent of the State.

The Contractor shall at all times comply with and observe all federal and state laws and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct.

24.0 EQUITABLE RELIEF: The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury shall not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Contract or under applicable law.

25.0 RIGHT TO PUBLISH OR DISCLOSE: Throughout the term of this Contract, the Contractor must secure the Department's written approval prior to the release of any information which pertains to work or activities covered by this Contract.

The parties agree that it is a breach of this Contract to disclose any information to any person that the Department or its governing boards may not disclose under Wis. Stat. § 40.07. Contractor acknowledges that it will be liable for damage or injury to persons whose Confidential Information is disclosed by any officer, employee, agent, or subcontractor of the Contractor without proper authorization.

26.0 TIME IS OF THE ESSENCE: Timely provision of the Services required under this Contract shall be of the essence of the Contract, including the provisions of the Services within the time agreed or on a date specified herein.

27.0 IDENTIFICATION OF KEY PERSONNEL AND PERSONNEL CHANGES: The Department will designate a contract administrator, who shall have oversight for performance of the Department's obligations under this Contract. The Department shall not change the person designated without prior written notification to the Contractor.

The State of Wisconsin reserves the right to approve all individuals assigned to this project. The Contractor agrees to use its best effort to minimize personnel changes during the Contract term.

At the time of contract negotiations, the Contractor shall furnish the Department with names of all key personnel assigned to perform work under this Contract and furnish the Department with criminal background checks.

The Contractor will designate a contract administrator who shall have executive and administrative oversight for performance of the Contractor's obligations under this Contract. The Contractor shall not change this designation without prior written notice to the Department.

The Contractor may not divert key personnel for any period of time except in accordance with the procedure identified in this section. The Contractor shall provide a notice of proposed diversion or replacement to the single person of contact (SPOC) at least sixty (60) days in advance, together with the name and qualifications of the person(s) who will take the place of the diverted or replaced staff. At least thirty (30) days before the proposed diversion or replacement, the Department shall notify the SPOC whether the proposed diversion or replacement is approved or rejected, and if rejected shall provide reasons for the rejection. Such approval by the Department shall not be unreasonably withheld or delayed.

Replacement staff shall be on-site within two (2) weeks of the departure date of the person being replaced. The Contractor shall provide the Department with reasonable access to any staff diverted by the Contractor.

Replacement of key personnel shall be with persons of equal ability and qualifications. The Department has the right to conduct separate interviews of proposed replacements for key personnel. The Department shall have the right to approve, in writing, the replacement of key personnel. Such approval shall not be unreasonably withheld. Failure of the Contractor to promptly replace key personnel within thirty (30) Calendar Days after departure shall entitle the Department to terminate this Contract. The notice and justification must include identification of proposed substitute key personnel and must provide sufficient detail to permit evaluation of the impact of the change on the project and/or maintenance.

Any of the Contractor's staff that the Department deems unacceptable shall be promptly and without delay removed by the Contractor from the project and replaced by the Contractor within thirty (30) Calendar Days by another employee with acceptable experience and skills subject to the prior approval of the Department. Such approval by the Department will not be unreasonably withheld or delayed.

An unauthorized change by the Contractor of any Contracted Personnel designed as key personnel will result in the imposition of liquidated damages, as defined in this Contract.

28.0 DATA SECURITY AND PRIVACY AGREEMENT

(a) PURPOSE AND SCOPE OF APPLICATION: This Data Security and Privacy Agreement (Agreement) is designed to protect the Department of Employee Trust Fund's (ETF) Confidential Information and ETF Information Resources (defined below). This Agreement describes the data security and privacy obligations of Contractor and its sub-contractors that connect to ETF Information Resources and/or gain access to Confidential Information.

(b) DEFINED TERMS:

(1) **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) Individual Personal 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); or (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 by Contractor on FORM D –Designation of Confidential and Proprietary Information (DOA-3027). Pricing information cannot be held confidential.

(2) **ETF Information Resources** means those devices, networks and related infrastructure that ETF has obtained for use to conduct ETF business. Devices include but are not limited to, ETF-owned, managed, used through service agreements storage, processing, communications devices and related infrastructure on which ETF data is accessed, processed, stored, or communicated, and may include personally owned devices. Data includes, but is not limited to, Confidential Information, other ETF created or managed business and research data, metadata, and credentials created by or issued on behalf of ETF.

(c) ACCESS TO ETF INFORMATION RESOURCES: In any circumstance when Contractor is provided access to ETF Information Resources, it is solely Contractor's responsibility to ensure that its access does not result in any access by unauthorized individuals to ETF Information Resources. Contractors who access ETF's systems from any ETF location must at a minimum conform with ETF security standards that are in effect at the ETF location(s) where the access is provided. Any Contractor technology and/or systems that gain access to ETF Information Resources must comply with, at a minimum, the elements in the Computer System Security Requirements set forth in this Agreement.

(d) COMPLIANCE WITH APPLICABLE LAWS: Contractor agrees to comply with all applicable state and federal laws, as well as industry best practices, governing the collection, access, use, disclosure, safeguarding and destruction of Confidential Information.

(e) PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor agrees to hold ETF's Confidential Information, and any information derived from such information, in strictest confidence. Contractor will not access, use or disclose Confidential Information other than to carry out the purposes for which ETF disclosed the Confidential Information to Contractor, except as permitted or required by applicable law, or as otherwise authorized in writing by ETF. For avoidance of doubt, this provision prohibits Contractor from using for its own benefit Confidential Information or any information derived from such information. If required by a court of competent jurisdiction or an administrative body to disclose Confidential Information, Contractor will notify ETF in writing immediately upon receiving notice of such requirement and prior to any such disclosure, to give ETF an opportunity to oppose or otherwise respond to such disclosure (unless prohibited by law from doing so).

(f) REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES: The Contractor's transmission, transportation or storage of Confidential Information outside the United States, or access of Confidential Information from outside the United States, is prohibited except on prior written authorization by ETF.

(g) SAFEGUARD STANDARD: Contractor agrees to protect the privacy and security of Confidential Information according to all applicable laws and regulations, including HIPAA, by commercially-acceptable frameworks or standards such as the ISO/IEC 27000-series, NIST, 800-53, RFC 2196, IEC 62443, and SANS CIS Top 20. ISO 270001, etc. Security Controls, and no less rigorously than it protects its own confidential information, but in no case less than reasonable care. Contractor will implement, maintain and use appropriate administrative, technical and physical security measures to preserve the confidentiality, integrity and availability of the Confidential Information. All Confidential Information stored on portable devices or media must be encrypted in accordance with the Federal Information Processing Standards (FIPS) Publication 140-2. Contractor will ensure that all security measures are regularly reviewed including ongoing monitoring, an annual penetration and vulnerability test, and an annual security incident response test, and revised, no less than annually, to address evolving threats and vulnerabilities while Contractor has responsibility for the Confidential Information under the terms of this Agreement. Prior to agreeing to the terms of this Agreement, and periodically thereafter (no more frequently than annually) at ETF's request, Contractor will provide assurance, in the form of a third-party audit report or other documentation acceptable to ETF, such as SOC2 Type II, demonstrating that appropriate information security safeguards and controls are in place.

(h) INFORMATION SECURITY PLAN:

(1) Contractor acknowledges that ETF is required to comply with information security standards for the protection of Confidential Information as required by law, regulation and regulatory guidance, as well as ETF's internal security program for information and systems protection.

(2) Contractor will establish, maintain and comply with an information security plan (Information Security Plan), which will contain, at a minimum, such elements as those set forth in this Agreement.

(3) Contractor's Information Security Plan will be designed to:

- **a.** Ensure the privacy, security, integrity, availability, and confidentiality of Confidential Information;
- **b.** Protect against any anticipated threats or hazards to the security or integrity of such information;
- **c.** Protect against unauthorized access to or use of such information that could result in harm or inconvenience to the person that is the subject of such information;
- **d.** Reduce risks associated with Contractor having access to ETF Information Resources; and
- **e.** Comply with all applicable legal and regulatory requirements for data protection.

(4) On at least an annual basis, Contractor will review its Information Security Plan, update and revise it as needed, and submit it to ETF upon request. At ETF's request, Contractor will make modifications to its Information Security Plan or to the procedures and practices thereunder to conform to ETF's security requirements as they exist from time to time. If there are any significant

modifications to Contractor's Information Security Plan, Contractor will notify ETF within a reasonable period of time, not to exceed two weeks. Any significant modification must include the same or a higher framework or information security standard maturity level than what currently exists in the Plan.

(i) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION:

Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

(1) Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

(2) Where feasible, return to ETF, or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;

(3) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;

(4) Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;

(5) Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and

(6) If required by ETF, transmit the Confidential Information to another contractor of ETF.

(j) NOTIFICATION OF CORRESPONDENCE CONCERNING CONFIDENTIAL INFORMATION: Contractor agrees to notify ETF immediately, both orally and in writing, but in no event more than twenty-four (24) hours after Contractor receives correspondence or a complaint regarding Confidential Information, including but not limited to, correspondence or a complaint that originates from a regulatory agency or an individual.

(k) BREACHES OF CONFIDENTIAL INFORMATION:

CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure of ETF's Confidential Information, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** The nature of the unauthorized access, use or disclosure;
- **b.** A list of any affected members (if available);
- **c.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **d.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **e.** The date of the discovery by Contractor;
- **f.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **g.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than twenty-four (24) hours before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons

potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

COORDINATION OF BREACH RESPONSE ACTIVITIES:

(4) Contractor will fully cooperate with ETF's investigation of any breach involving Contractor, including but not limited to making witnesses, documents, HIPAA logs, systems logs, video recordings, or other pertinent or useful information available immediately upon Contractor's reporting of the breach and throughout the investigation. Contractor's full cooperation will include but not be limited to Contractor:

- **a.** Immediately preserving any potential forensic evidence relating to the breach, and remedying the breach as quickly as circumstances permit
- **b.** Within forty-eight (48) hours designating a contact person to whom ETF will direct inquiries, and who will communicate Contractor responses to ETF inquiries; Contractor will designate a Privacy Officer and Security Officer to serve as contacts for ETF.
- **c.** As rapidly as circumstances permit, applying appropriate resources to remedy the breach condition, investigate, document, restore ETF service(s) as directed by ETF, and undertake appropriate response activities such as working with ETF, its representative, and law enforcement to identify the breach, identify the perpetrator(s), and take appropriate actions to remediate the security vulnerability;
- **d.** Providing status reports at least every two (2) hours until the root cause of the breach is identified and a plan is devised to fully remediate the breach;
- **e.** Once the root cause of the breach is identified and a plan is devised to fully remediate the breach, providing status reports daily or at mutually agreed upon timeframes, to ETF on breach response activities, findings, analyses, and conclusions;
- **f.** Coordinating all media, law enforcement, or other breach notifications with ETF in advance of such notification(s), unless expressly prohibited by law; and
- **g.** Ensuring that knowledgeable Contractor staff is available on short notice, if needed, to participate in ETF-initiated meetings and/or conference calls regarding the breach.

ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS:

(5) Contractor will make itself and any employees, subcontractors, or agents assisting Contractor in the performance of its obligations available to ETF at no cost to ETF to testify as witnesses, or otherwise, in the event of a breach or other unauthorized disclosure of Confidential Information caused by Contractor that results in litigation, governmental investigations, or administrative proceedings against ETF, its directors, officers, agents or employees based upon a claimed violation of laws relating to security and privacy or arising out of this Agreement or the Contract.

(l) RETENTION OF LOGS:

(1) HIPAA logs (logs of any systems that have information relating to HIPAA) must be kept for six (6) years.

(2) Firewall logs must be kept for twelve (12) months.

(m) ADDITIONAL INSURANCE: In addition to the insurance required under the Agreement, Contractor at its sole cost and expense will obtain, keep in force, and maintain an insurance policy (or policies) that provides coverage for privacy and data security breaches. This specific type of insurance is typically referred to as Privacy, Technology and Data Security Liability, Cyber Liability, or Technology Professional Liability. In some cases, Professional Liability policies may include some coverage for privacy and/or data breaches. Regardless of the type of policy in place, it needs to include coverage for reasonable costs in investigating and responding to privacy and/or data breaches with the following minimum limits unless ETF specifies otherwise: $1,000,000 Each Occurrence and $5,000,000 Aggregate.

(n) INFORMATION SECURITY PLAN REQUIREMENTS:

(1) Contractor will develop, implement, and maintain a comprehensive Information Security Plan that is written in one or more readily accessible parts and contains administrative, technical, and physical safeguards. The safeguards contained in such program must be consistent with the safeguards for protection of Confidential Information and information of a similar character set forth in any state or federal regulations by which the person who owns or licenses such information may be regulated.

(2) Without limiting the generality of the foregoing, every comprehensive Information Security Plan will include, but not be limited to:

a. Designating one or more employees to maintain the comprehensive Information Security Plan;

b. Identifying and assessing internal and external risks to the security, confidentiality, and/or integrity of any electronic, paper or other records containing Confidential Information and of ETF Information Resources, and evaluating and improving, where necessary, the effectiveness of the current safeguards for limiting such risks, including but not limited to:

c. Ongoing employee (including temporary and contract employee) training;

d. Employee compliance with policies and procedures; and

e. Means, including Contractor staff, processes, and technology, for detecting information system intrusions, data breaches, and anomalous system behavior or activity, and for preventing security breaches, intrusions, or unauthorized access to information systems or networks.

f. Developing security policies for employees relating to the storage, access and transportation of records containing Confidential Information outside of business premises.

g. Imposing disciplinary measures for violations of the comprehensive Information Security Plan rules.

h. Preventing terminated employees from accessing records containing Confidential Information and/or ETF Information Resources.

i. Overseeing service providers, by:

--Taking reasonable steps to select and retain third-party service providers that are capable of maintaining appropriate security measures to protect such Confidential Information and ETF Information Resources consistent with all applicable laws and regulations; and

-- Requiring such third-party service providers by contract to implement and maintain such appropriate security measures for Confidential Information.

j. Placing reasonable restrictions upon physical access to records containing Confidential Information and ETF Information Resources and requiring storage of such records and data in locked facilities, storage areas or containers.

k. Restrict physical access to any network or data centers that may have access to Confidential Information or ETF Information Resources.

l. Requiring regular monitoring to ensure that the comprehensive Information Security Plan is operating in a manner reasonably calculated to prevent unauthorized access to or

unauthorized use of Confidential Information and ETF Information Resources; and upgrading information safeguards as necessary to limit risks.

m. Reviewing the scope of the security measures at least annually or whenever there is a material change in business practices that may reasonably implicate the security or integrity of records containing Confidential Information and of ETF Information Resources.

n. Documenting responsive actions taken in connection with any incident involving a breach, and mandating post-incident review of events and actions taken, if any, to make changes in business practices relating to protection of Confidential Information and ETF Information Resources.

(o) COMPUTER SYSTEM SECURITY REQUIREMENTS: To the extent that Contractor electronically stores or transmits Confidential Information or has access to any ETF Information Resources, it will include in its written, comprehensive Information Security Plan the establishment and maintenance of a security system covering its computers, including any wireless system, that, at a minimum, and to the extent technically feasible, will have the following elements:

(1) Secure user authentication protocols including:

a. Control of user IDs and other identifiers;
b. A secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;
c. Multi-Factor Authentication (MFA);
c. Control of data security passwords to ensure that such passwords are kept in a location and/or format that does not compromise the security of the data they protect;
d. Multi-factor authentication for system administrators and others with 'super-user' access rights;
e. Restricting access to active users and active user accounts only;
f. Blocking access to user identification after multiple unsuccessful attempts to gain access or the limitation placed on access for the particular system; and
g. Periodic review of user access, access rights and audit of user accounts.

(2) Secure access control measures that:

a. Restrict access to records and files containing Confidential Information and systems that may have access to ETF Information Resources to those who need such information to perform their job duties; and
b. Assign unique identifications plus passwords, which are not vendor supplied default passwords, to each person with computer access, which are reasonably designed to maintain the integrity of the security of the access controls.

(3) Encryption of all transmitted records and files containing Confidential Information.

(4) Adequate security of all networks that connect to ETF Information Resources or access Confidential Information, including wireless networks.

(5) Reasonable monitoring of systems, for unauthorized use of or access to Confidential Information and ETF Information Resources.

(6) Encryption of all Confidential Information stored on Contractor devices, including laptops or other portable storage devices.

(7) For files containing Confidential Information on a system that is connected to the Internet or that may have access to ETF Information Resources, reasonably up-to-date firewall, router and switch protection and operating system security patches, reasonably designed to maintain the integrity of the Confidential Information.

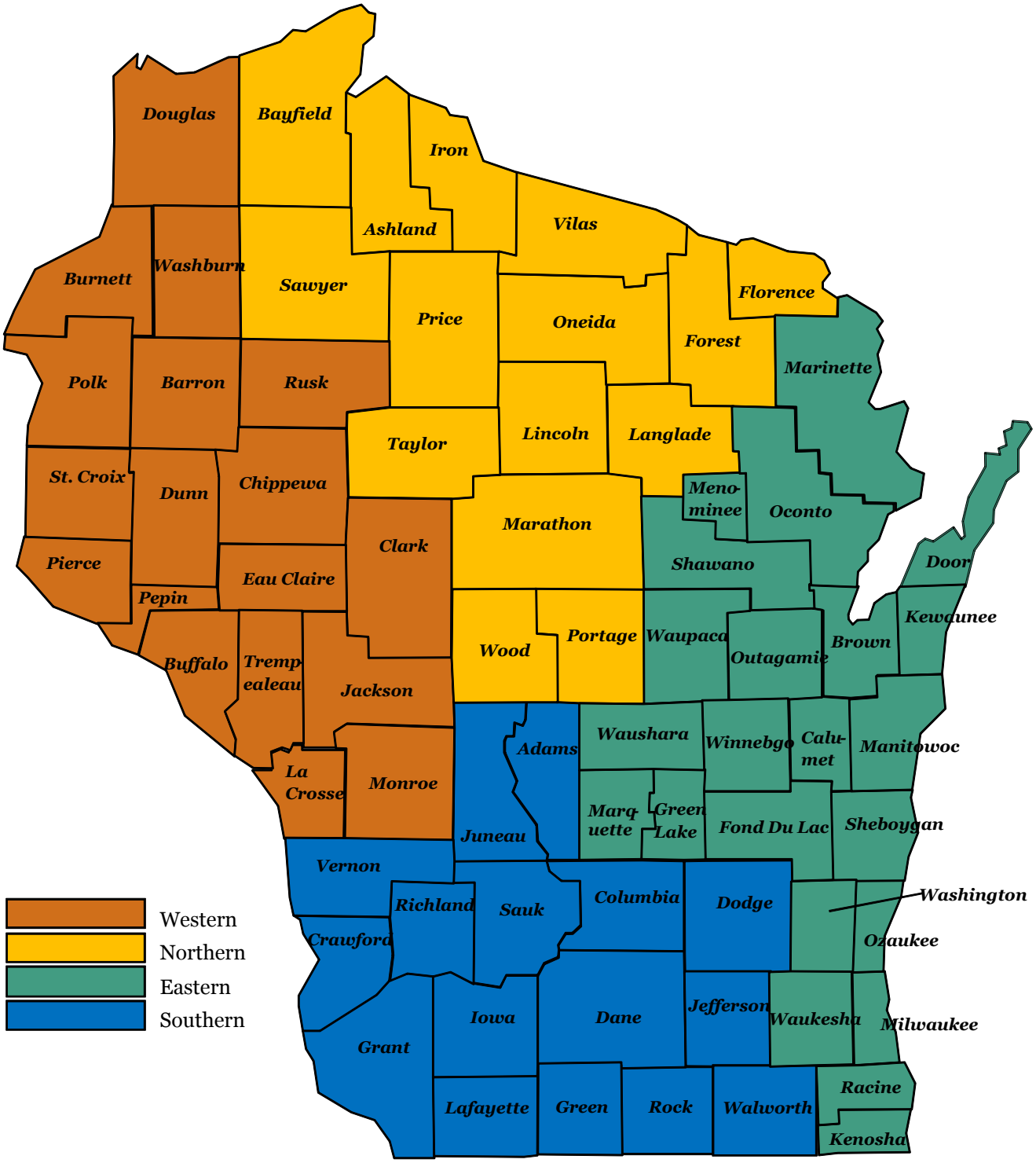
(8) Reasonably up-to-date versions of system security agent software, including intrusion detection systems, which must include malware protection and reasonably up-to-date patches and virus definitions, or a version of such software that can still be supported with up-to-date patches and virus definitions, and is set to receive the most current security updates on a regular basis.

(9) Education and training of employees on the proper use of the computer security system and the importance of Confidential Information and network security.

With reasonable notice to Contractor, ETF may require additional security measures which may be identified in additional guidance, contracts, communications or requirements.

State of Wisconsin
Department of Employee Trust Funds
Regional Map

RFP ETG0003
Exhibit 5: Map
Issued July 22, 2016



State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R07/2016)
§ 51.01(5) Wis. Stats. § 111.32(13m) Wis Stats

Department of Employee Trust Funds
801 W. Badger Road
P. O. Box 7931
Madison, WI 53707-7931

Contract

Commodity or Service: Administrative Services for the State of Wisconsin Health Benefit Program

Contract No./Request for Bid/Proposal No: ETG0003 (Q)
Authorized Board: Group Insurance Board

Contract Period: June 1, 2017 through December 31, 2020 with the optional renewal of three (3) two (2) year periods

1. This Contract is entered into by the State of Wisconsin, Department of Employee Trust Funds (Department), the State of Wisconsin Group Insurance Board (Board) and between Quartz Health Solutions, Inc. hereinafter referred to as the "Contractor", whose address and principal officer appears on page 2. The Department is the sole point of contact for this Contract.

2. Whereby the Department of Employee Trust Funds agrees to direct the purchase and the Contractor agrees to supply the Contract requirements cited in accordance with the State of Wisconsin standard terms and conditions and in accordance with the Contractor's proposal dated September 15, 2016 hereby made a part of this Contract by reference.

3. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employees or applicants for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s.51.01(5), Wis. Stats., sexual orientation as defined in s.111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

4. Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan. Contractors with an annual work force of less than fifty (50) employees are exempted from this requirement. Within fifteen (15) business days after the award of the Contract, the plan shall be submitted for approval to the Department. Technical assistance regarding this clause is provided by the Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931, 608.261.7952, or via e-mail at ETFProcurement@etf.wi.gov.

5. Contractor agrees to the Discount Guarantees and Gain Sharing Agreement in Exhibit B.

6 For purposes of administering this Contract, the order of precedence is:

   a) This Contract with Quartz Health Solutions, Inc.;
   b) Exhibit A, Contract clarifications from ETF;
   c) Exhibit B, Discount Guarantees and Gain Sharing Agreement;
   d) RFP Exhibit 1 – State of Wisconsin Health Benefit Program Agreement, dated May 1, 2017;
   e) RFP Exhibit 4 – Department Terms and Conditions, dated April 26, 2017;
   f) Appendix 4a Claims Data Specifications – Medical, dated March 29, 2017;
   g) Appendix 5 Provider Data Specifications, dated March 29, 2017;
   h) Request for Proposal (RFP) ETG0003 dated July 22, 2016, including all appendices, attachments, and amendments thereto; and,
   i) Contractor's proposal dated September 15, 2016.

Contract Number & Service: ETG0003 (Q) Administrative Services for the State of Wisconsin Health Benefit Program

State of Wisconsin Department of Employee Trust Funds	Contractor to Complete
By Authorized Board *(Name)* **Group Insurance Board**	Legal Company Name **Quartz Health Solutions, Inc.**
By *(Name)* **Michael Farrell**	Trade Name
Signature	Taxpayer Identification Number 46-5710709
Title **Chair** Group Insurance Board	Company Address *(City, State, Zip)* 840 Carolina Street Sauk City, WI 53583-1374
Phone 608.266.9854 (A. John Voelker, Deputy Secretary)	By *(print Name)* Terry R. Bolz
Date *(MM/DD/CCYY)*	Signature Terry R. Bolz
	Title President & CEO
	Phone 608.643.1401
	Date *(MM/DD/CCYY)* 05/03/2017

Exhibit A

Contract ETG0003 (Q): Clarifications and changes agreed to by the parties to the July 22, 2016 Request for Proposal (RFP) ETG0003 Administrative Services for the State of Wisconsin Health Benefit Program to be provided by Quartz Health Solutions, Inc. to the State of Wisconsin Department of Employee Trust Funds for the Health Insurance Programs Offered by the State of Wisconsin Group Insurance Board.

The following are clarifications to Contract terms:

#	Document / Section	Section Description	Clarification
1	n/a	n/a	Any dispute, disagreement or question of interpretation of Exhibits 2, 3, or 4 (the Terms and Conditions) and the application of those Exhibits to the terms of this contract is subject to discussion and resolution under Exhibit 4, Section 13.0 (Contract Dispute Resolution) of the Department Terms and Conditions."
2	Exhibit 1 Section 130	Premiums	The language in this section is not intended to hold a Contractor liable for payment of actuarial services related to a review of claims experience, trends and other factors covered by the rate renewal reports submitted by a Contractor pursuant to this section.
3	Exhibit 1 Section 135B	Administrative Fee Adjustments	Language as shown was drafted with the intention to allow for administrative fee increases, as recommended by ETF's actuary. Should an administrative fee change be implemented for which the TPA disagrees, the process on contract dispute resolution is provided in Exhibit 4.0, Section 13.0.
4	Exhibit 1 Section 215A	Disease Management / Prior Authorizations / Utilization Review	The contract requires prior authorizations to include member out-of-pocket cost sharing information. The intent is to base the authorization on the provider status at time of the authorization review with disclosure about any anticipated provider status change for the length of the approval period and disclosure that the member's deductible, coinsurance and/or copayment applies. Member out-of-pocket costs do not need to be amount specific and instruction should be provided on how members can obtain specific cost-sharing information. The contract also states the Contractor is responsible for the cost of services not covered under the contract when the member has received a prior authorization. The intent is to hold the Contractor accountable if it errors by prior authorizing a service that is not covered under the contract.

#	Document / Section	Section Description	Clarification
5	Exhibit 1 Sections 230 and 230D	Provider Contracts Provider Contracts Shall Include Compliance Plans	Including the provider agreement requirements outlined in Section 230 and the compliance plans outlined in Section 230D in a policy, program or process for which the provider contract requires compliance, even though the provider contract does not specifically identify such items, is deemed to meet this contractual requirement.
6	Exhibit 4 Section 28.0 (i)(2)	Data Security and Privacy Agreement	1) The data should be destroyed; 2) unless Contractor can definitely prove to ETF that the data was de-identified; and 3) that Contractor confirms to ETF in writing that no crosswalk exists to re-identify the data.
7	n/a	n/a	Based on the contract negotiations that ETF has conducted over the last several weeks with each of the six contractors, ETF now believes it is appropriate to delete references in the RFP and Section 135B of RFP Exhibit 1 specifically stating that the contractors are fiduciaries. The duties that contractors will perform are delineated throughout the RFP and Exhibit 1. Case law confirms that whether or not a contract specifically states that a contractor is a fiduciary, courts have issued decisions finding that the duties and facts in a particular situation demonstrate that a contractor is a fiduciary.
8	Exhibit 4 Section 12.0	Liquidated Damages	It is the Department's intent that the Contractor will be able to utilize the process described in Exhibit 4, Section 13.0 (Contract Dispute Resolution) prior to the Department imposing any Liquidated Damages.

Wisconsin Department of Employee Trust Funds
Discount Guarantees for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Quartz**
Region **Southern**

Vendor will provide 2018 expected overall level of discount.
ETF and Vendor will mutually agree on final starting point.

2018 Discount Target*

* A supplemental worksheet allows vendors to calculate this discount with enrollment and regional assumptions. Upon open enrollment these will be re-based accordingly.

Annual improvement - Spread between Eligible Charge Increase and Vendor Allowed Increase. Expectations on Discount improvement decrease with higher baseline discounts. Improvement is calculated as Assumed Spread x (1-Discount).

Assumed Spread

		Annual Improvement
2019 overall level of discount is expected to improve over 2018	**2019 Discount Target**	
2020 overall level of discount is expected to improve over 2019	**2020 Discount Target**	

Fees at Risk will vary by percentage below target for each of the 3 years based on the following Scale:

% of Actual Discount below Target	% of Total Admin Fees at Risk
	0%
	5%
	10%

Notes:
Actual Performance against Target Discounts will be calculated 6 months after the end of the Calendar Year with runout data available in the data warehouse at that time.
Large claims over $100,000, and any out-of-network claims, will be removed from the calculation.
Discount Percent is calculated as Total Submitted Eligible Charge less Total Allowed (state & member) divided by Total Submitted Eligible Charge.
Discount Guarantee is null and void if Gain-Sharing Actual PMPM is less than Target PMPM.

ETG0003

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Exhibit B

Vendor **Quartz**
Region **Southern**

Annual Shared Savings will be calculated based on two factors:
(1) Performance of Actual versus Target PMPM
(2) Performance of Actual versus Target Clinical Performance Measures

Performance of Actual versus Target PMPM

Illustrative Calculation

Prior Calendar Year allowed claims for those members who select vendor during open enrollment will be used as a starting point to determine a base aggregate PMPM. The data will be normalized to the vendor's network pricing. It is anticipated that this will include 12 months of incurred allowed claims. (TBD)

A claims completion factor will be applied to the allowed claims. This will be updated with runout during the settlement process with claims paid through June of the following Calendar Year. (TBD)

Total Calendar Year Incurred Claims

Apply Industry and Market Specific Trend (TBD) - Trend assumptions will be uniform across all vendors

Calendar Year Allowed PMPM Target

Amount of savings to be shared with vendor will vary by percentage of actual PMPM below Target PMPM based on the following Scale:

	CY 2018	CY 2019	CY 2020
% of Actual PMPM below Target	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**
< 3.00%	0%	0%	0%
3.00% - 6.00%	5%	7.5%	10%
> 6.00%	10%	17.5%	25%

Notes on PMPM:
1) Target PMPM will be set by March 1st of the current CY based on prior CY incurred claims with current year enrollment, adjustment for network pricing, completion factors and trend.
2) Performance of Actual versus Target PMPM will be calculated at the end of the CY when 6 months of runout is available in the data warehouse. This results in 18 months of runout for the Target PMPM and 6 months of runout for the Actual PMPM. Note that the Actual PMPM will have a completion factor applied.

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Quartz**
Region **Southern**

Performance of Actual versus Target Clinical Performance Measures

In addition to the shared savings amounts based on Actual versus Target PMPM Calculations, payments will be reduced based on the percentage of clinical targets met by the vendor for the Calendar Year. If all clinical targets are met, payouts will be 100% of the PMPM calculations described above. If, for example, 75% of the clinical targets are met, payouts will be 75% of the PMPM calculations described above.

Clinical Targets for each year of the contract will be determined for each vendor individually by comparing actual baseline for each vendor to an ultimate target for each measure. The difference between the vendor's baseline and target will be the gap that should be closed over 3 years with equal improvement in each of the 3 years to reach the target. Examples are shown below:

	Baseline	Target	Gap	2018 Target	2019 Target	2020 Target
Vendor A	50%	90%	40%	63%	77%	90%
Vendor B	80%	90%	10%	83%	87%	90%
Vendor C	95%	90%	-5%	90%	90%	90%

ETG0003

Wisconsin Department of Employee Trust Funds
Discount Guarantee Development Worksheet

Exhibit B

Vendor **Quartz**
Region **Southern**

		Preliminary Discount Guarantee			Final Discount Guarantee		
Region	Total Members	Expected Enrollment	Expected Distribution	Discount Guarantee	Open Enrollment	Final Distribution	Discount Guarantee
Eastern	63,766						
Northern	8,151						
Southern	113,299						
Western	21,024						
In-State	206,240						
Out-of-State	3,379						
Total Membership	209,619						

After open enrollment, a final discount guarantee will be developed based on vendor's actual enrollment.
Discount guarantees by region may not be altered during this process.

ETG0003

RFP ETG0003

Exhibit 1: State of Wisconsin Health Benefit Program Agreement

Issued May 1, 2017

State of Wisconsin Health Benefit Program Agreement

Issued by the State of Wisconsin

Department of Employee Trust Funds

On behalf of the Group Insurance Board

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000 DEFINITIONS

Unless otherwise defined herein, any term needing definition shall have the definition found in Uniform Benefits (of this AGREEMENT), the RFP, the PROPOSAL or in applicable Wisconsin law. These terms, when used and capitalized in this AGREEMENT are defined and limited to that meaning only:

AGREEMENT means the State of Wisconsin Health Benefit Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

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).

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).

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 attachments, supplements, endorsements riders and the CONTRACTOR'S PROPOSAL.

CONTRACTOR means the legal signatory to this AGREEMENT.

DAY means calendar DAY unless otherwise indicated.

DEPARTMENT means the State of Wisconsin Department of Employee Trust Funds.

DEPENDENT as defined in Uniform Benefits.

DOMESTIC PARTNER as defined in Uniform Benefits.

EFFECTIVE DATE means the date, as certified by the DEPARTMENT and shown on the records of the CONTRACTOR in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

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 program that provides group health BENEFITS to eligible State of Wisconsin and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

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.

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.

PBM means the Pharmacy Benefit Manager (PBM) which is a third party administrator that is contracted with the BOARD to administer the prescription drug benefits under this HEALTH BENEFIT PROGRAM. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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.

PROPOSAL means the complete response of a proposer submitted and setting forth the proposer's pricing for providing the services described in the Request for Proposal (RFP).

QUARTERLY means a period consisting of every consecutive three (3) months beginning January 2018.

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.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the CONTRACTOR for enrollment and who is entitled to BENEFITS.

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).

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETG0003 and in the PROPOSAL.

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 (forms 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).

110 Objectives

The BOARD's objectives of the HEALTH BENEFIT PROGRAM include, but are not limited to the following:

1) Management and delivery of health care services to PARTICIPANTS through contracted networks that provide for high-quality, cost-effective care.

2) To provide excellent customer service to PARTICIPANTS.

3) To offer networks of high value providers, and to incent PARTICIPANTS to choose benefit plan designs with high value providers.

4) To provide high-quality services at a competitive price.

5) Accurate, timely and responsive administration of health care claims.

6) 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.

7) To offer tools for PARTICIPANTS to increase engagement, including:

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

8) To ensure quality population health programs, including case management and disease management, which promote proactive management of PARTICIPANT health concerns.

9) 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 to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

3) Cooperate with the DEPARTMENT to develop procedures and protocols for sharing information as necessary.

4) Provide, in a format acceptable to the DEPARTMENT, at no cost and in a timely manner, all data and written or recorded material pertaining to this AGREEMENT.

5) Provide the specified level of services as indicated in this AGREEMENT to PARTICIPANTS.

6) Assist the DEPARTMENT with the administration of this AGREEMENT, including PARTICIPANT enrollment, record keeping, and general operations.

7) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT, including but not limited to, initial determination of eligibility for DEPENDENTS for disabled and full-time student status.

8) 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.

9) Have a mechanism, as approved by the DEPARTMENT, for handling complaints and grievances made by PARTICIPANTS.

   a) This includes a formal grievance procedure, which at a minimum complies with federal law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the 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.

10) Submit to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information.

11) Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in care from OUT-OF-NETWORK providers.

12) Comply with state and federal regulations pertaining to mandated or minimum BENEFITS which may be applicable to the CONTRACTOR under insurance statutes or as directed by the BOARD.

13) Provide DEPARTMENT approved materials to PARTICIPANTS as required under this AGREEMENT.

14) Provide notification of all significant events:

a) 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 (15%) percent 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 (51%) percent) interest in the CONTRACTOR or any transfer of ten (10%) percent or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the 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."

15) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT.

16) Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32.

17) Provide coverage for PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

18) 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.

19) Shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT.

20) 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, per Wis. Stat. § 40.02 (25) (b), eligible EMPLOYEES include:

1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS).

2) Elected state officials.

3) Members or EMPLOYEES of the legislature.

4) Any blind EMPLOYEES of the Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3.

5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance.

6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave (Wis. Stat. § 40.05 (4) (bm)).

7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority:

    a) Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

b) Any teacher who is a participating EMPLOYEE and who is employed by the UW System for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

c) Certain visiting faculty members in the UW System.

d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.

e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one (1) semester for academic year (nine (9) month) or six (6) months for annual (twelve (12) month) appointments.

f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of twenty-eight (28%) percent or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one (21%) percent or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.

g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.

h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospital and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.

8) ANNUITANTS and CONTINUANTS:

a) Any covered EMPLOYEE who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

b) The surviving spouse or DOMESTIC PARTNER of a SUBSCRIBER.

c) Covered EMPLOYEES who terminate employment, have attained minimum retirement age (fifty (50) for protective services or fifty-five (55) for all other categories), have twenty (20) years of WRS creditable service and defer their annuity are eligible to continue in the HEALTH BENEFIT PROGRAM if a timely application is submitted.

d) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll 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.

e) Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for coverage through the EMPLOYER.

f) Any retired public employee under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

125B Dependent Coverage Eligibility

Individual coverage covers only the SUBSCRIBER. All eligible DEPENDENTS listed on the application are covered under a family contract. A SUBSCRIBER cannot choose to exclude any eligible DEPENDENT from family coverage, unless that DEPENDENT is already covered under the HEALTH BENEFIT PROGRAM.

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

Notwithstanding the paragraph above, the birth or adoption of a child to a SUBSCRIBER under an individual benefit plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within sixty (60) DAYS of the birth, adoption, or placement for adoption.

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the 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.

125E Local Annuitants

LOCAL ANNUITANTS who cancel coverage for any reason are not eligible to reenroll in the program as a SUBSCRIBER.

125F Medicare Participants

ANNUITANTS and their DEPENDENTS, or surviving DEPENDENTS, who become enrolled in Medicare may continue to be covered at reduced PREMIUM rates, as specified by the BOARD.

Enrollment in Medicare by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the STATE or participating LOCAL EMPLOYER. Enrollment in Medicare Parts A and B is required for the EMPLOYEE and/or Medicare-eligible DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active EMPLOYEE'S group health benefit policy with another employer and that policy is the primary payer for Medicare Parts A and B charges, the ANNUITANT and/or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare reduced PREMIUM for coverage under this program.

As required by Medicare rules, Medicare is the primary payer for DOMESTIC PARTNERS age sixty-five (65) and older who are enrolled in Medicare, regardless of the work status of the SUBSCRIBER. The reduction in PREMIUM is available only when the coverage is provided under a non-employer group number.

Enrollment in Medicare by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the covered EMPLOYEE, ANNUITANT or DEPENDENT is required to pay a premium to enroll in the HOSPITAL portion of Medicare (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

130 Premiums

The BOARD determines the PREMIUM for its self-insured benefit plans as part of the HEALTH BENEFIT PROGRAM. This PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to:

1) Projection of incurred claims costs for the renewal benefit period.

2) The most recent thirty-six (36) months of incurred/paid triangular reports for the current benefit period.

3) Complete documentation of the methodology and assumptions utilized to develop the projected costs.

4) Disclosure of supporting data used in the calculation, including monthly paid claims and enrollment, network provider fee-structure analysis, provider negotiations updates, utilization analysis to report on unusual patterns, large claims analysis, trend analysis, and demographic analysis.

5) Substantiation of any proposed increase in fixed costs, such as administrative costs, via a thorough analysis of activities and costs covered by those fees.

6) Explanations for any unusual trend results (high or low relative to the market).

The CONTRACTOR will work with the BOARD'S consulting actuary independently to agree on a format, and the frequency of providing this data.

SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255.

The State of Wisconsin's current contribution toward the total health benefit for EMPLOYEES (non-retired) for both individual and family contracts is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The tiered structure is based on recommendations from the BOARD'S consulting actuary.

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 the Medicare HOSPTIAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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 coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. 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.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see Sections 125F and 220H.

135 Administrative Fee and Financial Administration

135A Invoicing and Banking

1) Claims Invoicing:

   a) The CONTRACTOR shall notify the DEPARTMENT every calendar week during the term of this AGREEMENT and inform the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. The amount due every week shall be the total amount of BENEFIT payments issued by the CONTRACTOR for the claims processed during the immediately prior calendar week (Saturday through Friday).

   b) The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT by the first Friday immediately following the DEPARTMENT'S receipt of the request for payment by the CONTRACTOR. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.

   c) The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within twenty (20) BUSINESS DAYS following month-end.

   d) The CONTRACTOR shall submit a claims invoice reconciliation report each month for the prior month. The report will reconcile the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. The weekly claims invoice must show claims by the benefit period in which they were incurred and by state and local subgroups.

2) Administrative Fee Invoicing:

   a) The CONTRACTOR must submit to the DEPARTMENT on the twentieth (20th) DAY of each calendar month (or the first BUSINESS DAY following the twentieth (20th) DAY of the calendar month), an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The monthly invoice must show the total amount of administration

fees, other approved fees and expenses due for the immediately following calendar month. The DEPARTMENT shall deposit funds into the bank account designated by the CONTRACTOR on the first BUSINESS DAY of the calendar month following the DEPARTMENT'S receipt of the invoice from the CONTRACTOR.

b) The CONTRACTOR shall be paid the administrative fee per month per PARTICIPANT as detailed in the CONTRACT. All administrative plan arrangement-related fees are included in the CONTRACTOR's administrative fee.

   The statewide/nationwide CONTRACTOR shall be paid for underwriting services to evaluate risk and submit recommendations for LOCAL EMPLOYERS requesting participation in the local HEALTH BENEFIT PROGRAM. The LOCAL EMPLOYER shall send payments for underwriting services to the DEPARTMENT. The DEPARTMENT shall forward one check for the appropriate amount shown in the Cost Proposal to the CONTRACTOR for their services.

3) Direct Pay SUBSCRIBER Invoicing:

   The CONTRACTOR shall not process any PREMIUM transactions related to enrollment, except for those direct pay SUBSCRIBERS.

135B Administrative Fee Adjustments

Administrative fee adjustments, if any, required as recommended by the BOARD's consulting actuary for BENEFIT changes, mandated BENEFIT payments, and/or operational changes, will occur on January 1 after the next contract period begins unless otherwise approved by the BOARD. The CONTRACTOR shall supply an administrative monthly invoice that must be based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The CONTRACTOR shall be paid the following administrative charge per month per PARTICIPANT for the AGREEMENT periods stated as follows:

Medical administration fee per individual and family contract. The medical administration fee includes, but is not limited to, the following:

1) Claims administration (including adjudication, payment, reprocessing, coordination of BENEFITS (excluding vendor recoveries), and overpayment collection).

2) Utilization review fees.

3) Network access fees.

4) MHSA claims administration.

5) Medical management (including medical review).

6) Disease management.

7) Customer service (to meet all requirements of this AGREEMENT, including all key personnel).

8) PARTICIPANT materials (including explanations of BENEFITS, summary of BENEFITS and coverage, web tools, ID cards, printing and mailing costs).

9) All required reports (including federally required reports and tax related forms).

10) Claims data extracts.

11) Administration, collection of, and passing through to the DEPARTMENT, premiums for direct pay SUBSCRIBERS (including reporting non-payment terminations).

12) IT services (including hardware and software).

13) Telecom (other program resource links, reporting, special usage or access requirements).

14) Required reviews (including fraud and abuse, and HOSPITAL bill).

15) Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing).

16) Telehealth services.

17) Twenty-four (24)-hour nurse line services.

18) Underwriting services (applies to a CONTRACTOR providing statewide/nationwide services under this AGREEMENT only).

135C Prohibited Fees

1) The CONTRACTOR is prohibited from including in their administrative fee:

   a) The cost to handle any claims paid outside of Uniform Benefits or IYC Medicare Plus administered by the statewide/nationwide CONTRACTOR.

   b) The cost to administer any optional health and wellness benefit(s) beyond Uniform Benefits, IYC Medicare Plus that is administered by the statewide/nationwide CONTRACTOR or the Well Wisconsin program.

2) The CONTRACTOR is prohibited from billing separate fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

135D Recovery of Overpayments

1) Overpayments:
   If it is determined that any payment has been made under this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or

shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.

If any overpayments made to ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments. Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR'S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments. Any overpayment caused by the CONTRACTOR'S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.

The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures.

2) The BOARD shall hold the CONTRACTOR and its directors, officers, and employees harmless from any liability for any overpayments and/or underpayments made to any ineligible former PARTICIPANT when payments result from a failure of the BOARD, the DEPARTMENT or any other State department or agency to make a timely report to the CONTRACTOR of any PARTICIPANT'S loss of eligibility.

   The DEPARTMENT shall not hold the CONTRACTOR responsible for any overpayments caused by DEPARTMENT or EMPLOYER errors or fraud by a person other than an employee of the CONTRACTOR.

   The CONTRACTOR shall assist the DEPARTMENT in identifying overpayments caused by such error or fraud.

3) The BOARD reserves the sole right to institute litigation for the purpose of recovering any overpayment. The BOARD reserves the right to join in any litigation instituted by the CONTRACTOR for the purpose of recovering any overpayment which is the responsibility of the CONTRACTOR.

4) The CONTRACTOR shall be given full credit for all refunds that result from recovery of any overpayment to the extent that the CONTRACTOR is held financially responsible for such overpayment within this AGREEMENT.

5) Disputes over Charges:

   Notwithstanding any other terms, conditions, and provisions of this AGREEMENT, the CONTRACTOR shall pay CHARGES as determined by the CONTRACTOR. Disputes as to CHARGES will be referred, on a timely basis, to the CONTRACTOR who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

   If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT shall contact the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR shall notify the DEPARTMENT about the lawsuit.

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 administrative fees or other 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:

1) Providers to request and receive electronic funds transfer (EFT) of claims payments for BENEFITS.

2) SUBSCRIBERS to submit EFT of direct pay PREMIUM payments. The CONTRACTOR must support other mechanisms for payment of direct pay PREMIUMS.

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.

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.

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. 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. The next roll-out for the new system is currently scheduled for 2018.

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.

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 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.

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 Claims Data Specifications document, all claims processed for PARTICIPANTS. At least ninety-five (95%) percent of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred (100%) percent of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

b) 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, 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. 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 and integrate the data as required under Section 240. 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 provided by the DEPARTMENT with 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 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 RFP, 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. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file. 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 and are the direct result of the CONTRACTOR's failure to meet the

DEPARTMENT'S data submission requirements or timelines and which the DEPARTMENT will deduct from any payment owed the CONTRACTOR in the payment period.

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.

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 Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits. All amounts recovered under this program shall be paid forty-five (45%) percent to the CONTRACTOR and fifty-five (55%) percent to the BOARD.

155D 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.

155E 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) 16 and provide a copy of the CPA's report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.) The audit report must be submitted annually.

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.

155F 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. For information see Section 135D.

2) Contractor Provider 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; and,

n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. 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 personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

4) The actual impact list (as soon as known).

5) A copy of any correspondence sent to affected PARTICIPANTS (this must be pre-approved by the DEPARTMENT).

6) A description of the steps taken to ensure a similar incident will not be repeated.

This notification requirement shall apply only to PHI or PII received or maintained by the CONTRACTOR pursuant to this AGREEMENT. The CONTRACTOR shall make good faith efforts to communicate with the DEPARTMENT about breaches by major provider groups if the CONTRACTOR knows those breaches affect PARTICIPANTS.

The CONTRACT shall notify the DEPARTMENT Program Manager and Privacy Officer no less than one (1) BUSINESS DAY before any external communications are made regarding a data breach.

155H 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.

155I 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 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) In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.

4) Membership changes and corrections not processed during the term of the contract will continue to be processed by the CONTRACTOR during the entire run-out period. During the entire run-out period, all performance standards and penalties remain in force.

5) The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT'S approval.

155J Transition Plan

During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. In the event that the CONTRACTOR terminates the CONTRACT, an updated

transition plan must accompany the notice of termination. In the event the BOARD terminates the CONTRACT, the CONTRACTOR must send an updated transition plan to the DEPARTMENT within thirty (30) DAYS of the written notice of termination to the CONTRACTOR. The transition plan must be approved by the DEPARTMENT prior to the transition begin date and must include the CONTRACTOR'S cooperation and participation in planning calls or meetings with the succeeding vendor.

The CONTRACTOR must administer a program run-out period to process claims and to handle related customer service inquiries. The run-out period begins on the CONTRACT termination date and will be no longer than one (1) year. The CONTRACTOR shall be paid three (3) months of administrative expenses based on the membership census as of November 1 of the last year of the contract. The administrative fee shall be the fee in effect during the last year the contract. The fee shall be paid in three (3) installments. The first installment shall be paid in December of the last year of the contact. The second installment shall be paid in January of the year of run-out. The final payment will be made no later than December of the year of run-out unless issues arise with data submission to the DEPARTMENT'S data warehouse. In the event of issues receiving run-out claims per the DEPARTMENT'S timeline, the DEPARTMENT will withhold the final fee payment until all run-out claims are received.

Leading up to and during the run-out period, the CONTRACTOR must:

1) Participate in all DEPARTMENT requested meetings.

2) Provide all reports for program close out.

3) Report on performance standards specified in Section 315.

4) Invoice the DEPARTMENT as specified in Section 135A.

5) Transmit program data to the new vendor.

6) Continue grievance, hospital bill audit, subrogation services and overage disabled dependent reviews.

7) Transmit run-out claims data to the DEPARTMENT'S data warehouse as specified in Section 150.

155K Health Underwriting for Statewide/Nationwide Contractor only

LOCAL EMPLOYERS with one or more employees requesting participation in the local HEALTH BENEFIT PROGRAM are subject to underwriting. The CONTRACTOR shall evaluate risk and submit a recommendation back to the DEPARTMENT for final approval by the BOARD'S actuary. The effective date shall be determined by the DEPARTMENT. The fees described in the Cost Proposal, or as agreed upon by the DEPARTMENT, shall be administered per Section 135A.

Employers with fifty-one (51) or more EMPLOYEES shall submit claims and enrollment experience including high cost claims data for the most recent available twenty-four (24) months along with the fees to the DEPARTMENT.

Employers with fifty (50) or less EMPLOYEES shall submit small employer information as required by the CONTRACTOR to the DEPARTMENT along with the fees.

The DEPARTMENT will submit information and appropriate fees to the 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.

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. 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) 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 Eligibility

The 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.

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

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 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 as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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. See Appendix 6, Guidance for DEPARTMENT Initiatives, for additional detail.

The current DEPARTMENT Initiatives 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) High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.

3) Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.

4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.

5) 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.

215C Quality Initiatives

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.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in Uniform Benefits to all PARTICIPANTS with the exception of the statewide/nationwide CONTRACTOR who must provide the BENEFITS and services listed in the IYC Medicare Plus certificate to all Medicare 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 high deductible health plan (HDHP) 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger 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 Preferred Provider Organization (PPO)

The BOARD may offer different copayment and deductible schedules for OUT-OF-NETWORK providers, except in the case of emergency, urgent care or when the services are not reasonably available IN-NETWORK.

If the PARTICIPANT resides in a CONTRACTOR'S service area, the PPO must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty IN-NETWORK provider when determining if that provider is reasonably available.

220G Medicare

The CONTRACTOR will provide BENEFITS and services as described in Uniform Benefits to PARTICIPANTS enrolled in Medicare with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS.

The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare.

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 EMPLOYEE, 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. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payer after this thirty (30)-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty (30) -month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer. No reduction in PREMIUM is available for active EMPLOYEES under this section.

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, change from or to the IYC HDHP).

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:

1) If a PARTICIPANT changes benefit plans.

2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER (or combination of spouse-to-DOMESTIC PARTNER) transfer resulting in a change of SUBSCRIBER, but does not change benefit plans.

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.

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. For HDHPs, medical and pharmacy accumulations are combined.

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.

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 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 audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year, which includes 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 commercially insured adult 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.

c) The results of the survey shall be used for the measurement of PARTICIPANT satisfaction as specified in the performance standards in Section 315G.

4) The DEPARTMENT will monitor health care quality and/or customer satisfaction using performance measures available in the data warehouse and visual business intelligence tool, and will establish performance metrics, baseline results, and target performance levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage performance improvement.

   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.

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 and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how 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.

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.

The 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 their provider network for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150.

The DEPARTMENT will use this data to ensure provider access standards are met. 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 (33%) percent 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 the following minimum requirements:

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 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 the access standards above, including accepting 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. 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 Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in Uniform Benefits with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS. Targets for claims processing performance standards and associated penalties are specified in Section 315C.

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. The CONTRACTOR shall pay claims of providers according to a time standard mutually established by the CONTRACTOR and the DEPARTMENT.

Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR shall provide the total dollar amount of claims paid by the HEALTH BENEFIT PROGRAM.

In accordance with state statute, the CONTRACTOR must maintain individual documentation used for claim adjudication for a minimum of seven (7) years.

240 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 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.

245 Grievances

245A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with the HHS-administered federal external review in accordance with federal law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections 245E, 245F, and 265A.

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 245A – H.

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

4) Notification of DEPARTMENT Administrative Review Rights (not all grievances eligible): Administrative review by DEPARTMENT staff, and/or the DEPARTMENT appeals process including filing an appeal with the BOARD, an administrative appeal hearing, consideration of the appeal by the BOARD, right to appeal the BOARD's final decision to circuit court; or,

5) Federal external review (not all grievances eligible).

245B 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.

245C 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.

245D 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.

245E Notification of Department Administrative Review Rights

In the final grievance decision letters, the CONTRACTOR shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR shall cite the specific Uniform Benefits contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision with the exception of the statewide/nationwide CONTRACTOR who will cite the specific IYC Medicare Plus contractual provision(s) for Medicare PARTICIPANTS.

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 HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

BOARD decisions can only be further reviewed as provided by Wis. Stat. § 40.08 (12) and Wis. Adm. Code ETF 11.15.

245F External Review

The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an 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.

245G 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.

245H 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.

245I 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.

245J 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.

250 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see Section 260D.

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.

255 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt. It is acceptable to credit the collected direct pay PREMIUM amount on the administrative monthly invoice provided that it contains itemized SUBSCRIBER level detail.

Direct pay PREMIUMS may be submitted to the CONTRACTOR via electronic funds transfer or 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.

260 Continuation

260A 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.

260B 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.

260C Conversion / Marketplace

The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment.

260D 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.

265 Miscellaneous Program Requirements

265A 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.

The CONTRACTOR is required to perform and/or manage the following activities by the date indicated:

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Nondiscrimination Testing Plan: The CONTRACTOR works with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.	Within thirty (30) DAYS of execution of this CONTRACT
Transition Plan: The transition plan is established in a mutually agreed upon format and submitted to the DEPARTMENT Program Manager or designee for review.	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2018 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	August 18, 2017
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 1, 2017
Employer Meeting: The CONTRACTOR attends the It's Your Choice EMPLOYER Kick-Off meeting.	Fall 2017 (Date TBD)
Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.	September 30, 2017
Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2017
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	September 2017 (Date TBD)
Employer Health Fairs: The CONTRACTOR shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area.	October – November 2017
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation.	November 16, 2017

Activity	Due Dates
Financial Administration: Financial administration requirements are operational, including but not limited to: • Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. • Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). • Direct pay invoicing process. • ACH mechanism for EFT of claims payments and direct pay PREMIUMS.	November 30, 2017
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2017
ID Cards: The CONTRACTOR issues welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018.	December 15, 2017
Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM are fully operational.	January 1, 2018
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2018
Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly.	January 15, 2018
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2018
Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2018
Claims Data: The claims data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	March 31, 2018

265B Account Management and Staffing

Upon execution of this CONTRACT, the CONTRACTOR shall designate an Account Manager and a backup, assigned to the DEPARTMENT for the life of the CONTRACT, who is accountable for and has the authority to:

1) Manage the entire range of services specified in the CONTRACT;

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

4) Implement the DEPARTMENT changes to benefit plan design and procedures; and,

5) Resolve general administrative problems identified by the DEPARTMENT.

The Account Manager or backup must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the contract. The Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR shall resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR must have a designated Information Technology contact and a backup Information Technology contact who will have overall responsibility for the information technology aspects of the CONTRACT. The Information Technology contact shall be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR shall provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. The CONTRACTOR shall ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT, have the experience and credentials necessary to perform the work required. The CONTRACTOR shall provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS.

The CONTRACTOR shall notify the DEPARTMENT if the Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to deny the CONTRACTOR'S designees.

The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must acknowledge receipt of the inquiry from the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the payroll processing centers and/or other payroll.

The CONTRACTOR shall provide onsite staff attendance at the annual IYC EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the annual IT'S YOUR CHOICE OPEN ENROLLMENT period.

The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR'S operations and policies.

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the 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 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting HEALTH BENEFIT PROGRAM services.

265C Customer Service

The CONTRACTOR shall operate a dedicated 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 315D 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, EMPLOYER group);

5) The representative that handled the inquiry;

6) For phone inquiries, the length of call; and,

7) The resolution of the inquiry (including a resolution code using a coding scheme).

Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request.

At the DEPARTMENT'S request, the CONTRACTOR must provide the policies and procedures related to the operation of the customer service department. The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each 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.

265D 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.).

265E 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.

265F 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR.

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.

265G 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 "personal information", as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;

2) Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,

3) Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record that would violate Wis. Stat. § 40.07 (1) or (2), respectively, if the disclosure was made by the DEPARTMENT.

265H 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.

265I Subrogation and Other Payers

The CONTRACTOR shall correspond with PARTICIPANTS to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other payers such as worker's compensation, insurance contracts, or government-sponsored benefit programs.

The CONTRACTOR shall have authority to retain any attorneys or law firms regarding such subrogation rights and lawsuits involving such rights to represent the BOARD to pursue the BOARD'S subrogation rights in accordance with this AGREEMENT. Any subrogation settlement agreed to by the CONTRACTOR shall be deemed acceptable by the BOARD. The CONTRACTOR may forego subrogation where, at the CONTRACTOR'S discretion, the circumstances in a particular subrogation matter warrant such a decision.

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel or utilize in-house counsel to provide the BOARD with subrogation litigation services on the BOARD'S behalf at a contingency fee not to exceed thirty (30%) percent for outside legal counsel or twenty (20%) percent for in-house counsel of net dollars recovered by such counsel, with those attorneys' fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

For such subrogation matters, the BOARD shall not pay or provide any additional reimbursement for the outside legal counsel's or in-house counsel's legal fees, expenses, costs and disbursements incurred by such counsel while providing subrogation-related legal services and such legal fees, expenses, costs and disbursements are included in, and will be paid out of, the maximum thirty (30%) percent contingency fee that is paid to the outside legal counsel or twenty (20%) percent fee paid to in-house counsel as set forth in this subsection. The CONTRACTOR will not be paid or receive any portion of the contingency fee that is paid to the outside legal counsel if outside legal counsel is hired. The BOARD shall be solely responsible and liable for paying the contingency fee to outside legal counsel for its attorneys' fees, legal costs and disbursements incurred by the outside legal counsel representing the BOARD in subrogation cases, not the CONTRACTOR. The CONTRACTOR is not responsible or liable for paying the contingency fee or any outside counsel attorneys' fees, legal costs and disbursements.

265J 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.

265K Other

The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the HEALTH BENEFIT PROGRAM.

265L 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.

265M Conflict of Interest

During the term of this AGREEMENT, the CONTRACTOR shall have no interest, direct or indirect, that would conflict in any manner or degree with the performance of services required under this AGREEMENT.

Without limiting the generality of the preceding paragraph, the CONTRACTOR agrees that it shall not, during the initial AGREEMENT period and any extension thereof, acquire or hold any business interest that conflicts with the CONTRACTOR'S ability relating to its performance of its services under this AGREEMENT.

The CONTRACTOR shall not engage in any conduct which violates, or induces others to violate, the provision of the Wisconsin statutes regarding the conduct of public employees. If a BOARD member or an organization in which a BOARD member holds at least ten (10%) percent interest is a party to this AGREEMENT, then this AGREEMENT is voidable by the BOARD unless appropriate disclosure has been made to the Wisconsin Ethics Commission.

300 DELIVERABLES

305 Reporting Requirements

As required by the CONTRACT, the CONTRACTOR must submit reports to the DEPARTMENT. Reports must be submitted by SECURE email to the DEPARTMENT, the DEPARTMENT'S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify reporting requirements as deemed necessary to monitor the CONTRACT and programs.

Instructions and specific due dates will be provided by the DEPARTMENT annually.

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the 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 Invoicing	The CONTRACTOR notifies the DEPARTMENT every calendar week during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. *(See Section 135A, 1, a.)*	Weekly
3) Administrative Fee Invoice	The CONTRACTOR submits to the DEPARTMENT an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. *(See Section 135A, 2, a.)*	Monthly
4) 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, 1.)*	Monthly
5) Bank Reconciliation Report	The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. *(See Section 135A, 1, c.)*	Monthly
6) Claims Invoice Reconciliation Report	The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. *(See Section 135A, 1, d.)*	Monthly

Report	Description	Frequency
7) 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 265C.)*	Monthly
8) 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, 2..)*	Monthly
9) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155F, 2.)*	Quarterly
10) Hospital Bill Audit	The CONTRACTOR performs a HOSPITAL bill audit process for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and provides results of material findings to the DEPARTMENT. *(See Section 155C.)*	Quarterly
11) 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
12) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
13) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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, High Tech Radiology, Low Back Surgery, Shared Decision Making, and Advance Care Planning. *(See Section 215B.)*	Semi-annually
14) 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 215C.)*	Semi-annually
15) 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.)*	Semi-annually

Report	Description	Frequency
16) 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
17) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. *(See Section 225, 3, b.)*	Annually
18) 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
19) 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
20) 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.)*	Annually
21) 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
22) 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
23) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year. *(See Section 225, 3, a.)*	Annually
24) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually

Report	Description	Frequency
25) Rate Renewal Reports	To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. *(See Section 130.)*	Annually
26) 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 16 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 DEPARTMENT Program Manager or designee. *(See Section 265A.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. *(See Sections 265A and 265B.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. *(See Section 155F, 2 and Section 265A.)*	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section 205B, 2.)*	Upon identification of issue
5) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section 265B.)*	April August

Deliverable	Description	Frequency
7) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. *(See Section 230A.)*	June
8) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July
9) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
10) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
11) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
12) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. *(See Section 140B, 1.)*	October
13) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
14) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
15) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 265D, 1a and 1p.)*	As directed by the DEPARTMENT
16) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred 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
17) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 265B.)*	As needed
18) Recovery of Overpayments	The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures. *(See Section 135F.)*	As needed
19) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 245K.)*	As needed

Deliverable	Description	Frequency
20) Notification of Legal Action Against PARTICIPANT in Dispute over Charges	If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit's status in a mutually agreeable format. *(See Section 135F.)*	As needed
21) Notification of 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 personal 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 155G.)*	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 245F.)*	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, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. *(See Section 155J.)*	During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • The HEALTH BENEFIT PROGRAM provider directory or directions on how to request a printed copy of the provider directory. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. *(See Section 230C.)*	See description
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. *(See Section 245B.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. *(See Section 245D.)*	See description
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment. *(See Section 260C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed
10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

Performance standards are specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book-of-business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT upon realization that a standard will not be met, prior to the deadline.

The penalties assessed in Section 150B and Section 315 shall not exceed twenty-five (25%) percent of the CONTRACTOR'S total administrative fee in any given quarter. After implementation, all performance standards will be measured by the DEPARTMENT on a QUARTERLY basis and assessed based on PARTICIPANT counts as of the first calendar DAY of the quarter, as determined by DEPARTMENT enrollment records. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

Section	Performance Category	Maximum Penalty
315A	Implementation	Three (3%) percent
315B	Account Management	Three (3%) percent
315C	Claims Processing	Four (4%) percent
315D	Customer Service	Four (4%) percent
315E	Data Management	Four (4%) percent
315F	Enrollment	Four (4%) percent
315G	Other	Three (3%) percent
	TOTAL	Twenty-five (25%) percent

315A Implementation

The CONTRACTOR shall complete the task by the date specified below. If an alternate date is approved by the DEPARTMENT in the implementation plan, the CONTRACTOR shall complete the task by the alternate date. The total penalties for this performance category shall not exceed three (3%) percent of the total estimated administrative fee for year one (1) of the CONTRACT.

Performance Standards – three (3%) percent Penalty	Penalties
1) Program Information: All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards – three (3%) percent Penalty	Penalties
2) Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) Customer Service: The CONTRACTOR's dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained no later than September 30, 2017. (*See Section 265A.)*	
4) Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. *(See Section 265A.)*	
5) Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 265A.)*	
6) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. *(See Section 265A.)*	
7) Financial Administration: Financial administration requirements are operational no later than November 30, 2017. *(See Section 265A.)*	
8) Grievance Procedure: The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT'S review and approval. *(See Section 265A.)*	
9) ID Cards: No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018. *(See Section 265A.)*	
10) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018. *(See Section 265A.)*	

Performance Standards – three (3%) percent Penalty	Penalties
11) Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
12) Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly no later than January 31, 2018. *(See Section 265A.)*	
13) Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than February 28, 2018. *(See Section 265A.)*	
14) Claims Data Transfer: The claims data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than March 31, 2018. *(See Section 265A.)*	

315B Account Management

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(*See *Section 265B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey

Performance Standards	Penalties
2) **Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 265D, 1.)*	Five thousand ($5,000) dollars per incident

315C Claims Processing

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Financial Accuracy:** At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid in the correct amount divided by the total claim dollars paid. *(See Section 235.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
2) **Processing Accuracy:** At least ninety-seven (97%) percent level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section 235.)*	
3) **Claims Processing Time:** At least ninety-five (95%) percent of all claims received must be processed within fifteen (15) BUSINESS DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 235.)*	

315D Customer Service

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Call Answer Timeliness**: At least eighty (80%) percent of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)

Performance Standards	Penalties
2) Call Abandonment Rate: Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
3) Open Call Resolution Turn-Around-Time: At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section 265C.)*	
4) Inquiry Resolution Tracking Document/Log: Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request. *(See Section 265C.)*	
5) Electronic Written Inquiry Response: At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section 265C.)*	

315E Data Management

The DEPARTMENT will specify the timetable and dates for which the claims and provider data transfers must be provided. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Claims Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a and 150B, 1.)*	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, 2.)*	

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 155G.)*	

315F Enrollment

The CONTRACTOR shall report QUARTERLY any DAY for which any of the following standards are not met. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 150A, 4, a and c.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Enrollment Discrepancies: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. *(See Section 150A, 4, a.)*	
3) ID Cards: The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
4) ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID cards by December 15 (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.)*	

Performance Standards	Penalties
5) Direct Pay Terminations: The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section 255.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

315G Other

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155E.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Grievance Resolution: Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. *(See Section 245C.)*	
3) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	
4) PARTICIPANT Satisfaction Surveys: The CONTRACTOR shall achieve at or above a ninety (90%) percent satisfaction rating (defined as “top three-boxes” using a zero (0) to ten (10) rating scale with ten (10) being the highest ranking) on the health plan rating question on the CAHPS survey tool or other survey instrument as approved by the DEPARTMENT. *(See Section 225, 3, c.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
5) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident

Performance Standards	Penalties
6) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

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 2018.

These are the Uniform Benefits or "Summary Plan Description" offered under the Health Benefit Program.

This portion of the Agreement is often excerpted and provided to PARTICIPANTS as their Summary Plan Description.

The contractor shall not alter the language, benefits or exclusions and limitations, herein.

These Uniform Benefits are provided to SUBSCRIBERS via the It's Your Choice materials as their Summary Plan Description. The language in this section is written to the audience of the PARTICIPANT. Included in this section is a set of definitions which is specific to Uniform Benefits. The contractor does not need to recreate the description of benefits nor distribute it to PARTICIPANTS.

These Uniform Benefits are provided to a SUBSCRIBER who is a retired public employee under Wis. Stat. § 40.02 (25) (b) 11, or any DEPENDENT of such an employee, and, if eligible, has acted under Wis. Stat. § 40.51 (10) to elect group health insurance coverage. SUBSCRIBERS or DEPENDENTS who are ineligible and unenrolled in Medicare may join Program Option 16. SUBSCRIBERS or DEPENDENTS who are eligible and enrolled in Medicare may join Program Option 12. Benefits will be provided to SUBSCRIBERS via the Local Annuitant Health Program (LAHP) materials.

I. Schedule of Benefits

All benefits are paid according to the terms of this contract between the THIRD PARTY ADMINISTRATOR(S) (TPA), the PBM, and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the contract. The SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, EMERGENCY services received from an OUT-OF-NETWORK PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE.

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

This Summary Plan Description applies to services received from IN-NETWORK PROVIDERS. If any OUT-OF-NETWORK benefits are available, YOU will be provided with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by OUT-OF-NETWORK PROVIDERS. OUT-OF-NETWORK DEDUCTIBLE amounts do not accumulate to the IN-NETWORK OUT-OF-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 TPA before such services are obtained.

The covered benefits are subject to the following:

1) DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Annual medical DEDUCTIBLE	$250 individual/$500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	None.	$1,500 per individual plan / $3,000 per family plan The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the plan pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).
Annual medical COINSURANCE	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies OOPL except as described below.	BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL.
Annual medical OUT-OF-POCKET LIMIT (OOPL)	$1,250 PARTICIPANT / $2,500 aggregate family limit except as described below.[1]	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]	After DEDUCTIBLE: $2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN pays 100%.	Covered 100%.	BENEFIT PLAN pays 100%.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $75 COPAYMENT (counts towards to OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit).[2]	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. §632.895 (16), covered 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	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 and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). 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 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Prescription Drugs	See below.	See below.	After DEDUCTIBLE: subject to medical DEDUCTIBLE above. After DEDUCTIBLE, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2]Federally required preventive services are covered at 100%.

[3] State of Wisconsin MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the MEDICARE Prime Uniform Benefits SCHEDULE OF BENEFITS.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical DEDUCTIBLE	None.	$250 individual / $500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	$500 individual / $1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). When an individual within a family plan meets the $500 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.	$1,500 per individual plan / $3,000 per family plan. The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the BENEFIT PLAN pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical COINSURANCE	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLEMEDICAL EQUIPMENT, cochlear implants and hearing aids.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visits, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.	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.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / 10% applies to medical services except for office visits, and as described below. COINSURANCE applies to OOPL except as described below.
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]	$1,250 individual / $2,500 aggregate family limit except as described below.[1]	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOPL.[1]	$2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
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	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15 per visit. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.	PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
Cochlear Implants for PARTICIPANTS age 18 and older	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLANS pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), BENEFIT PLANS pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
		treatment per PARTICIPANT per calendar year.		treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.
Prescription Drugs	See below.	See below.	See below.	After DEDUCTIBLE: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2] Federally required preventive services are covered at 100%.

[3] Wisconsin Public Employer MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the PO2 Uniform Benefits SCHEDULE OF BENEFITS.

1) Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE

2) Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.

3) Diagnostic Services Limitations: PRIOR AUTHORIZATION may be required.

4) Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): Covered up to 50 visits per PARTICIPANT for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional MEDICALLY NECESSARY visits may be available when PRIOR AUTHORIZED by the TPA, up to a maximum of 50 additional visits per therapy per PARTICIPANT per calendar year.

5) Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when MEDICALLY NECESSARY and PRIOR AUTHORIZED by the TPA; and HOSPITAL CHARGES. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for PARTICIPANTS under 18 years of age are payable as described in the preceding grid.

6) Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), hearing aids for PARTICIPANTS under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.

7) Home Care Benefits Maximum: 50 visits per PARTICIPANT per calendar year. 50 additional MEDICALLY NECESSARY visits per PARTICIPANT per calendar year may be available when authorized by the TPA.

8) HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the TPA.

9) Transplants: Limited to transplants listed in Benefits and Services Section.

10) Licensed Skilled Nursing Home Maximum: 120 days per BENEFIT PERIOD payable for SKILLED CARE.

11) Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.

12) Vision Services: One routine exam per PARTICIPANT per calendar year. Non-routine eye exams are covered as MEDICALLY NECESSARY. (Contact lens fittings are not part of the routine exam and are not covered.)

13) Oral Surgery: Limited to procedures listed in Benefits and Services Section.

14) Temporomandibular Disorders as required by Wis. Stat. §632.895 (11): The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per PARTICIPANT per calendar year. Intraoral splints are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

15) Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services Section.

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.

b) Preventive Prescription Drugs:

i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.

ii) Under the HDHP, preventive prescription drugs are not subject to the DEDUCTIBLE; however, if the preventive prescription drug is not covered at 100% as required by federal law, a COPAYMENT will be required according to the provisions of this program's benefits.

iii) The PBM will publish a list of prescriptions drugs affected by these provisions.

Prescription Drug Copayments:
Level 1 COPAYMENT: $5.00
The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:
Level 2 COINSURANCE: 20% ($50 max)
The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 COINSURANCE: 40% ($150 max)
The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOPL:
Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $600 per individual or $1,200 per family for all PARTICIPANTS.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): no annual OOPL.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS
Specialty Drug Cost Share:
Level 4 COPAYMENT: $50
The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 COINSURANCE: 40% ($200 max)
The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

3) **Certain grandfathered erectile dysfunction medication as defined by the PBM (Viagra and Caverject Injection):** the 40% Level 4 COINSURANCE ($200 max) applies to these prescription medications. However, the COINSURANCE does not accumulate toward any OOPL. YOU must continue to pay Level 4 COINSURANCE for these drugs even after other annual OOPLs have been met.

4) **Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.

5) **Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits description, are defined and limited to that meaning only:

ADVANCE CARE PLANNING: A process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. ADVANCE CARE PLANNING includes:

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

3) Weighing YOUR options about what kind of care and treatment YOU would want or not want.

4) Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive.

5) Communicating YOUR wishes and any documents with YOUR family, friends, clergy, other advisors and physician and other health care professionals.

BED AND BOARD: Means all usual and customary HOSPITAL CHARGES for: (a) Room and meals; and (b) all general care needed by registered bed patients.

BENEFIT PERIOD: Means the total duration of CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CHARGE: An amount for a health care service from a PROVIDER that is reasonable, as determined by the TPA. The TPA considers, as part of determination of CHARGE:

1) Amounts charged for similar health care services in the same general area under comparable circumstances,

2) the TPA's methodology guidelines,

3) pricing guidelines of any third party responsible for pricing a claim,

4) the negotiated rate determined between the TPA and an IN-NETWORK PROVIDER, and

5) other factors.

The term “area” means a county or other geographical area which the TPA determines is appropriate to obtain a representative cross section of amounts. For example, the “area” may be an entire state.

In some cases the amount the TPA determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the health care service. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: A specified percentage of the CHARGES that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the IN-NETWORK PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

DEPENDENT: Means, as provided herein, the SUBSCRIBER'S:

1) Spouse.[1]

2) DOMESTIC PARTNER, if elected.[2]

3) Child.[3, 4, 5]

4) Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19. [3, 4, 5]

5) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.[3, 4, 5]

6) Stepchild.[1, 3, 4, 5]

7) Child of the DOMESTIC PARTNER insured on the policy.[2, 3, 4, 5]

8) Grandchild if the parent is a DEPENDENT child.[3, 4, 5, 6]

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

[2] A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

[3] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, 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.

[4] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

[5] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

[6] A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

DOMESTIC PARTNER: Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

1) Each individual is at least 18 years old and otherwise competent to enter into a contract.

2) Neither individual is married to, or in a domestic partnership with, another individual.

3) The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.

4) The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY.

5) The two individuals agree to be responsible for each other's basic living expenses.

6) The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

   a) Only one of the individuals has legal ownership of the residence.

   b) One or both of the individuals have one or more additional residences not shared with the other individual.

   c) One of the individuals leaves the common residence with the intent to return.

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 TPA and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

ELIGIBLE EMPLOYEE: As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.

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 TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the TPA and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the TPA and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

GENERIC EQUIVALENT: Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

GRIEVANCE: Means a written complaint filed with the TPA and/or PBM concerning some aspect of the TPA and/or PBM. Some examples would be a rejection of a claim, denial of a formal REFERRAL, etc.

HABILITATION SERVICES: Means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A benefit plan that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OOPL set by the IRS. An HDHP does not pay any health care costs until the annual DEDUCTIBLE has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the TPA.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

2) qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission of Accreditation of HOSPITALS.

The term HOSPITAL does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal HOSPITAL.

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses or DOMESTIC PARTNERS.

INJURY: Means bodily damage that results directly and independently of all other causes from an accident.

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The TPA agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the TPA in advance of the services being provided.

LEVEL "M" DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be on the MEDICARE PRESCRIPTION DRUG PLAN'S MEDICARE Part D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the TPA.

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the TPA after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the TPA:

1) Used primarily to treat an ILLNESS or INJURY, and

2) generally not useful to a person in the absence of an ILLNESS or INJURY, and

3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and

4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the TPA and/or PBM:

1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and

2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and

3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and

4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICARE: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

MEDICAID: Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this TPA.

NATURAL TOOTH: Means a tooth that would not have required restoration in the absence of a PARTICIPANT’S trauma or INJURY, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM’S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

1) Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician.

2) Re-assessment and intervention (individual and group).

3) Diabetes outpatient self-management training services (individual and group sessions).

4) Dietitian visit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-NETWORK PROVIDER: A PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the TPA'S professional directory of providers. Care from an OUT-OF-NETWORK PROVIDER may require PRIOR-AUTHORIZATION from the TPA unless it is EMERGENCY or URGENT CARE.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the allowed amount. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PHARMACY BENEFIT MANAGER (PBM): The PBM is a THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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 TPA before obtaining the services. Unless otherwise indicated by YOUR TPA, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the TPA and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the TPA PRIOR AUTHORIZATION form and approved by the TPA in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each TPA and are described in the It's Your Choice materials. The authorization from the TPA will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED visits and the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the TPA before services are rendered.

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-

language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

SELF-ADMINISTERED 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 TPA to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a TPA or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The TPA or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, DOMESTIC PARTNERS, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

SKILLED NURSING FACILITY: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a SKILLED NURSING FACILITY.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

SUBSCRIBER: An ELIGIBLE EMPLOYEE or annuitant who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits.

THIRD PARTY ADMINISTRATOR (TPA): The THIRD PARTY ADMINISTRATOR who is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the TPA, when taking into consideration, among other factors determined by the TPA, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases the amount the TPA determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. TPA approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits and Services

The benefits and services provided under the Health Benefit Program are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of IN-NETWORK chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the TPA reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see item A, 1 and item A, 2 below).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the TPA's written PRIOR AUTHORIZATION for covered services from an OUT-OF-NETWORK PROVIDER or YOU will be financially responsible for the services. The TPA may also require PRIOR AUTHORIZATION for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached SCHEDULE OF BENEFITS, a PARTICIPANT, in consideration of the employer's payment of the applicable TPA and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the TPA and/or PBM.

A. Medical/Surgical Services

1) EMERGENCY Care

a) Medical care for an EMERGENCY, as defined in Section II. Refer to the SCHEDULE OF BENEFITS for information on the EMERGENCY room COPAYMENT.

b) YOU should use IN-NETWORK HOSPITAL EMERGENCY rooms whenever possible. If YOU are not able to reach YOUR IN-NETWORK PROVIDER, go to the nearest appropriate medical facility. If YOU must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU call the TPA by the next business day or as soon as possible and tell the TPA where YOU received EMERGENCY care. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA. In addition to the cost sharing described in the SCHEDULE OF BENEFITS, EMERGENCY care from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.

c) It is recommended, to expedite claims processing, that YOU (or another individual on YOUR behalf) notify the TPA of EMERGENCY or URGENT CARE OUT-OF-NETWORK HOSPITAL admissions or facility CONFINEMENTS by the next business day after admission or as soon

as reasonably possible. This will help to expedite claims payment. OUT-OF-AREA SERVICE means medical care received outside the defined SERVICE AREA.

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

xiv) Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the EMERGENCY room.

2) URGENT CARE

a) Medical care received in an URGENT CARE situation as defined in Section II. URGENT CARE is not EMERGENCY care. It does not include care that can be safely postponed until the PARTICIPANT can receive care from an IN-NETWORK PROVIDER.

b) YOU must receive URGENT CARE from an IN-NETWORK PROVIDER if YOU are in the SERVICE AREA, unless it is not reasonably possible. If YOU are out of the SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If YOU must go to an

OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU contact YOUR TPA by the next business day or as soon as possible and tell the TPA where YOU received URGENT CARE; this will expedite claims payment. URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA.

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

3) Surgical Services
Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include:

a) PREOPERATIVE and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

This does not include oral surgery procedures, which are covered as described under item 16 of this section.

PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the TPA for any PARTICIPANT who has not completed an optimal regimen of conservative care for low back pain (LBP). PRIOR AUTHORIZATION is not required for a PARTICIPANT who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PARTICIPANTS seeking surgical treatment of LBP must participate in a credible SHARED DECISION MAKING (SDM) program provided by the TPA or its contracted PROVIDERS consistent with the PRIOR AUTHORIZATION requirement.

4) Reproductive Services and Contraceptives
The following services do not require a REFERRAL to an IN-NETWORK PROVIDER who specializes in obstetrics and gynecology, however, the TPA may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

   i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit 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 TPA terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the TPA may request notification of the inpatient stay prior to the delivery or shortly thereafter.

5) Medical Services
MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an IN-NETWORK PROVIDER (or a PROVIDER that was PRIOR AUTHORIZED by YOUR TPA).

a) Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

b) Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

c) Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

d) Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e) MEDICALLY NECESSARY travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the PARTICIPANT by the TPA. It does not apply to travel required for work. (See Exclusions, Section IV, A, 2, e.)

f) Injectable and infusible medications, except for SELF-ADMINISTERED INJECTABLE medications.

g) NUTRITIONAL COUNSELING provided by a participating registered dietician or an IN-NETWORK PROVIDER.

h) A second opinion from an IN-NETWORK PROVIDER or when PRIOR AUTHORIZED by the TPA.

i) Preventive services as required by the federal Patient Protection and Affordable Care Act.

6) Anesthesia Services
Covered when provided in connection with other medical and surgical services covered under these Uniform Benefits. It will also include anesthesia services for dental care as provided under item B, 1, c of this section.

7) Radiation Therapy and Chemotherapy
Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an IN-NETWORK PROVIDER.

8) Detoxification Services
Covers MEDICALLY NECESSARY detoxification services provided by an IN-NETWORK PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an IN-NETWORK PROVIDER.

9) Ambulance Service
Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the TPA) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the TPA'S SERVICE AREA, the TPA or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or urgent transportation is obtained.

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if

correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PRIOR AUTHORIZATIONS are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11) Outpatient Rehabilitation, Physical, Speech and Occupation Therapy
MEDICALLY NECESSARY HABILITATION or REHABILITATION SERVICES and treatment as a result of ILLNESS or INJURY, provided by an IN-NETWORK PROVIDER. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be PRIOR AUTHORIZED by the TPA if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12) Home Care Benefits
Care and treatment of a PARTICIPANT under a plan of care. The IN-NETWORK PROVIDER must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)

d) MEDICAL SUPPLIES, drugs and medicines prescribed by an IN-NETWORK PROVIDER; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.

e) NUTRITIONAL COUNSELING. A registered dietician must give or supervise these services.

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

Home care will not be covered unless the attending physician certifies that:

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A PARTICIPANT may have been CONFINED IN A HOSPITAL just before home care started. If so, the home care plan must be approved, at its start, by the PROVIDER who was the primary PROVIDER of care during the HOSPITAL CONFINEMENT.

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the TPA if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the TPA. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the TPA.

Covers ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

Covers a one-time in-home palliative consult after the PARTICIPANT receives a terminal diagnosis regardless of whether his or her life expectancy is 6 months or less.

HOSPICE CARE is available to a PARTICIPANT who is CONFINED. Inpatient CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a TPA-approved or MEDICARE-certified HOSPICE CARE facility.

When benefits are payable under both this HOSPICE CARE benefit and the Home Care Benefits, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14) Phase II Cardiac Rehabilitation

Services must be approved by the TPA and provided in an outpatient department of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of:

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

15) Extraction of NATURAL TEETH and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/or total replacement (limited to, bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the TPA before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

16) Oral Surgery

PARTICIPANTS should contact the TPA prior to any oral surgery to determine if PRIOR AUTHORIZATION by the TPA is required. When performed by IN-NETWORK PROVIDERS, approved surgical procedures are as follows:

a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

e) Apicoectomy. (Excision of apex of tooth root.)

f) Excision of exostoses of the jaws and hard palate.

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

18) Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the TPA in order to be a covered transplant. Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

a) Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:

i) Aplastic anemia

ii) Acute leukemia

iii) Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the TPA.

h) In addition to the above-listed diagnoses for covered transplants, the TPA may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the TPA determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants 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 TPA.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The TPA may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the TPA.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

   c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
   EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up

care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA.

   a) Outpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "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 TPA within 72 hours after the initial provision of service.

   d) Other
   Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section 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 TPA.

(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 TPA:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the TPA, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the TPA.

k) Other medical equipment and supplies as approved by the TPA. Rental or purchase of equipment/supplies is at the option of the TPA.

l) When PRIOR AUTHORIZED as determined by the TPA, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the TPA will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the TPA. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the TPA. Additional visits may be approved by the TPA. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any TPA under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and

dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for 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 TPA.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The TPA, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED 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 TPA or a contracted PROVIDER administers the injection. If the TPA or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.

d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED 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 TPAs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 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 TPA and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   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 TPA.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, 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 TPA.

c) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

d) All separately billed donor-related services, except for kidney transplants.

e) Non-human organ transplants or artificial organs.

7) Reproductive Services

a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c) Services for storage or processing of semen (sperm); donor sperm.

d) Harvesting of eggs and their cryopreservation.

e) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the TPA.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the TPA.

c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the TPA.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the TPA. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED 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 TPA and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) 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 TPA and/or PBM, or services received after the TPA and/or PBM coverage or eligibility terminates. Except when

a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under TPAs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding TPA will be the responsibility of the succeeding TPA unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding TPA's network. In this instance, the liability will remain with the previous TPA.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the TPA and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

   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 TPA.

v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the TPA. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the TPA.

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 TPA 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 TPA. The treatment of the complication must be a covered benefit of the TPA and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any TPA as part of this program.

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 TPA to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the TPA's and/or PBM's Control: If, due to circumstances not reasonably within the control of the TPA and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the TPA and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the TPA, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other

benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section 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 TPA has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the TPA any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the TPA may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The TPA will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the TPA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1) The persons it has paid or for whom it has paid,

2) Insurance companies, or

3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the TPA and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the TPA and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the TPA, provide any relevant and reasonably available information which the TPA believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the TPA and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the TPA's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The TPA, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the TPA, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The TPA may employ a professional staff to provide case management services. As part of this case management, the TPA or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the TPA agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the TPA's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the TPA. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the TPA or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The TPA and/or PBM might pay more than the TPA and/or PBM owes under the policy. If so, the TPA and/or PBM can recover the excess from YOU. The TPA and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the TPA and/or PBM.

Each PARTICIPANT agrees to reimburse the TPA and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the TPA and/or PBM. At the option of the TPA and/or PBM, benefits for future CHARGES may be reduced by the TPA and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a TPA or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the TPA provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The TPA'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

1) The third party or any liability or other insurance covering the third party.

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the TPA or DEPARTMENT to such extent.

The TPA'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the TPA'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the TPA'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the TPA or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the TPA or DEPARTMENT such additional information as is reasonably requested by the TPA or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the TPA'S or DEPARTMENT'S rights against a third party. The TPA or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the TPA or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the TPA or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the TPA or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the TPA or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the TPA or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the TPA or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in

making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the TPA or DEPARTMENT for all amounts theretofore or thereafter paid by the TPA or DEPARTMENT which would have otherwise been recoverable under such acts and the TPA or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the TPA or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the TPA and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the TPA, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the TPA and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the TPA and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating TPAs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the TPA and/or PBM. Contact the TPA and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the TPA and/or PBM. The TPA and/or PBM will advise YOU of YOUR

right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the TPA and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the TPA and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the TPA's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the TPA and/or PBM breached its contract with the Group Insurance Board.

EXHIBIT 2

Standard Terms And Conditions (Request For Bids / Proposals)

1.0 SPECIFICATIONS: The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid/proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 DEVIATIONS AND EXCEPTIONS: Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 QUALITY: Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 QUANTITIES: The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 DELIVERY: Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 PRICING AND DISCOUNT: The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the contractor which are demonstrated to be industrywide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 UNFAIR SALES ACT: Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 ACCEPTANCE-REJECTION: The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 METHOD OF AWARD: Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 ORDERING: Purchase orders or releases via purchasing cards shall be placed directly to the contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements

are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW AND COMPLIANCE: This contract shall be governed under the laws of the State of Wisconsin. The contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel this contract if the contractor fails to follow the requirements of s. 77.66, Wis. Stats., and related statutes regarding certification for collection of sales and use tax. The State of Wisconsin also reserves the right to cancel this contract with any federally debarred contractor or a contractor that is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

16.0 ANTITRUST ASSIGNMENT: The contractor and the State of Wisconsin recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State of Wisconsin (purchaser). Therefore, the contractor hereby assigns to the State of Wisconsin any and all claims for such overcharges as to goods, materials or services purchased in connection with this contract.

17.0 ASSIGNMENT: No right or duty in whole or in part of the contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION / AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan by the contractor. An exemption occurs from this requirement if the contractor has a workforce of less than fifty (50) employees. Within fifteen (15) working days after the contract is awarded, the contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

19.2 The contractor agrees to post in conspicuous places, available for employees and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the contractor's becoming declared an "ineligible" contractor, termination of the contract, or withholding of payment.

20.0 PATENT INFRINGEMENT: The contractor selling to the State of Wisconsin the articles described herein guarantees the articles were manufactured or produced in accordance with applicable federal labor laws. Further, that the sale or use of the articles described herein will not infringe any United States patent. The contractor covenants that it will at its own expense defend every suit which shall be brought against the State of Wisconsin (provided that such contractor is promptly notified of such suit, and all papers therein are delivered to it) for any alleged infringement of any patent by reason of the sale or use of such articles, and agrees that it will pay all costs, damages, and profits recoverable in any such suit.

21.0 SAFETY REQUIREMENTS: All materials, equipment, and supplies provided to the State of Wisconsin must comply fully with all safety requirements as set forth by the Wisconsin Administrative Code and all applicable OSHA Standards.

22.0 WARRANTY: Unless otherwise specifically stated by the bidder/proposer, equipment purchased as a result of this request shall be warranted against defects by the bidder/proposer for one (1) year from date of receipt. The equipment manufacturer's standard warranty shall apply as a minimum and must be honored by the contractor.

23.0 INSURANCE RESPONSIBILITY: The contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employees engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin public records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot be copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin public records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employees and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

31.0 PROMOTIONAL ADVERTISING / NEWS RELEASES: Reference to or use of the State of Wisconsin, any of its departments, agencies or other subunits, or any state official or employee for commercial promotion is prohibited. News releases pertaining to this procurement shall not be made without prior approval of the State of Wisconsin. Release of broadcast e-mails pertaining to this procurement shall not be made without prior written authorization of the contracting agency.

32.0 HOLD HARMLESS: The contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the contractor, or of any of its contractors, in prosecuting work under this agreement.

33.0 FOREIGN CORPORATION: A foreign corporation (any corporation other than a Wisconsin corporation) which becomes a party to this Agreement is required to conform to all the requirements of Chapter 180, Wis. Stats., relating to a foreign corporation and must possess a certificate of authority from the Wisconsin Department of Financial Institutions, unless the corporation is transacting business in interstate commerce or is otherwise exempt from the requirement of obtaining a certificate of authority. Any foreign corporation which desires to apply for a certificate of authority should contact the Department of Financial Institutions, Division of Corporation, P. O. Box 7846, Madison, WI 53707-7846; telephone (608) 261-7577.

34.0 WORK CENTER PROGRAM: The successful bidder/proposer shall agree to implement processes that allow the State agencies, including the University of Wisconsin System, to satisfy the State's obligation to purchase goods and services produced by work centers certified under the State Use Law, s.16.752, Wis. Stat. This shall result in requiring the successful bidder/proposer to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses.

35.0 FORCE MAJEURE: Neither party shall be in default by reason of any failure in performance of this Agreement in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the party.

State of Wisconsin
Department of Administration
DOA-3681 (01/2001)
ss. 16, 19 and 51, Wis. Stats.

Division of Agency Services
Bureau of Procurement

EXHIBIT 3

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor; and

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential contractor shall certify in writing to the procuring agency that no relationship exists between the potential contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employee or who is retained as a contractor full-time by a State of Wisconsin agency from being retained as a contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.0831 Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

7.0 RECORDKEEPING AND RECORD RETENTION: The contractor shall establish and maintain adequate records of all expenditures incurred under the contract. All records must be kept in accordance with generally accepted accounting procedures. All procedures must be in accordance with federal, state and local ordinances.

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the contractor. The contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

8.0 INDEPENDENT CAPACITY OF CONTRACTOR: The parties hereto agree that the contractor, its officers, agents, and employees, in the performance of this agreement shall act in the capacity of an independent contractor and not as an officer, employee, or agent of the state. The contractor agrees to take such steps as may be necessary to ensure that each subcontractor of the contractor will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the state.

EXHIBIT 4

Department Terms and Conditions

1.0 ENTIRE AGREEMENT: This Contract, its exhibits, subsequent amendments and the documents incorporated by order of precedence contain the entire understanding between the parties on the subject matter hereof, and no representations, inducements, promises, or agreements, oral or otherwise, not embodied herein shall be of any force or effect. This Contract supersedes any other oral or written agreement entered into between the parties on the subject matter hereof.

This Contract may be amended at any time by written mutual agreement, but any such amendment shall be without prejudice to any claim arising prior to the date of the change. No one, except duly authorized officers or agents of the Contractor and the Department, shall alter or amend this Contract. No change in this Contract shall be valid unless evidenced by an amendment that is signed by such officers of the Contractor and the Department.

2.0 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW: In the event of a conflict between this Contract and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state.

The Contractor shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the Department upon request.

The Contractor acknowledges that Wis. Stat. § 40.07 specifically exempts information related to individuals in the records of the Department of Employee Trust Funds from the Wisconsin Public Records Law. Contractor shall treat any such records provided to or accessed by Contractor as non-public records as set forth in Wis. Stat. § 40.07.

Contractor will comply with the provisions of Wis. Stat. § 134.98**.**

3.0 LEGAL RELATIONS: The Contractor shall at all times comply with and observe all federal and State laws, local laws, ordinances, and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct. This includes but is not limited to laws regarding compensation, hours of work, conditions of employment and equal opportunities for employment.

In carrying out any provisions of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters that the Department acts as an agent of the State.

The Contractor accepts full liability and agrees to hold harmless the State, the Department's governing boards, the Department, its employees, agents and contractors for any act or omission of the Contractor, or any of its employees, in connection with this Contract.

No employee of the Contractor may represent himself or herself as an employee of the Department or the State.

4.0 CONTRACTOR: The Contractor will be the sole point of contact with regard to contractual matters, including the performance of Services and the payment of any and all charges resulting from contractual obligations.

None of the Services to be provided by the Contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without prior written notification to, and approval of, the Department.

After execution of the Contract, ETF will provide a designated contact person and commit to a timely approval process for notification of a change in subcontractor(s) and/or delegated services.

The Contractor shall be solely responsible for its actions and those of its agents, employees or subcontractors under this Contract. The Contractor will be responsible for Contract performance when subcontractors are used. Subcontractors must abide by all terms and conditions of this Contract.

Neither the Contractor nor any of the foregoing parties has the authority to act or speak on behalf of the State of Wisconsin.

The Contractor will be responsible for payment of any losses by subcontractors or agents.

Any notice required or permitted to be given shall be deemed to have been given on the date of delivery or three (3) Business Days after mailing by the United States Postal Service, certified or registered mail-receipt requested. In the event the Contractor moves or updates contact information, the Contractor shall inform the Department of such changes in writing within ten (10) Business Days. The Department shall not be held responsible for payments delayed due to the Contractor's failure to provide such notice.

5.0 **CONTRACTOR PERFORMANCE:** Work under this Contract shall be performed in a timely, professional and diligent matter by qualified and efficient personnel and in conformity with the strictest quality standards mandated or recommended by all generally-recognized organizations establishing quality standards for the work of the type to be performed hereunder. The Contractor shall be solely responsible for controlling the manner and means by which it and its employees or its subcontractors perform the Services, and the Contractor shall observe, abide by, and perform all of its obligations in accordance with all legal and Contract requirements.

Without limiting the foregoing, the Contractor shall control the manner and means of the Services so as to perform the work in a reasonably safe manner and comply fully with all applicable codes, regulations and requirements imposed or enforced by any government agencies. Notwithstanding the foregoing, any stricter standard provided in plans, specifications or other documents incorporated as part of this Contract shall govern.

The Contractor shall provide the Services with all due skill, care, and diligence, in accordance with accepted industry practices and legal requirements, and to the Department's satisfaction; the Department's decision in that regard shall be final and conclusive.

All Contractor's Services under this Contract shall be performed in material compliance with the applicable federal and state laws and regulations in effect at the time of performance, except when imposition of a newly enacted or revised law or regulation would result in an unconstitutional impairment of this Contract.

The Contractor will make commercially reasonable efforts to ensure that Contractor's professional and managerial staff maintain a working knowledge and understanding of all federal and state laws, regulations, and administrative code appropriate for the performance of their respective duties, as well as contemplated changes in such law which affect or may affect the Service under this Contract.

The Contractor shall maintain a written contingency plan describing in detail how it will continue operations and Services under the Contract in certain events including, but not limited to, strike and disaster, and shall submit it to the Department upon request.

6.0 **AUDIT PROVISION:** The Contractor and its authorized subcontractors are subject to audits by the State of Wisconsin, the Legislative Audit Bureau (LAB), an independent Certified Public Accountant (CPA), or other representatives as authorized by the State of Wisconsin. The Contractor will cooperate with such efforts and provide all requested information permitted under the law.

Authorized personnel shall have access to interview any Contractor's or subcontractor's employee or authorized agent involved with this Contract in conjunction with any audit, review, or investigation deemed necessary by the State of Wisconsin.

7.0 **CRIMINAL BACKGROUND VERIFICATION:** The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://oser.state.wi.us/docview.asp?docid=6658). The Contractor is expected to perform background checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

8.0 **COMPLIANCE WITH ON-SITE PARTY RULES AND REGULATIONS:** Contractor and the State of Wisconsin agree that their employees, while working at or visiting the premises of the other party, shall comply with all internal rules and regulations of the other party, including security procedures, and all applicable federal, state, and local laws and regulations applicable to the location where said employees are working or visiting.

The Department is responsible for allocating building and equipment access, as well as any other necessary Services available from the Department that may be used by the Contractor. Any use of the Department facilities, equipment, internet access, and/or services shall only be for project purposes as authorized by the Department. The Contractor will provide its own personal computers, which must comply with the Department security policies before connection

to the Department's local computer network.

9.0 SECURITY OF PREMISES, EQUIPMENT, DATA AND PERSONNEL: The State of Wisconsin shall have the right, acting by itself or through its authorized representatives, to enter the premises of the Contractor at mutually agreeable times to inspect and copy the records of the Contractor and the Contractor's compliance with this section. In the course of performing Services under this Contract, the Contractor may have access to the personnel, premises, equipment, and other property, including data files, information, or materials (collectively referred to as "data") belonging to the State.

The Contractor shall be responsible for damage to the State's equipment, workplace, and its contents, or for the loss of data, when such damage or loss is caused by the Contractor, contracted personnel, or subcontractors, and shall reimburse the State accordingly upon demand. This remedy shall be in addition to any other remedies available to the State by law or in equity.

10.0 BREACH NOT WAIVER: A failure to exercise any right, or a delay in exercising any right, power or remedy hereunder on the part of either party shall not operate as a waiver thereof. Any express waiver shall be in writing and shall not affect any event or default other than the event or default specified in such waiver. A waiver of any covenant, term or condition contained herein shall not be construed as a waiver of any subsequent breach of the same covenant, term or condition. The making of any payment to the Contractor under this Contract shall not constitute a waiver of default, evidence of proper Contractor performance, or acceptance of any defective item or Services furnished by the Contractor.

11.0 SEVERABILITY: The provisions of this Contract shall be deemed severable and the unenforceability of any one or more provisions shall not affect the enforceability of any of the other provisions. If any provision of this Contract, for any reason, is declared to be invalid, unenforceable, or illegal, the parties shall substitute an enforceable provision that, to the maximum extent possible in accordance with applicable law, preserves the original intentions and economic positions of the parties.

12.0 LIQUIDATED DAMAGES: The Contractor and Department acknowledge that it can be difficult to ascertain actual damages when a Contractor fails to carry out the responsibilities of this Contract. Because of that, the Contractor and Department will negotiate liquidated damages, as required by the State of Wisconsin, for this Contract. The Contractor agrees that the Department shall have the right to liquidate such damages, through deduction from the Contractor's invoices, in the amount equal to the damages incurred, or by direct billing to the Contractor.

The Department shall notify the Contractor in writing of any claim for liquidated damages pursuant to this section within thirty (30) Calendar Days after the Contractor's failure to perform in accordance with the terms and conditions of this Contract.

Notwithstanding the foregoing language, when necessary the Department will identify in the RFP specific financial penalties for failure of the Contractor to meet performance standards and guarantees that may be set forth in the RFP.

13.0 CONTRACT DISPUTE RESOLUTION: In the event of any dispute or disagreement between the parties under this Contract, whether with respect to the interpretation of any provision of this Contract, or with respect to the performance of either party hereto, except for breach of Contractor's intellectual property rights, each party shall appoint a representative to meet for the purpose of endeavoring to resolve such dispute or negotiate for and adjustment to such provision.

No legal action of any kind, except for the seeking of equitable relief in the case of the public's health, safety or welfare, may begin in regard to the dispute until this dispute resolution procedure has been elevated to the Contractor's highest executive authority and the equivalent executive authority within the Department, and either of the representatives in good faith concludes, after a good faith attempt to resolve the dispute, that amicable resolution through continued negotiation of the matter at issue does not appear likely.

The party believing itself aggrieved (the "Invoking Party") shall call for progressive management involvement in the dispute negotiation by delivering written notice to the other party. Such notice shall be without prejudice to the Invoking Party's right to any other remedy permitted by this Contract. After such notice, the parties shall use all reasonable efforts to arrange personal meetings and/or telephone conferences as needed, at mutually convenient times and places, between authorized negotiators for the parties at the following successive management levels, each of which shall have a period of allotted time as specified below which to attempt to resolve the dispute:

Level	Contractor	The Department	Allotted Time
First Second	Level 1 entity	Deputy Office Director Office	10 Business Days
	Level 2 entity	Director	20 Business Days
Third	Level 3 entity	Secretary	30 Business Days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is days from the date that the Invoking Party's notice was originally received by the other party. If the Third Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's

original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the section below. The time periods herein are in addition to those periods for a party to cure provided elsewhere in this Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

14.0 **CONTROLLING LAW:** All questions as to the execution, validity, interpretation, construction and performance of this Contract shall be construed in accordance with the laws of the State of Wisconsin, without regard to any conflicts of laws or choice of law principles. Any court proceeding arising or related to this Contract or a party's obligations hereunder shall be exclusively brought and exclusively maintained in the State of Wisconsin, Dane County Circuit Court, or in the District Court of the United States Western District (if jurisdiction is proper in federal court), or upon appeal to the appellate courts of corresponding jurisdiction, and Contractor hereby consents to the exclusive jurisdiction and exclusive venue therein and waives any right to object to such jurisdiction or venue. To the extent that in any jurisdiction Contractor may now or hereafter be entitled to claim for itself or its assets immunity from suit, execution, attachment (before or after judgment) or other legal process, Contractor, to the extent it may effectively do so, irrevocably agrees not to claim, and it hereby waives, the same.

15.0 **RIGHT TO SUSPEND OPERATIONS:** If, at any time during the period of this Contract, the Department determines that the best interest of the Department or its governing boards would be best served by the Contractor's temporarily holding of all Services, the Department will promptly notify the Contractor. Upon receipt of such notice, the Contractor shall suspend all Services.

16.0 **TERMINATION OF THIS CONTRACT:** The Department may terminate this Contract at any time at its sole discretion by delivering one-hundred eighty (180) Calendar Days written notice to the Contractor.

Upon termination, the Department's liability shall be limited to the prorated cost of the Services performed as of the date of termination plus expenses incurred with the prior written approval of the Department.

If the Contractor terminates this Contract, it shall refund all payments made hereunder by the Department to the Contractor for work not completed or not accepted by the Department. Such termination shall require written notice to that effect to be delivered by the Contractor to the Department not less than one-hundred eighty (180) Calendar Days prior to said termination.

Upon any termination of this Contract, the Contractor shall perform the Services specified in a transition plan if so requested by the Department; provided, however, that except as expressly set forth otherwise herein, the Contractor shall not be obligated to perform such Services unless all amounts due to the Contractor under this Contract, including payment for the transition Services, have been paid. Failure of the Contractor to comply with a transition plan upon request and upon payment shall constitute a separate breach for which the Contractor shall be liable.

Upon the expiration or termination for any reason, each party shall be released from all obligations to the other arising after the expiration date or termination date, except for those that by their terms survive such termination or expiration.

17.0 **TERMINATION FOR CAUSE:** If the Contractor fails to perform any material requirement of this Contract, breaches any material requirement of this Contract, or if the Contractor's full and satisfactory performance of this Contract is substantially endangered, the Department may terminate this Contract. Before terminating this Contract, the Department shall give written notice of its intent to terminate to Contractor after a thirty (30) Day written notice and cure period.

The State of Wisconsin reserves the right to cancel this Contract in whole or in part without penalty in one (1) or more of the following occurrences:

- **(a)** If the Contractor intentionally furnished any statement, representation, warranty, or certification in connection with its Proposal which is materially false, incorrect, or incomplete;
- **(b)** If applicable, fails to follow the sales and use tax certification requirements of Wis. Stat. § 77.66;
- **(c)** Incurs a delinquent Wisconsin tax liability;
- **(d)** Fails to submit a non-discrimination or affirmative action plan per the requirements of Wis. Stat. § 16.765 and Wisconsin's Fair Employment Law, subch. II, Chapter 111 of the Wisconsin Statutes as required herein;
- **(e)** Is presently identified on the list of parties excluded from State of Wisconsin procurement and non-procurement Contracts;
- **(f)** Becomes a state or federal debarred Contractor, or becomes excluded from state Contracts, or;
- **(g)** Fails to maintain and keep in force all required insurance, permits and licenses as required per this Contract;
- **(h)** Fails to maintain the confidentiality of the State of Wisconsin's information that is considered to be Confidential Information or Protected Health Information;
- **(i)** Files a petition in bankruptcy, become insolvent, or otherwise takes action to dissolve as a legal entity; or,
- **(j)** If at any time the Contractor's performance threatens the health or safety of a State of Wisconsin employee, citizen, or customer.
- **(k)** Violation of any requirements in Section 22 regarding Confidential Information.

In the event of a termination for cause by the State of Wisconsin, the State of Wisconsin shall be liable for payments for

any work accepted by the State of Wisconsin prior to the date of termination.

18.0 **REMEDIES OF THE STATE:** The State of Wisconsin shall be free to invoke any and all remedies permitted under Wisconsin law. In particular, if the Contractor fails to perform as specified in this Contract, the State of Wisconsin may issue a written notice of default providing for at least a seven (7) Business Day period in which the Contractor shall have an opportunity to cure, provided that cure is possible, feasible, and approved in writing by the State of Wisconsin. Time allowed for cure of a default shall not diminish or eliminate the Contractor's liability. If the default remains, after opportunity to cure, then the State of Wisconsin may: (1) exercise any remedy provided in law or in equity or (2) terminate Contractor's Services.

If the Contractor fails to remedy any delay or other problem in its performance of this Contract after receiving reasonable notice from the State of Wisconsin to do so, the Contractor shall reimburse the State of Wisconsin for all reasonable costs incurred as a direct consequence of the Contractor's delay, action, or inaction.

In case of failure to deliver Services in accordance with or Services from other sources as necessary, Contractor shall be responsible for the additional cost, including purchase price and administrative fees. This remedy shall be in addition to any other legal remedies available to the State of Wisconsin.

19.0 **TRANSITIONAL SERVICES:** Upon cancellation, termination, or expiration of this Contract for any reason, the Contractor shall provide reasonable cooperation, assistance and Services, and shall assist the State of Wisconsin to facilitate the orderly transition of the work hereunder to the State of Wisconsin and or to an alternative Contractor selected for the transition upon written notice to the Contractor at least thirty (30) business days prior to termination or cancellation, and subject to the terms and conditions set forth herein.

20.0 **ADDITIONAL INSURANCE RESPONSIBILITY:** The Contractor shall exercise due diligence in providing Services under this Contract. In order to protect the Board's governing the Department and any Department employee against liability, cost, or expenses (including reasonable attorney fees) which may be incurred or sustained as a result of Contractors errors or other failure to comply with the terms of this Contract, the selected Contractor shall maintain errors and omissions insurance including coverage for network and privacy risks, breach of privacy and wrongful disclosure of information in an amount acceptable to the Department with a minimum of **$1,000,000** and **$5,000,000** aggregate per claim in force during this Contract period and for a period of three (3) years thereafter for Services completed. Contractor shall furnish the Department with a certificate of insurance for such amount. Further, this certificate shall designate the State of Wisconsin Employee Trust Funds and its affiliated boards as additional insured parties. The Department reserves the right to require higher or lower limits where warranted.

21.0 **OWNERSHIP OF MATERIALS:** Except as otherwise provided in subsection (t) of Section 22, all information, data, reports and other materials as are existing and available from the Department and which the Department determines to be necessary to carry out the scope of Services under this Contract shall be furnished to the Contractor and shall be returned to the Department upon completion of this Contract. The Contractor shall not use it for any purpose other than carrying out the work described in this Contract.

The Department will be furnished without additional charge all data, models, information, reports, and other materials associated with and generated under this Contract by the Contractor.

The Department shall solely own all customized software, documents, and other materials developed under this Contract. Use of such software, documents, and materials by the Contractor shall only be with the prior written approval of the Department.

This Contract shall in no way affect or limit the Department's rights to use, disclose or duplicate, for any purpose whatsoever, all information and data pertaining to the Department or covered individuals and generated by the claims administration and other Services provided by Contractor under this Contract.

All files (paper or electronic) containing any Wisconsin claimant or employee information and all records created and maintained in the course of the work specified by this Contract are the sole and exclusive property of the Department. Contractor may maintain copies of such files during the term of this Contract as may be necessary or appropriate for its performance of this Contract. Moreover, Contractor may maintain copies of such files after the term of this Contract (i) for one hundred twenty (120) days after termination, after which all such files shall be transferred to the Department or destroyed by Contractor, except for any files as to which a claim has been made, and (ii) for an unlimited period of time after termination for Contractor's use for statistical purposes, if Contractor first deletes all information in the records from which the identity of a claimant or employee could be determined and certifies to the Department that all personal identifiers have been removed from the retained files.

22.0 **CONFIDENTIAL INFORMATION AND HIPAA BUSINESS ASSOCIATE AGREEMENT:** This Section is intended to cover handling of Confidential Information under state and federal law, and specifically to comply with the requirements of HIPAA, HITECH, and the Genetic Information Nondiscrimination Act (GINA) and the federal implementing regulations for those statutes requiring a written agreement with business associates.

(a) DEFINITIONS: As used in this Section, unless the context otherwise requires:

(1) Business Associate. "Business Associate" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Contractor (insert name of Contractor).

(2) Confidential Information has the meaning ascribed to it in Section 1.5 of the RFP.

(3) Covered Entity. "Covered Entity" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Department of Employee Trust Funds.

(4) HIPAA Rules. "HIPAA Rules" mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(5) Individual Personal Information "Individual Personal Information" has the meaning ascribed to it at Wis. Admin. Code ETF § 10.70 (1).

(6) Medical Record. "Medical Record" has the meaning ascribed to it at Wis. Admin. Code ETF 10.01 (3m).

(b) PROVISION OF CONFIDENTIAL INFORMATION FOR CONTRACTED SERVICES: ETF, a different business associate of ETF or a contractor performing Services for ETF may provide Confidential Information to the Contractor under this Contract as the Department determines is necessary for the proper administration of this Contract, as provided by Wis. Stat. § 40.07 (1m) (d) and (3).

(c) DUTY TO SAFEGUARD CONFIDENTIAL INFORMATION: The Contractor shall safeguard Confidential Information supplied to the Contractor or its employees under this Contract. In addition, the Contractor will only share Confidential Information with its employees on a need-to-know basis. Should the Contractor fail to properly protect Confidential Information, any cost the Department pays to mitigate the failure will be subtracted from the Contractor's invoice(s).

(d) USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor shall:

(1) Not use or disclose Confidential Information for any purpose other than as permitted or required by this Contract or as required by law. Contractor shall not use or disclose member names, addresses, or other data for any purpose other than specifically provided for in this Contract;

(2) Make uses and disclosures and requests for any Confidential Information following the minimum necessary standard in the HIPAA Rules;

(3) Use appropriate safeguards to prevent use or disclosure of Confidential Information other than as provided for by this Contract, and with respect to Protected Health Information, comply with Subpart C of 45 CFR Part 164;

(4) Not use or disclose Confidential Information in a manner that would violate Subpart E of 45 CFR Part 164 or Wis. Stat. § 40.07 if done by ETF; and

(5) If applicable, be allowed to use or disclose Confidential Information for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided the disclosures are required by law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been or is suspected of being breached.

(e) COMPLIANCE WITH ELECTRONIC TRANSACTIONS AND CODE SET STANDARDS: The Contractor shall comply with each applicable requirements of 45 C.F.R. Part 162 if the Contractor conducts standard transactions, as that term is defined in HIPAA, for or on behalf of ETF.

(f) MANDATORY REPORTING: Contractor shall report to ETF in the manner set forth in Subsection (l) any use or disclosure or suspected use or disclosure of Confidential Information not provided for by this Contract, of which it becomes aware, including breaches or suspected breaches of unsecured Protected Health Information as required at 45 CFR 164.410.

(g) DESIGNATED RECORD SET: Contractor shall make available Protected Health Information in a designated record set to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.524.

(h) AMENDMENT IN DESIGNATED RECORD SET: Contractor shall make any amendment to Protected Health Information in a designated record set as directed or agreed to by ETF pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy ETF's obligations under 45 CFR 164.526.

(i) ACCOUNTING OF DISCLOSURES: Contractor shall maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.528.

(j) COMPLIANCE WITH SUBPART E OF 45 CFR 164: To the extent Contractor is to carry out one or more of ETF's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to a covered entity in the performance of such obligation; and

(k) INTERNAL PRACTICES: Contractor shall make its internal practices, books, and records available to the Secretary of the United States Department of Labor for purposes of determining compliance with the HIPAA Rules.

(l) CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** A list of any affected members (if available);
- **b.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **c.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **d.** The date of the discovery by Contractor;
- **e.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **f.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than one (1) business day before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

(m) CLASSIFICATION LABELS: Contractor shall ensure that all data classification labels contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed by the Department.

(n) SUBCONTRACTORS: If applicable, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit Confidential Information on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information.

(o) NOTICE OF LEGAL PROCEEDINGS: If Contractor or any of its employees, agents, or subcontractors is legally required in any administrative, regulatory or judicial proceeding to disclose any Confidential Information, contractor shall give the Department prompt notice (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

(p) MITIGATION: The Contractor shall take immediate steps to mitigate any harmful effects of the suspected or actual unauthorized use, disclosure, or loss of any Confidential Information provided to Contractor under this Contract. The Contractor shall reasonably cooperate with the Department's efforts to comply with the breach notification requirements of HIPAA, to seek appropriate injunctive relief or otherwise prevent or curtail such suspected or actual unauthorized use, disclosure or loss, or to recover its Confidential Information, including complying with a

reasonable corrective action plan, as directed by the Department.

(q) COMPLIANCE REVIEWS: The Department may conduct a compliance review of the Contractor's security procedures before and during this Contract term to protect Confidential Information.

(r) AMENDMENT: The Parties agree to take such action as is necessary to amend the Contract as necessary for compliance with the HIPAA Rules and other applicable law.

(s) SURVIVAL: The obligations of Contractor under this Section survive the termination of the underlying Contract.

(t) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION: Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

1. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to ETF or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;
4. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;
5. Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and
6. If required by ETF, transmit the Confidential Information to another contractor of ETF.

23.0 INDEMNIFICATION:

23.1 SCOPE OF INDEMNIFICATION FOR INTELLECTUAL PROPERTY RIGHTS INFRINGEMENT: In the event of a claim against the Parties for Intellectual Property Rights Infringement associated with a claim for benefits, Contractor agrees to defend, indemnify and hold harmless Board and Department ("Indemnified Parties") from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Board, Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section.

23.2 SCOPE OF OTHER INDEMNIFICATION: In addition to the foregoing Section, Contractor shall defend, indemnify and hold harmless the Indemnified Parties from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section, or liability arising from or in connection with the following: (a) Contractor's performance of or failure to perform any duties or obligations under any agreement between Contractor and any third party; (b) injury to persons (including death or illness) or damage to property caused by the act or omission of Contractor or Contractor Personnel; (c) any claims or losses for Services rendered by any subcontractor, person, or firm performing or supplying Services, materials, or supplies in connection with the Contractor's performance of this Contract; (d) any claims or losses resulting to any person or third party entity injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under this Contract in a manner not authorized by this Contract, or by Federal or State statutes or regulations; and (e) any failure of the Contractor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

23.3 INDEMNIFICATION NOTICE: Department shall give Contractor prompt written notice of such claim, suit, demand, or action (provided that a failure to give such prompt notice will not relieve Contractor of its indemnification obligations hereunder except to the extent Contractor can demonstrate actual, material prejudice to its ability to mount a defense as a result of such failure). Department will cooperate, assist, and consult with Contractor in the defense or investigation of any claim made or suit filed against Department resulting from Contractor's performance under the Contract.

23.4 NO INDEMNIFICATION OBLIGATIONS: Contractor shall as soon as practicable, notify Department of any claim made or suit filed against Contractor resulting from Contractor's obligations under this Contract if such claim may involve the Department. Department has no obligation to provide legal counsel or defense to Contractor if a suit, claim, or action is brought against Contractor or its subcontractors as a result of Contractor's performance of its obligations under this Contract. In addition, Department has no obligation for the payment of any judgments or the settlement of any claims against Contractor arising from or related to this Contract. Department has not waived any right or entitlement to claim sovereign immunity under this Contract.

23.5 CONTRACTOR'S DUTY TO INDEMNIFY: Contractor shall comply with its obligations to indemnify, defend and hold the Indemnified Parties harmless with regard to claims, damages, losses and/or expenses arising from a claim for benefits under the Plan as provided herein. Contractor shall be entitled to control the defense of any such claim and to defend or settle any such claim, in its sole discretion, with counsel of its own choosing; however, Contractor shall consult with Department regarding its defense of any claim and not settle or compromise any claim or action in a manner that imposes restrictions or obligations on Department, requires any financial payment by Department, or grants rights or concessions to a third party without first obtaining Department's prior written consent. Contractor shall have the right to assert any and all defenses on behalf of the Indemnified parties, including sovereign immunity.

In carrying out any provision of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters the Department acts as an agent of the State.

The Contractor shall at all times comply with and observe all federal and state laws and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct.

24.0 EQUITABLE RELIEF: The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury shall not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Contract or under applicable law.

25.0 RIGHT TO PUBLISH OR DISCLOSE: Throughout the term of this Contract, the Contractor must secure the Department's written approval prior to the release of any information which pertains to work or activities covered by this Contract.

The parties agree that it is a breach of this Contract to disclose any information to any person that the Department or its governing boards may not disclose under Wis. Stat. § 40.07. Contractor acknowledges that it will be liable for damage or injury to persons whose Confidential Information is disclosed by any officer, employee, agent, or subcontractor of the Contractor without proper authorization.

26.0 TIME IS OF THE ESSENCE: Timely provision of the Services required under this Contract shall be of the essence of the Contract, including the provisions of the Services within the time agreed or on a date specified herein.

27.0 IDENTIFICATION OF KEY PERSONNEL AND PERSONNEL CHANGES: The Department will designate a contract administrator, who shall have oversight for performance of the Department's obligations under this Contract. The Department shall not change the person designated without prior written notification to the Contractor.

The State of Wisconsin reserves the right to approve all individuals assigned to this project. The Contractor agrees to use its best effort to minimize personnel changes during the Contract term.

At the time of contract negotiations, the Contractor shall furnish the Department with names of all key personnel assigned to perform work under this Contract and furnish the Department with criminal background checks.

The Contractor will designate a contract administrator who shall have executive and administrative oversight for performance of the Contractor's obligations under this Contract. The Contractor shall not change this designation without prior written notice to the Department.

The Contractor may not divert key personnel for any period of time except in accordance with the procedure identified in this section. The Contractor shall provide a notice of proposed diversion or replacement to the single person of contact (SPOC) at least sixty (60) days in advance, together with the name and qualifications of the person(s) who will take the place of the diverted or replaced staff. At least thirty (30) days before the proposed diversion or replacement, the Department shall notify the SPOC whether the proposed diversion or replacement is approved or rejected, and if rejected shall provide reasons for the rejection. Such approval by the Department shall not be unreasonably withheld or delayed.

Replacement staff shall be on-site within two (2) weeks of the departure date of the person being replaced. The Contractor shall provide the Department with reasonable access to any staff diverted by the Contractor.

Replacement of key personnel shall be with persons of equal ability and qualifications. The Department has the right to conduct separate interviews of proposed replacements for key personnel. The Department shall have the right to approve, in writing, the replacement of key personnel. Such approval shall not be unreasonably withheld. Failure of the Contractor to promptly replace key personnel within thirty (30) Calendar Days after departure shall entitle the Department to terminate this Contract. The notice and justification must include identification of proposed substitute key personnel and must provide sufficient detail to permit evaluation of the impact of the change on the project and/or maintenance.

Any of the Contractor's staff that the Department deems unacceptable shall be promptly and without delay removed by the Contractor from the project and replaced by the Contractor within thirty (30) Calendar Days by another employee with acceptable experience and skills subject to the prior approval of the Department. Such approval by the Department will not be unreasonably withheld or delayed.

An unauthorized change by the Contractor of any Contracted Personnel designed as key personnel will result in the imposition of liquidated damages, as defined in this Contract.

28.0 DATA SECURITY AND PRIVACY AGREEMENT

(a) PURPOSE AND SCOPE OF APPLICATION: This Data Security and Privacy Agreement (Agreement) is designed to protect the Department of Employee Trust Fund's (ETF) Confidential Information and ETF Information Resources (defined below). This Agreement describes the data security and privacy obligations of Contractor and its sub-contractors that connect to ETF Information Resources and/or gain access to Confidential Information.

(b) DEFINED TERMS:

(1) **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) Individual Personal 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); or (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 by Contractor on FORM D –Designation of Confidential and Proprietary Information (DOA-3027). Pricing information cannot be held confidential.

(2) **ETF Information Resources** means those devices, networks and related infrastructure that ETF has obtained for use to conduct ETF business. Devices include but are not limited to, ETF-owned, managed, used through service agreements storage, processing, communications devices and related infrastructure on which ETF data is accessed, processed, stored, or communicated, and may include personally owned devices. Data includes, but is not limited to, Confidential Information, other ETF created or managed business and research data, metadata, and credentials created by or issued on behalf of ETF.

(c) ACCESS TO ETF INFORMATION RESOURCES: In any circumstance when Contractor is provided access to ETF Information Resources, it is solely Contractor's responsibility to ensure that its access does not result in any access by unauthorized individuals to ETF Information Resources. Contractors who access ETF's systems from any ETF location must at a minimum conform with ETF security standards that are in effect at the ETF location(s) where the access is provided. Any Contractor technology and/or systems that gain access to ETF Information Resources must comply with, at a minimum, the elements in the Computer System Security Requirements set forth in this Agreement.

(d) COMPLIANCE WITH APPLICABLE LAWS: Contractor agrees to comply with all applicable state and federal laws, as well as industry best practices, governing the collection, access, use, disclosure, safeguarding and destruction of Confidential Information.

(e) PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor agrees to hold ETF's Confidential Information, and any information derived from such information, in strictest confidence. Contractor will not access, use or disclose Confidential Information other than to carry out the purposes for which ETF disclosed the Confidential Information to Contractor, except as permitted or required by applicable law, or as otherwise authorized in writing by ETF. For avoidance of doubt, this provision prohibits Contractor from using for its own benefit Confidential Information or any information derived from such information. If required by a court of competent jurisdiction or an administrative body to disclose Confidential Information, Contractor will notify ETF in writing immediately upon receiving notice of such requirement and prior to any such disclosure, to give ETF an opportunity to oppose or otherwise respond to such disclosure (unless prohibited by law from doing so).

(f) REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES: The Contractor's transmission, transportation or storage of Confidential Information outside the United States, or access of Confidential Information from outside the United States, is prohibited except on prior written authorization by ETF.

(g) SAFEGUARD STANDARD: Contractor agrees to protect the privacy and security of Confidential Information according to all applicable laws and regulations, including HIPAA, by commercially-acceptable frameworks or standards such as the ISO/IEC 27000-series, NIST, 800-53, RFC 2196, IEC 62443, and SANS CIS Top 20. ISO 270001, etc. Security Controls, and no less rigorously than it protects its own confidential information, but in no case less than reasonable care. Contractor will implement, maintain and use appropriate administrative, technical and physical security measures to preserve the confidentiality, integrity and availability of the Confidential Information. All Confidential Information stored on portable devices or media must be encrypted in accordance with the Federal Information Processing Standards (FIPS) Publication 140-2. Contractor will ensure that all security measures are regularly reviewed including ongoing monitoring, an annual penetration and vulnerability test, and an annual security incident response test, and revised, no less than annually, to address evolving threats and vulnerabilities while Contractor has responsibility for the Confidential Information under the terms of this Agreement. Prior to agreeing to the terms of this Agreement, and periodically thereafter (no more frequently than annually) at ETF's request, Contractor will provide assurance, in the form of a third-party audit report or other documentation acceptable to ETF, such as SOC2 Type II, demonstrating that appropriate information security safeguards and controls are in place.

(h) INFORMATION SECURITY PLAN:

(1) Contractor acknowledges that ETF is required to comply with information security standards for the protection of Confidential Information as required by law, regulation and regulatory guidance, as well as ETF's internal security program for information and systems protection.

(2) Contractor will establish, maintain and comply with an information security plan (Information Security Plan), which will contain, at a minimum, such elements as those set forth in this Agreement.

(3) Contractor's Information Security Plan will be designed to:

- **a.** Ensure the privacy, security, integrity, availability, and confidentiality of Confidential Information;
- **b.** Protect against any anticipated threats or hazards to the security or integrity of such information;
- **c.** Protect against unauthorized access to or use of such information that could result in harm or inconvenience to the person that is the subject of such information;
- **d.** Reduce risks associated with Contractor having access to ETF Information Resources; and
- **e.** Comply with all applicable legal and regulatory requirements for data protection.

(4) On at least an annual basis, Contractor will review its Information Security Plan, update and revise it as needed, and submit it to ETF upon request. At ETF's request, Contractor will make modifications to its Information Security Plan or to the procedures and practices thereunder to conform to ETF's security requirements as they exist from time to time. If there are any significant

modifications to Contractor's Information Security Plan, Contractor will notify ETF within a reasonable period of time, not to exceed two weeks. Any significant modification must include the same or a higher framework or information security standard maturity level than what currently exists in the Plan.

(i) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION:

Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

(1) Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

(2) Where feasible, return to ETF, or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;

(3) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;

(4) Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;

(5) Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and

(6) If required by ETF, transmit the Confidential Information to another contractor of ETF.

(j) NOTIFICATION OF CORRESPONDENCE CONCERNING CONFIDENTIAL INFORMATION: Contractor agrees to notify ETF immediately, both orally and in writing, but in no event more than twenty-four (24) hours after Contractor receives correspondence or a complaint regarding Confidential Information, including but not limited to, correspondence or a complaint that originates from a regulatory agency or an individual.

(k) BREACHES OF CONFIDENTIAL INFORMATION:

CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure of ETF's Confidential Information, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** The nature of the unauthorized access, use or disclosure;
- **b.** A list of any affected members (if available);
- **c.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **d.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **e.** The date of the discovery by Contractor;
- **f.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **g.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than twenty-four (24) hours before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons

potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

COORDINATION OF BREACH RESPONSE ACTIVITIES:

(4) Contractor will fully cooperate with ETF's investigation of any breach involving Contractor, including but not limited to making witnesses, documents, HIPAA logs, systems logs, video recordings, or other pertinent or useful information available immediately upon Contractor's reporting of the breach and throughout the investigation. Contractor's full cooperation will include but not be limited to Contractor:

- **a.** Immediately preserving any potential forensic evidence relating to the breach, and remedying the breach as quickly as circumstances permit
- **b.** Within forty-eight (48) hours designating a contact person to whom ETF will direct inquiries, and who will communicate Contractor responses to ETF inquiries; Contractor will designate a Privacy Officer and Security Officer to serve as contacts for ETF.
- **c.** As rapidly as circumstances permit, applying appropriate resources to remedy the breach condition, investigate, document, restore ETF service(s) as directed by ETF, and undertake appropriate response activities such as working with ETF, its representative, and law enforcement to identify the breach, identify the perpetrator(s), and take appropriate actions to remediate the security vulnerability;
- **d.** Providing status reports at least every two (2) hours until the root cause of the breach is identified and a plan is devised to fully remediate the breach;
- **e.** Once the root cause of the breach is identified and a plan is devised to fully remediate the breach, providing status reports daily or at mutually agreed upon timeframes, to ETF on breach response activities, findings, analyses, and conclusions;
- **f.** Coordinating all media, law enforcement, or other breach notifications with ETF in advance of such notification(s), unless expressly prohibited by law; and
- **g.** Ensuring that knowledgeable Contractor staff is available on short notice, if needed, to participate in ETF-initiated meetings and/or conference calls regarding the breach.

ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS:

(5) Contractor will make itself and any employees, subcontractors, or agents assisting Contractor in the performance of its obligations available to ETF at no cost to ETF to testify as witnesses, or otherwise, in the event of a breach or other unauthorized disclosure of Confidential Information caused by Contractor that results in litigation, governmental investigations, or administrative proceedings against ETF, its directors, officers, agents or employees based upon a claimed violation of laws relating to security and privacy or arising out of this Agreement or the Contract.

(l) RETENTION OF LOGS:

(1) HIPAA logs (logs of any systems that have information relating to HIPAA) must be kept for six (6) years.

(2) Firewall logs must be kept for twelve (12) months.

(m) ADDITIONAL INSURANCE: In addition to the insurance required under the Agreement, Contractor at its sole cost and expense will obtain, keep in force, and maintain an insurance policy (or policies) that provides coverage for privacy and data security breaches. This specific type of insurance is typically referred to as Privacy, Technology and Data Security Liability, Cyber Liability, or Technology Professional Liability. In some cases, Professional Liability policies may include some coverage for privacy and/or data breaches. Regardless of the type of policy in place, it needs to include coverage for reasonable costs in investigating and responding to privacy and/or data breaches with the following minimum limits unless ETF specifies otherwise: $1,000,000 Each Occurrence and $5,000,000 Aggregate.

(n) INFORMATION SECURITY PLAN REQUIREMENTS:

(1) Contractor will develop, implement, and maintain a comprehensive Information Security Plan that is written in one or more readily accessible parts and contains administrative, technical, and physical safeguards. The safeguards contained in such program must be consistent with the safeguards for protection of Confidential Information and information of a similar character set forth in any state or federal regulations by which the person who owns or licenses such information may be regulated.

(2) Without limiting the generality of the foregoing, every comprehensive Information Security Plan will include, but not be limited to:

a. Designating one or more employees to maintain the comprehensive Information Security Plan;

b. Identifying and assessing internal and external risks to the security, confidentiality, and/or integrity of any electronic, paper or other records containing Confidential Information and of ETF Information Resources, and evaluating and improving, where necessary, the effectiveness of the current safeguards for limiting such risks, including but not limited to:

c. Ongoing employee (including temporary and contract employee) training;

d. Employee compliance with policies and procedures; and

e. Means, including Contractor staff, processes, and technology, for detecting information system intrusions, data breaches, and anomalous system behavior or activity, and for preventing security breaches, intrusions, or unauthorized access to information systems or networks.

f. Developing security policies for employees relating to the storage, access and transportation of records containing Confidential Information outside of business premises.

g. Imposing disciplinary measures for violations of the comprehensive Information Security Plan rules.

h. Preventing terminated employees from accessing records containing Confidential Information and/or ETF Information Resources.

i. Overseeing service providers, by:

--Taking reasonable steps to select and retain third-party service providers that are capable of maintaining appropriate security measures to protect such Confidential Information and ETF Information Resources consistent with all applicable laws and regulations; and

-- Requiring such third-party service providers by contract to implement and maintain such appropriate security measures for Confidential Information.

j. Placing reasonable restrictions upon physical access to records containing Confidential Information and ETF Information Resources and requiring storage of such records and data in locked facilities, storage areas or containers.

k. Restrict physical access to any network or data centers that may have access to Confidential Information or ETF Information Resources.

l. Requiring regular monitoring to ensure that the comprehensive Information Security Plan is operating in a manner reasonably calculated to prevent unauthorized access to or

unauthorized use of Confidential Information and ETF Information Resources; and upgrading information safeguards as necessary to limit risks.

m. Reviewing the scope of the security measures at least annually or whenever there is a material change in business practices that may reasonably implicate the security or integrity of records containing Confidential Information and of ETF Information Resources.

n. Documenting responsive actions taken in connection with any incident involving a breach, and mandating post-incident review of events and actions taken, if any, to make changes in business practices relating to protection of Confidential Information and ETF Information Resources.

(o) COMPUTER SYSTEM SECURITY REQUIREMENTS: To the extent that Contractor electronically stores or transmits Confidential Information or has access to any ETF Information Resources, it will include in its written, comprehensive Information Security Plan the establishment and maintenance of a security system covering its computers, including any wireless system, that, at a minimum, and to the extent technically feasible, will have the following elements:

(1) Secure user authentication protocols including:

a. Control of user IDs and other identifiers;
b. A secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;
c. Multi-Factor Authentication (MFA);
c. Control of data security passwords to ensure that such passwords are kept in a location and/or format that does not compromise the security of the data they protect;
d. Multi-factor authentication for system administrators and others with 'super-user' access rights;
e. Restricting access to active users and active user accounts only;
f. Blocking access to user identification after multiple unsuccessful attempts to gain access or the limitation placed on access for the particular system; and
g. Periodic review of user access, access rights and audit of user accounts.

(2) Secure access control measures that:

a. Restrict access to records and files containing Confidential Information and systems that may have access to ETF Information Resources to those who need such information to perform their job duties; and
b. Assign unique identifications plus passwords, which are not vendor supplied default passwords, to each person with computer access, which are reasonably designed to maintain the integrity of the security of the access controls.

(3) Encryption of all transmitted records and files containing Confidential Information.

(4) Adequate security of all networks that connect to ETF Information Resources or access Confidential Information, including wireless networks.

(5) Reasonable monitoring of systems, for unauthorized use of or access to Confidential Information and ETF Information Resources.

(6) Encryption of all Confidential Information stored on Contractor devices, including laptops or other portable storage devices.

(7) For files containing Confidential Information on a system that is connected to the Internet or that may have access to ETF Information Resources, reasonably up-to-date firewall, router and switch protection and operating system security patches, reasonably designed to maintain the integrity of the Confidential Information.

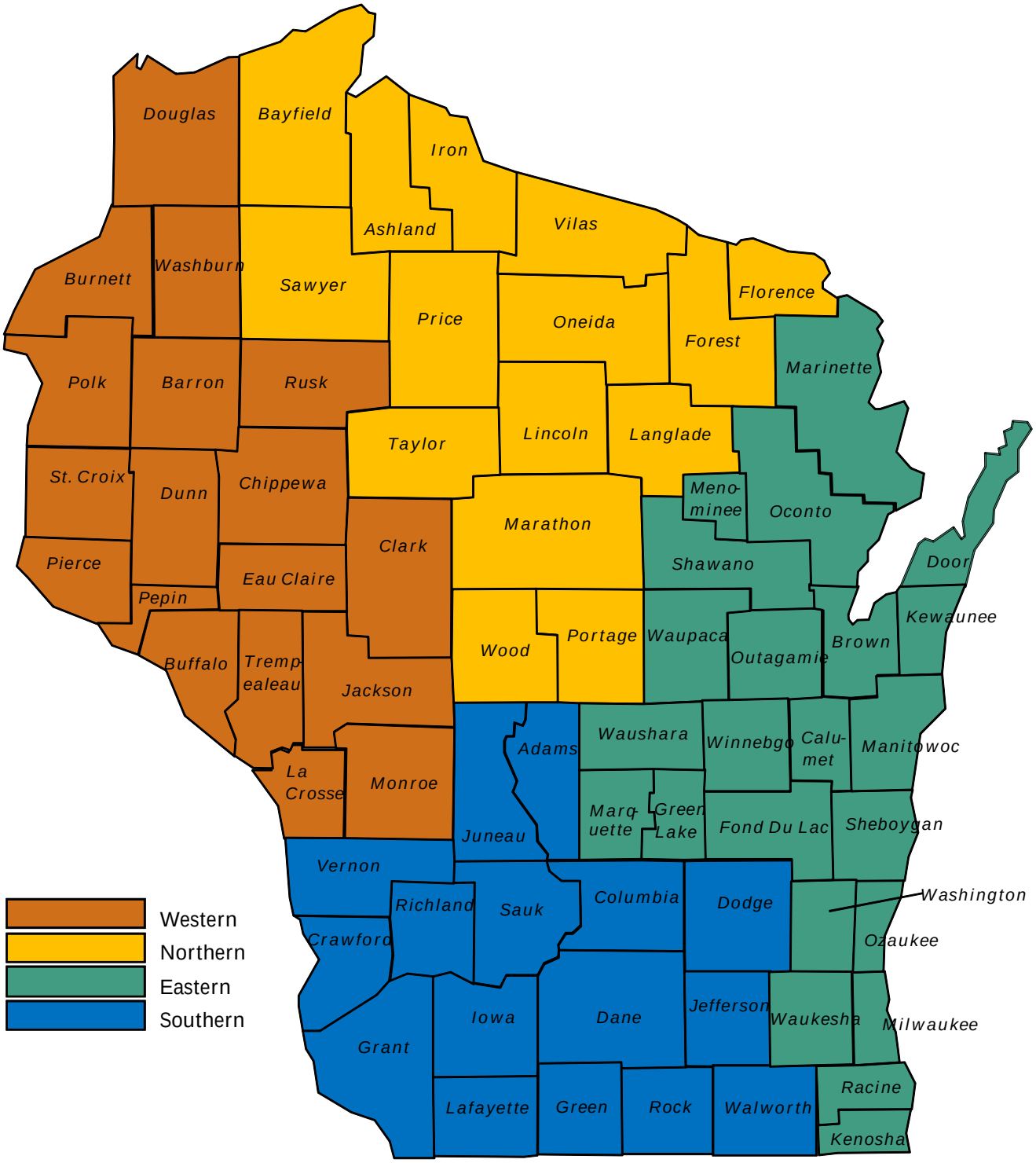
(8) Reasonably up-to-date versions of system security agent software, including intrusion detection systems, which must include malware protection and reasonably up-to-date patches and virus definitions, or a version of such software that can still be supported with up-to-date patches and virus definitions, and is set to receive the most current security updates on a regular basis.

(9) Education and training of employees on the proper use of the computer security system and the importance of Confidential Information and network security.

With reasonable notice to Contractor, ETF may require additional security measures which may be identified in additional guidance, contracts, communications or requirements.

State of Wisconsin
Department of Employee Trust Funds
Regional Map

RFP ETG0003
Exhibit 5: Map
Issued July 22, 2016



State of Wisconsin
Department of Employee Trust Funds
DOA-3049 (R07/2016)
§ 51.01(5) Wis. Stats. § 111.32(13m) Wis. Stats.

Department of Employee Trust Funds
801 W. Badger Road
P. O. Box 7931
Madison, WI 53707-7931

Contract

Commodity or Service: Administrative Services for the State of Wisconsin Health Benefit Program

Contract No./Request for Bid/Proposal No: ETG0003 (H)
Authorized Board: Group Insurance Board

Contract Period: June 1, 2017 through December 31, 2020 with the optional renewal of three (3) two (2) year periods

1. This Contract is entered into by the State of Wisconsin, Department of Employee Trust Funds (Department), the State of Wisconsin Group Insurance Board (Board) and between HealthPartners Administrators, Inc. hereinafter referred to as the "Contractor", whose address and principal officer appears on page 2. The Department is the sole point of contact for this Contract.

2. Whereby the Department of Employee Trust Funds agrees to direct the purchase and the Contractor agrees to supply the Contract requirements cited in accordance with the State of Wisconsin standard terms and conditions and in accordance with the Contractor's proposal dated September 19, 2016 hereby made a part of this Contract by reference.

3. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employees or applicants for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s.51.01(5), Wis. Stats., sexual orientation as defined in s.111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

4. Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan. Contractors with an annual work force of less than fifty (50) employees are exempted from this requirement. Within fifteen (15) business days after the award of the Contract, the plan shall be submitted for approval to the Department. Technical assistance regarding this clause is provided by the Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931, 608.261.7952, or via e-mail at ETFProcurement@etf.wi.gov.

5. Contractor agrees to the Discount Guarantees and Gain Sharing Agreement in Exhibit B.

6. For purposes of administering this Contract, the order of precedence is:
   a) This Contract with HealthPartners Administrators, Inc.
   b) Exhibit A, Contract clarifications from ETF;
   c) Exhibit B, Discount Guarantees and Gain Sharing Agreement;
   d) RFP Exhibit 1 – State of Wisconsin Health Benefit Program Agreement, dated May 1, 2017;
   e) RFP Exhibit 4 – Department Terms and Conditions, dated April 26, 2017;
   f) Appendix 4a Claims Data Specifications – Medical, dated March 29, 2017;
   g) Appendix 5 Provider Data Specifications, dated March 29, 2017;
   h) Request for Proposal (RFP) ETG0003 dated July 22, 2016, including all appendices, attachments, and amendments thereto; and,
   i) Contractor's proposal dated September 19, 2016.

Contract Number & Service: ETG0003 (H) Administrative Services for the State of Wisconsin Health Benefit Program

State of Wisconsin Department of Employee Trust Funds	Contractor to Complete
By Authorized Board *(Name)* **Group Insurance Board**	Legal Company Name **HealthPartners Administrators, Inc.**
By *(Name)* **Michael Farrell**	Trade Name
Signature	Taxpayer Identification Number **41-1629390**
Title **Chair** Group Insurance Board	Company Address *(City, State, Zip)* 8170 – 33rd Avenue South, PO Box 1309 Bloomington, MN 55425-4516
Phone 608.266.9854 (A. John Voelker, Deputy Secretary)	By *(print Name)* Robert Cumming
Date *(MM/DD/CCYY)*	Signature Robert Cumming
	Title President
	Phone 5/3/2017
	Date *(MM/DD/CCYY)* 952.883.6000

Exhibit A

Contract ETG0003 (H): Clarifications and changes agreed to by the parties to the July 22, 2016 Request for Proposal (RFP) ETG0003 Administrative Services for the State of Wisconsin Health Benefit Program to be provided by HealthPartners Administrators, Inc. to the State of Wisconsin Department of Employee Trust Funds for the Health Insurance Programs Offered by the State of Wisconsin Group Insurance Board.

The following are clarifications to Contract terms:

#	Document / Section	Section Description	Clarification
1	n/a	n/a	Any dispute, disagreement or question of interpretation of Exhibits 2, 3, or 4 (the Terms and Conditions) and the application of those Exhibits to the terms of this contract is subject to discussion and resolution under Exhibit 4, Section 13.0 (Contract Dispute Resolution) of the Department Terms and Conditions."
2	Exhibit 1 Section 130	Premiums	The language in this section is not intended to hold a Contractor liable for payment of actuarial services related to a review of claims experience, trends and other factors covered by the rate renewal reports submitted by a Contractor pursuant to this section.
3	Exhibit 1 Section 135B	Administrative Fee Adjustments	Language as shown was drafted with the intention to allow for administrative fee increases, as recommended by ETF's actuary. Should an administrative fee change be implemented for which the TPA disagrees, the process on contract dispute resolution is provided in Exhibit 4.0, Section 13.0.
4	Exhibit 1 Section 215A	Disease Management / Prior Authorizations / Utilization Review	The contract requires prior authorizations to include member out-of-pocket cost sharing information. The intent is to base the authorization on the provider status at time of the authorization review with disclosure about any anticipated provider status change for the length of the approval period and disclosure that the member's deductible, coinsurance and/or copayment applies. Member out-of-pocket costs do not need to be amount specific and instruction should be provided on how members can obtain specific cost-sharing information. The contract also states the Contractor is responsible for the cost of services not covered under the contract when the member has received a prior authorization. The intent is to hold the Contractor accountable if it errors by prior authorizing a service that is not covered under the contract.

#	Document / Section	Section Description	Clarification
5	Exhibit 1 Sections 230 and 230D	Provider Contracts Provider Contracts Shall Include Compliance Plans	Including the provider agreement requirements outlined in Section 230 and the compliance plans outlined in Section 230D in a policy, program or process for which the provider contract requires compliance, even though the provider contract does not specifically identify such items, is deemed to meet this contractual requirement.
6	Exhibit 4 Section 28.0 (i)(2)	Data Security and Privacy Agreement	1) The data should be destroyed; 2) unless Contractor can definitely prove to ETF that the data was de-identified; and 3) that Contractor confirms to ETF in writing that no crosswalk exists to re-identify the data.
7	n/a	n/a	Based on the contract negotiations that ETF has conducted over the last several weeks with each of the six contractors, ETF now believes it is appropriate to delete references in the RFP and Section 135B of RFP Exhibit 1 specifically stating that the contractors are fiduciaries. The duties that contractors will perform are delineated throughout the RFP and Exhibit 1. Case law confirms that whether or not a contract specifically states that a contractor is a fiduciary, courts have issued decisions finding that the duties and facts in a particular situation demonstrate that a contractor is a fiduciary.
8	Exhibit 4 Section 12.0	Liquidated Damages	It is the Department's intent that the Contractor will be able to utilize the process described in Exhibit 4, Section 13.0 (Contract Dispute Resolution) prior to the Department imposing any Liquidated Damages.

Wisconsin Department of Employee Trust Funds
Discount Guarantees for Self-Insured Contracts
Calendar Years 2018 through 2020

Vendor **Health Partners**
Region **Western**

Vendor will provide 2018 expected overall level of discount.
ETF and Vendor will mutually agree on final starting point.

2018 Discount Target*

* A supplemental worksheet allows vendors to calculate this discount with enrollment and regional assumptions. Upon open enrollment these will be re-based accordingly.

Annual improvement - Spread between Eligible Charge Increase and Vendor Allowed Increase. Expectations on Discount improvement decrease with higher baseline discounts. Improvement is calculated as Assumed Spread x (1-Discount).

Assumed Spread

		Annual Improvement
2019 overall level of discount is expected to improve over 2018	**2019 Discount Target**	
2020 overall level of discount is expected to improve over 2019	**2020 Discount Target**	

Fees at Risk will vary by percentage below target for each of the 3 years based on the following Scale:

% of Actual Discount below Target	% of Total Admin Fees at Risk
	0%
	5%
	10%

Notes:
Actual Performance against Target Discounts will be calculated 6 months after the end of the Calendar Year with runout data available in the data warehouse at that time.
Large claims over $100,000, and any out-of-network claims, will be removed from the calculation.
Discount Percent is calculated as Total Submitted Eligible Charge less Total Allowed (state & member) divided by Total Submitted Eligible Charge.
Discount Guarantee is null and void if Gain-Sharing Actual PMPM is less than Target PMPM.

ETG0003

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Exhibit B

Vendor **Health Partners**
Region **Western**

Annual Shared Savings will be calculated based on two factors:
(1) Performance of Actual versus Target PMPM
(2) Performance of Actual versus Target Clinical Performance Measures

Performance of Actual versus Target PMPM

Illustrative Calculation

Prior Calendar Year allowed claims for those members who select vendor during open enrollment will be used as a starting point to determine a base aggregate PMPM. The data will be normalized to the vendor's network pricing. It is anticipated that this will include 12 months of incurred allowed claims. (TBD)

A claims completion factor will be applied to the allowed claims. This will be updated with runout during the settlement process with claims paid through June of the following Calendar Year. (TBD)

Total Calendar Year Incurred Claims

Apply Industry and Market Specific Trend (TBD) - Trend assumptions will be uniform across all vendors

Calendar Year Allowed PMPM Target

Amount of savings to be shared with vendor will vary by percentage of actual PMPM below Target PMPM based on the following Scale:

	CY 2018	CY 2019	CY 2020
% of Actual PMPM below Target	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**	**% of Savings Shared with Vendor**
< 3.00%	0%	0%	0%
3.00% - 6.00%	5%	7.5%	10%
> 6.00%	10%	17.5%	25%

Notes on PMPM:
1) Target PMPM will be set by March 1st of the current CY based on prior CY incurred claims with current year enrollment, adjustment for network pricing, completion factors and trend.
2) Performance of Actual versus Target PMPM will be calculated at the end of the CY when 6 months of runout is available in the data warehouse. This results in 18 months of runout for the Target PMPM and 6 months of runout for the Actual PMPM. Note that the Actual PMPM will have a completion factor applied.

Wisconsin Department of Employee Trust Funds
Gain Sharing Model for Self-Insured Contracts
Calendar Years 2018 through 2020

Exhibit B

Vendor **Health Partners**
Region **Western**

Performance of Actual versus Target Clinical Performance Measures

In addition to the shared savings amounts based on Actual versus Target PMPM Calculations, payments will be reduced based on the percentage of clinical targets met by the vendor for the Calendar Year. If all clinical targets are met, payouts will be 100% of the PMPM calculations described above. If, for example, 75% of the clinical targets are met, payouts will be 75% of the PMPM calculations described above.

Clinical Targets for each year of the contract will be determined for each vendor individually by comparing actual baseline for each vendor to an ultimate target for each measure. The difference between the vendor's baseline and target will be the gap that should be closed over 3 years with equal improvement in each of the 3 years to reach the target. Examples are shown below:

	Baseline	Target	Gap	2018 Target	2019 Target	2020 Target
Vendor A	50%	90%	40%	63%	77%	90%
Vendor B	80%	90%	10%	83%	87%	90%
Vendor C	95%	90%	-5%	90%	90%	90%

ETG0003

Wisconsin Department of Employee Trust Funds
Discount Guarantee Development Worksheet

Exhibit B

Vendor **Health Partners**
Region **Western**

		Preliminary Discount Guarantee			Final Discount Guarantee		
Region	Total Members	Expected Enrollment	Expected Distribution	Discount Guarantee	Open Enrollment	Final Distribution	Discount Guarantee
Eastern	63,766						
Northern	8,151						
Southern	113,299						
Western	21,024						
In-State	206,240						
Out-of-State	3,379						
Total Membership	209,619						

After open enrollment, a final discount guarantee will be developed based on vendor's actual enrollment.
Discount guarantees by region may not be altered during this process.

ETG0003

RFP ETG0003

Exhibit 1: State of Wisconsin Health Benefit Program Agreement

Issued May 1, 2017

State of Wisconsin Health Benefit Program Agreement

Issued by the State of Wisconsin

Department of Employee Trust Funds

On behalf of the Group Insurance Board

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000 DEFINITIONS

Unless otherwise defined herein, any term needing definition shall have the definition found in Uniform Benefits (of this AGREEMENT), the RFP, the PROPOSAL or in applicable Wisconsin law. These terms, when used and capitalized in this AGREEMENT are defined and limited to that meaning only:

AGREEMENT means the State of Wisconsin Health Benefit Program Agreement, which is the binding agreement between the BOARD and CONTRACTOR for the administration of the HEALTH BENEFIT PROGRAM.

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).

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).

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 attachments, supplements, endorsements riders and the CONTRACTOR'S PROPOSAL.

CONTRACTOR means the legal signatory to this AGREEMENT.

DAY means calendar DAY unless otherwise indicated.

DEPARTMENT means the State of Wisconsin Department of Employee Trust Funds.

DEPENDENT as defined in Uniform Benefits.

DOMESTIC PARTNER as defined in Uniform Benefits.

EFFECTIVE DATE means the date, as certified by the DEPARTMENT and shown on the records of the CONTRACTOR in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

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 program that provides group health BENEFITS to eligible State of Wisconsin and participating LOCAL EMPLOYEES, ANNUITANTS, CONTINUANTS and their eligible DEPENDENTS in accordance with Chapter 40, Wisconsin Statutes. This program is established, maintained and administered by the BOARD.

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.

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.

PBM means the Pharmacy Benefit Manager (PBM) which is a third party administrator that is contracted with the BOARD to administer the prescription drug benefits under this HEALTH BENEFIT PROGRAM. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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.

PROPOSAL means the complete response of a proposer submitted and setting forth the proposer's pricing for providing the services described in the Request for Proposal (RFP).

QUARTERLY means a period consisting of every consecutive three (3) months beginning January 2018.

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.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the CONTRACTOR for enrollment and who is entitled to BENEFITS.

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).

This AGREEMENT is subject to all other terms, conditions, and provisions in the Request for Proposal (RFP) #ETG0003 and in the PROPOSAL.

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 (forms 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).

110 Objectives

The BOARD's objectives of the HEALTH BENEFIT PROGRAM include, but are not limited to the following:

1) Management and delivery of health care services to PARTICIPANTS through contracted networks that provide for high-quality, cost-effective care.

2) To provide excellent customer service to PARTICIPANTS.

3) To offer networks of high value providers, and to incent PARTICIPANTS to choose benefit plan designs with high value providers.

4) To provide high-quality services at a competitive price.

5) Accurate, timely and responsive administration of health care claims.

6) 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.

7) To offer tools for PARTICIPANTS to increase engagement, including:

a) Knowledge of provider cost and quality.

b) Wellness and disease management.

c) Self-responsibility.

8) To ensure quality population health programs, including case management and disease management, which promote proactive management of PARTICIPANT health concerns.

9) 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 to another. Also, assist with the transferring of accumulations towards PARTICIPANTS' meeting deductibles, BENEFIT maximums, and out-of-pocket limits (OOPL).

3) Cooperate with the DEPARTMENT to develop procedures and protocols for sharing information as necessary.

4) Provide, in a format acceptable to the DEPARTMENT, at no cost and in a timely manner, all data and written or recorded material pertaining to this AGREEMENT.

5) Provide the specified level of services as indicated in this AGREEMENT to PARTICIPANTS.

6) Assist the DEPARTMENT with the administration of this AGREEMENT, including PARTICIPANT enrollment, record keeping, and general operations.

7) Have a mechanism for accurately maintaining records for a minimum of seven (7) years on each PARTICIPANT, including but not limited to, initial determination of eligibility for DEPENDENTS for disabled and full-time student status.

8) 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.

9) Have a mechanism, as approved by the DEPARTMENT, for handling complaints and grievances made by PARTICIPANTS.

   a) This includes a formal grievance procedure, which at a minimum complies with federal law, whereby the individual is provided the opportunity to present a complaint to the CONTRACTOR and the CONTRACTOR will consider the complaint and advise the PARTICIPANT of its final decision. PARTICIPANTS must be advised of the grievance process when a claim or referral is denied or if the 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.

10) Submit to the DEPARTMENT or its designee, as required by the DEPARTMENT, statistical report(s) showing financial and utilization data that includes claims and enrollment information.

11) Have a process for managing services and charges in the event a PARTICIPANT incurs claims in an emergency or urgent situation that results in care from OUT-OF-NETWORK providers.

12) Comply with state and federal regulations pertaining to mandated or minimum BENEFITS which may be applicable to the CONTRACTOR under insurance statutes or as directed by the BOARD.

13) Provide DEPARTMENT approved materials to PARTICIPANTS as required under this AGREEMENT.

14) Provide notification of all significant events:

a) 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 (15%) percent 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 (51%) percent) interest in the CONTRACTOR or any transfer of ten (10%) percent or more of the indicia of ownership, including but not limited to shares of stock. The CONTRACTOR agrees to provide to the BOARD at least sixty (60) DAYS advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify.

c) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another entity in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the 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."

15) Agree to utilize identification numbers (group and SUBSCRIBER) according to the system established by the DEPARTMENT. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the SUBSCRIBER'S data file and may be used for identification purposes only and not disclosed or used for any other purpose. CONTRACTORS must always keep record of Social Security numbers for providing data and other reports to the DEPARTMENT or its authorized vendors and track the eight (8)-digit unique member identification number that is assigned by the DEPARTMENT.

16) Comply with the provider network access standards set forth in WI Adm. Code § INS 9.32.

17) Provide coverage for PARTICIPANTS deemed eligible and enrolled by the DEPARTMENT.

18) 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.

19) Shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT.

20) 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, per Wis. Stat. § 40.02 (25) (b), eligible EMPLOYEES include:

1) General state EMPLOYEES: active state and university EMPLOYEES participating in the Wisconsin Retirement System (WRS).

2) Elected state officials.

3) Members or EMPLOYEES of the legislature.

4) Any blind EMPLOYEES of the Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 40.02 (25) (a) 3.

5) Any EMPLOYEE on leave of absence who has chosen to continue their insurance.

6) Any EMPLOYEE on layoff whose PREMIUMS are being paid from accumulated unused sick leave (Wis. Stat. § 40.05 (4) (bm)).

7) The following in the University of Wisconsin (UW) System and UW Hospital and Clinics Authority:

    a) Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

b) Any teacher who is a participating EMPLOYEE and who is employed by the UW System for an expected duration of not fewer than six (6) months on at least a one-third (33%) full-time appointment.

c) Certain visiting faculty members in the UW System.

d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one (1) semester per academic year (nine month) appointments or six (6) months for annual (twelve month) appointments.

e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one (1) semester for academic year (nine (9) month) or six (6) months for annual (twelve (12) month) appointments.

f) Short-term academic staff who are employed in positions not covered under the Wisconsin Retirement System (WRS) and who are holding a fixed-term terminal, acting/provisional or interim (non UW-Madison) appointment of twenty-eight (28%) percent or more with an expected duration of at least one (1) semester but less than one (1) academic year if on an academic year (nine (9) month) appointment or have an appointment of twenty-one (21%) percent or more with an expected duration of at least six (6) months but fewer than twelve (12) months if on an annual (twelve (12) month) appointment.

g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible.

h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the UW Hospital and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six (6) months.

8) ANNUITANTS and CONTINUANTS:

a) Any covered EMPLOYEE who is retired on an immediate annuity or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

b) The surviving spouse or DOMESTIC PARTNER of a SUBSCRIBER.

c) Covered EMPLOYEES who terminate employment, have attained minimum retirement age (fifty (50) for protective services or fifty-five (55) for all other categories), have twenty (20) years of WRS creditable service and defer their annuity are eligible to continue in the HEALTH BENEFIT PROGRAM if a timely application is submitted.

d) Any participating STATE EMPLOYEE who terminates employment after attaining twenty (20) years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll 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.

e) Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for coverage through the EMPLOYER.

f) Any retired public employee under Wis. Stat. § 40.02 (25) (b) 11, who is receiving an annuity under the Wisconsin Retirement System (but not a disability benefit under Wis. Stat. § 40.65 or Long Term Disability Insurance (LTDI)), or any DEPENDENT of such an employee, who is receiving a continuation of the employee's annuity, and, if eligible, and who has acted under Wis. Stat. § 40.51 (10) to elect the Local Annuitant Health Program (LAHP).

125B Dependent Coverage Eligibility

Individual coverage covers only the SUBSCRIBER. All eligible DEPENDENTS listed on the application are covered under a family contract. A SUBSCRIBER cannot choose to exclude any eligible DEPENDENT from family coverage, unless that DEPENDENT is already covered under the HEALTH BENEFIT PROGRAM.

125C Change to Family Coverage

An EMPLOYEE eligible for and enrolled in individual coverage only may change to family coverage effective on the date of change to family status, including transfer of custody of eligible DEPENDENTS, if an application is received by the EMPLOYER within thirty (30) DAYS after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS shall be subject to this provision, except that those ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contribution toward PREMIUM shall submit the application to the DEPARTMENT.

Notwithstanding the paragraph above, the birth or adoption of a child to a SUBSCRIBER under an individual benefit plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the EMPLOYER within sixty (60) DAYS of the birth, adoption, or placement for adoption.

125D No Double Coverage

A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the 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.

125E Local Annuitants

LOCAL ANNUITANTS who cancel coverage for any reason are not eligible to reenroll in the program as a SUBSCRIBER.

125F Medicare Participants

ANNUITANTS and their DEPENDENTS, or surviving DEPENDENTS, who become enrolled in Medicare may continue to be covered at reduced PREMIUM rates, as specified by the BOARD.

Enrollment in Medicare by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the STATE or participating LOCAL EMPLOYER. Enrollment in Medicare Parts A and B is required for the EMPLOYEE and/or Medicare-eligible DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active EMPLOYEE'S group health benefit policy with another employer and that policy is the primary payer for Medicare Parts A and B charges, the ANNUITANT and/or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare reduced PREMIUM for coverage under this program.

As required by Medicare rules, Medicare is the primary payer for DOMESTIC PARTNERS age sixty-five (65) and older who are enrolled in Medicare, regardless of the work status of the SUBSCRIBER. The reduction in PREMIUM is available only when the coverage is provided under a non-employer group number.

Enrollment in Medicare by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the covered EMPLOYEE, ANNUITANT or DEPENDENT is required to pay a premium to enroll in the HOSPITAL portion of Medicare (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

130 Premiums

The BOARD determines the PREMIUM for its self-insured benefit plans as part of the HEALTH BENEFIT PROGRAM. This PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to:

1) Projection of incurred claims costs for the renewal benefit period.

2) The most recent thirty-six (36) months of incurred/paid triangular reports for the current benefit period.

3) Complete documentation of the methodology and assumptions utilized to develop the projected costs.

4) Disclosure of supporting data used in the calculation, including monthly paid claims and enrollment, network provider fee-structure analysis, provider negotiations updates, utilization analysis to report on unusual patterns, large claims analysis, trend analysis, and demographic analysis.

5) Substantiation of any proposed increase in fixed costs, such as administrative costs, via a thorough analysis of activities and costs covered by those fees.

6) Explanations for any unusual trend results (high or low relative to the market).

The CONTRACTOR will work with the BOARD'S consulting actuary independently to agree on a format, and the frequency of providing this data.

SUBSCRIBER PREMIUM payments will be arranged through deductions from salary, accumulated sick leave account (STATE EMPLOYEES only), or annuity. For all other SUBSCRIBERS, PREMIUMS will be paid directly to the CONTRACTOR and the CONTRACTOR must notify the DEPARTMENT of SUBSCRIBERS who terminate or reinstate coverage. Also see Section 255.

The State of Wisconsin's current contribution toward the total health benefit for EMPLOYEES (non-retired) for both individual and family contracts is based on a tiered structure in accordance with Wis. Stat. § 40.51 (6). The tiered structure is based on recommendations from the BOARD'S consulting actuary.

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 the Medicare HOSPTIAL and medical insurance BENEFITS (Parts A and B) as the primary payer and coverage is provided under an ANNUITANT group number, or under an EMPLOYER group number in the case of a LOCAL EMPLOYER paid ANNUITANT.

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 coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payer, or who subsequently cancels Medicare coverage, shall be limited in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. 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.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR. In such cases, the CONTRACTOR will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

Also see Sections 125F and 220H.

135 Administrative Fee and Financial Administration

135A Invoicing and Banking

1) Claims Invoicing:

   a) The CONTRACTOR shall notify the DEPARTMENT every calendar week during the term of this AGREEMENT and inform the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. The amount due every week shall be the total amount of BENEFIT payments issued by the CONTRACTOR for the claims processed during the immediately prior calendar week (Saturday through Friday).

   b) The DEPARTMENT shall deposit funds into the bank account designated by the DEPARTMENT by the first Friday immediately following the DEPARTMENT'S receipt of the request for payment by the CONTRACTOR. This bank account shall be used to disburse funds and make claim payments made on behalf of the DEPARTMENT.

   c) The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within twenty (20) BUSINESS DAYS following month-end.

   d) The CONTRACTOR shall submit a claims invoice reconciliation report each month for the prior month. The report will reconcile the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. The weekly claims invoice must show claims by the benefit period in which they were incurred and by state and local subgroups.

2) Administrative Fee Invoicing:

   a) The CONTRACTOR must submit to the DEPARTMENT on the twentieth (20th) DAY of each calendar month (or the first BUSINESS DAY following the twentieth (20th) DAY of the calendar month), an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The monthly invoice must show the total amount of administration

fees, other approved fees and expenses due for the immediately following calendar month. The DEPARTMENT shall deposit funds into the bank account designated by the CONTRACTOR on the first BUSINESS DAY of the calendar month following the DEPARTMENT'S receipt of the invoice from the CONTRACTOR.

b) The CONTRACTOR shall be paid the administrative fee per month per PARTICIPANT as detailed in the CONTRACT. All administrative plan arrangement-related fees are included in the CONTRACTOR's administrative fee.

   The statewide/nationwide CONTRACTOR shall be paid for underwriting services to evaluate risk and submit recommendations for LOCAL EMPLOYERS requesting participation in the local HEALTH BENEFIT PROGRAM. The LOCAL EMPLOYER shall send payments for underwriting services to the DEPARTMENT. The DEPARTMENT shall forward one check for the appropriate amount shown in the Cost Proposal to the CONTRACTOR for their services.

3) Direct Pay SUBSCRIBER Invoicing:

   The CONTRACTOR shall not process any PREMIUM transactions related to enrollment, except for those direct pay SUBSCRIBERS.

135B Administrative Fee Adjustments

Administrative fee adjustments, if any, required as recommended by the BOARD's consulting actuary for BENEFIT changes, mandated BENEFIT payments, and/or operational changes, will occur on January 1 after the next contract period begins unless otherwise approved by the BOARD. The CONTRACTOR shall supply an administrative monthly invoice that must be based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. The CONTRACTOR shall be paid the following administrative charge per month per PARTICIPANT for the AGREEMENT periods stated as follows:

Medical administration fee per individual and family contract. The medical administration fee includes, but is not limited to, the following:

1) Claims administration (including adjudication, payment, reprocessing, coordination of BENEFITS (excluding vendor recoveries), and overpayment collection).

2) Utilization review fees.

3) Network access fees.

4) MHSA claims administration.

5) Medical management (including medical review).

6) Disease management.

7) Customer service (to meet all requirements of this AGREEMENT, including all key personnel).

8) PARTICIPANT materials (including explanations of BENEFITS, summary of BENEFITS and coverage, web tools, ID cards, printing and mailing costs).

9) All required reports (including federally required reports and tax related forms).

10) Claims data extracts.

11) Administration, collection of, and passing through to the DEPARTMENT, premiums for direct pay SUBSCRIBERS (including reporting non-payment terminations).

12) IT services (including hardware and software).

13) Telecom (other program resource links, reporting, special usage or access requirements).

14) Required reviews (including fraud and abuse, and HOSPITAL bill).

15) Various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing).

16) Telehealth services.

17) Twenty-four (24)-hour nurse line services.

18) Underwriting services (applies to a CONTRACTOR providing statewide/nationwide services under this AGREEMENT only).

135C Prohibited Fees

1) The CONTRACTOR is prohibited from including in their administrative fee:

   a) The cost to handle any claims paid outside of Uniform Benefits or IYC Medicare Plus administered by the statewide/nationwide CONTRACTOR.

   b) The cost to administer any optional health and wellness benefit(s) beyond Uniform Benefits, IYC Medicare Plus that is administered by the statewide/nationwide CONTRACTOR or the Well Wisconsin program.

2) The CONTRACTOR is prohibited from billing separate fees that are not pre-approved by the BOARD, including, but not limited to travel and meal expenses.

135D Recovery of Overpayments

1) Overpayments:
   If it is determined that any payment has been made under this AGREEMENT to an ineligible person, or if it is determined that more or less than the correct amount has been paid by the CONTRACTOR, the CONTRACTOR shall make a diligent attempt to recover the payment, or

shall adjust the underpayment. The CONTRACTOR shall not be required to initiate court proceedings to obtain any such recovery.

If any overpayments made to ineligible persons were the result of fraud or criminal acts or omissions on the part of the CONTRACTOR or any of its directors, officers, and employees, the CONTRACTOR shall reimburse the DEPARTMENT for the amount of such excess payments. Overpayments resulting from negligence of the CONTRACTOR or any of its directors, officers and employees and which are caused by a systemic problem due to the CONTRACTOR'S design and/or operation of its claims processing system, including maintenance or pricing arrangements, which are determined by the CONTRACTOR to be uncollectible, despite diligent efforts by the CONTRACTOR to recover the overpayments, shall be recoverable from the CONTRACTOR by the DEPARTMENT provided that the determination of the amount due shall be based on actual verified overpayments. Any overpayment caused by the CONTRACTOR'S error shall be the responsibility of the CONTRACTOR, not to be charged to the DEPARTMENT, regardless of whether or not any such overpayment can be recovered by the CONTRACTOR. The DEPARTMENT shall provide reasonable cooperation to the CONTRACTOR in its recovery efforts.

The CONTRACTOR and the DEPARTMENT shall agree upon reasonable procedures to be used by the CONTRACTOR to recover or collect overpayments and underpayments. The CONTRACTOR shall notify the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures.

2) The BOARD shall hold the CONTRACTOR and its directors, officers, and employees harmless from any liability for any overpayments and/or underpayments made to any ineligible former PARTICIPANT when payments result from a failure of the BOARD, the DEPARTMENT or any other State department or agency to make a timely report to the CONTRACTOR of any PARTICIPANT'S loss of eligibility.

   The DEPARTMENT shall not hold the CONTRACTOR responsible for any overpayments caused by DEPARTMENT or EMPLOYER errors or fraud by a person other than an employee of the CONTRACTOR.

   The CONTRACTOR shall assist the DEPARTMENT in identifying overpayments caused by such error or fraud.

3) The BOARD reserves the sole right to institute litigation for the purpose of recovering any overpayment. The BOARD reserves the right to join in any litigation instituted by the CONTRACTOR for the purpose of recovering any overpayment which is the responsibility of the CONTRACTOR.

4) The CONTRACTOR shall be given full credit for all refunds that result from recovery of any overpayment to the extent that the CONTRACTOR is held financially responsible for such overpayment within this AGREEMENT.

5) Disputes over Charges:

   Notwithstanding any other terms, conditions, and provisions of this AGREEMENT, the CONTRACTOR shall pay CHARGES as determined by the CONTRACTOR. Disputes as to CHARGES will be referred, on a timely basis, to the CONTRACTOR who shall actively attempt to settle the dispute with the provider in a reasonable time frame.

   If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT shall contact the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR shall notify the DEPARTMENT about the lawsuit.

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 administrative fees or other 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:

1) Providers to request and receive electronic funds transfer (EFT) of claims payments for BENEFITS.

2) SUBSCRIBERS to submit EFT of direct pay PREMIUM payments. The CONTRACTOR must support other mechanisms for payment of direct pay PREMIUMS.

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.

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.

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. 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. The next roll-out for the new system is currently scheduled for 2018.

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.

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 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.

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 Claims Data Specifications document, all claims processed for PARTICIPANTS. At least ninety-five (95%) percent of claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within ninety (90) DAYS of the end date of the claims time period. One hundred (100%) percent of the claims must be submitted to the DEPARTMENT'S data warehouse in the correct file layout within one hundred eighty (180) DAYS. Within two (2) BUSINESS DAYS of notification, unless otherwise approved by the DEPARTMENT in writing, the CONTRACTOR shall resolve any data errors on the file as identified by the DEPARTMENT'S data warehouse or the DEPARTMENT.

b) 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, 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. 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 and integrate the data as required under Section 240. 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 provided by the DEPARTMENT with 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 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 RFP, 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. A unique person/member identifier is required on all data files and the identifier must match the person identifier on the DEPARTMENT'S eligibility file. 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 and are the direct result of the CONTRACTOR's failure to meet the

DEPARTMENT'S data submission requirements or timelines and which the DEPARTMENT will deduct from any payment owed the CONTRACTOR in the payment period.

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.

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 Hospital Bill Audit

The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for hospital bill audits. All amounts recovered under this program shall be paid forty-five (45%) percent to the CONTRACTOR and fifty-five (55%) percent to the BOARD.

155D 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.

155E 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) 16 and provide a copy of the CPA's report to the DEPARTMENT. (Allowable time will be given to provide this information, if the CONTRACTOR doesn't currently have a completed SSAE 16 audit.) The audit report must be submitted annually.

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.

155F 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. For information see Section 135D.

2) Contractor Provider 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; and,

n) Billing for a known work-related injury.

155G Privacy Breach Notification

The CONTRACTOR shall comply with all state and federal laws regarding patient privacy, as well as the confidentiality provision of terms and conditions of the CONTRACT. 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 personal identifiable information (PII) of one (1) or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98, HIPAA, and GINA. The CONTRACTOR is required to report using the form provided by the DEPARTMENT.

Even if the full details are not known, the CONTRACTOR must report all identified information to the DEPARTMENT, then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:

1) A description of the incident(s).

2) The identified root cause(s).

3) The actual or estimated number of PARTICIPANTS impacted.

4) The actual impact list (as soon as known).

5) A copy of any correspondence sent to affected PARTICIPANTS (this must be pre-approved by the DEPARTMENT).

6) A description of the steps taken to ensure a similar incident will not be repeated.

This notification requirement shall apply only to PHI or PII received or maintained by the CONTRACTOR pursuant to this AGREEMENT. The CONTRACTOR shall make good faith efforts to communicate with the DEPARTMENT about breaches by major provider groups if the CONTRACTOR knows those breaches affect PARTICIPANTS.

The CONTRACT shall notify the DEPARTMENT Program Manager and Privacy Officer no less than one (1) BUSINESS DAY before any external communications are made regarding a data breach.

155H 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.

155I 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 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) In the event of contract termination or non-renewal, the CONTRACTOR will be responsible for processing claims during the run-out period specified by the DEPARTMENT.

4) Membership changes and corrections not processed during the term of the contract will continue to be processed by the CONTRACTOR during the entire run-out period. During the entire run-out period, all performance standards and penalties remain in force.

5) The CONTRACTOR will be required to coordinate turnover and transition planning and activities, subject to the DEPARTMENT'S approval.

155J Transition Plan

During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination, the CONTRACTOR must provide a comprehensive transition plan in a mutually agreed upon format that provides a timeline of major tasks, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. In the event that the CONTRACTOR terminates the CONTRACT, an updated

transition plan must accompany the notice of termination. In the event the BOARD terminates the CONTRACT, the CONTRACTOR must send an updated transition plan to the DEPARTMENT within thirty (30) DAYS of the written notice of termination to the CONTRACTOR. The transition plan must be approved by the DEPARTMENT prior to the transition begin date and must include the CONTRACTOR'S cooperation and participation in planning calls or meetings with the succeeding vendor.

The CONTRACTOR must administer a program run-out period to process claims and to handle related customer service inquiries. The run-out period begins on the CONTRACT termination date and will be no longer than one (1) year. The CONTRACTOR shall be paid three (3) months of administrative expenses based on the membership census as of November 1 of the last year of the contract. The administrative fee shall be the fee in effect during the last year the contract. The fee shall be paid in three (3) installments. The first installment shall be paid in December of the last year of the contact. The second installment shall be paid in January of the year of run-out. The final payment will be made no later than December of the year of run-out unless issues arise with data submission to the DEPARTMENT'S data warehouse. In the event of issues receiving run-out claims per the DEPARTMENT'S timeline, the DEPARTMENT will withhold the final fee payment until all run-out claims are received.

Leading up to and during the run-out period, the CONTRACTOR must:

1) Participate in all DEPARTMENT requested meetings.

2) Provide all reports for program close out.

3) Report on performance standards specified in Section 315.

4) Invoice the DEPARTMENT as specified in Section 135A.

5) Transmit program data to the new vendor.

6) Continue grievance, hospital bill audit, subrogation services and overage disabled dependent reviews.

7) Transmit run-out claims data to the DEPARTMENT'S data warehouse as specified in Section 150.

155K Health Underwriting for Statewide/Nationwide Contractor only

LOCAL EMPLOYERS with one or more employees requesting participation in the local HEALTH BENEFIT PROGRAM are subject to underwriting. The CONTRACTOR shall evaluate risk and submit a recommendation back to the DEPARTMENT for final approval by the BOARD'S actuary. The effective date shall be determined by the DEPARTMENT. The fees described in the Cost Proposal, or as agreed upon by the DEPARTMENT, shall be administered per Section 135A.

Employers with fifty-one (51) or more EMPLOYEES shall submit claims and enrollment experience including high cost claims data for the most recent available twenty-four (24) months along with the fees to the DEPARTMENT.

Employers with fifty (50) or less EMPLOYEES shall submit small employer information as required by the CONTRACTOR to the DEPARTMENT along with the fees.

The DEPARTMENT will submit information and appropriate fees to the 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.

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. 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) 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 Eligibility

The 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.

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

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 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 as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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. See Appendix 6, Guidance for DEPARTMENT Initiatives, for additional detail.

The current DEPARTMENT Initiatives 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) High Tech Radiology – The CONTRACTOR must have prior authorization procedures for elective, out-patient computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), positron emission tomography (PET) scans, and nuclear stress tests. Such prior authorizations are not required for PARTICIPANTS that require immediate or expedited orthopedic or other specialty referrals.

3) Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical or other specialty referrals.

4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.

5) 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.

215C Quality Initiatives

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.

220 Benefits

220A Overview

The CONTRACTOR must provide the BENEFITS and services listed in Uniform Benefits to all PARTICIPANTS with the exception of the statewide/nationwide CONTRACTOR who must provide the BENEFITS and services listed in the IYC Medicare Plus certificate to all Medicare 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 high deductible health plan (HDHP) 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger 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 Preferred Provider Organization (PPO)

The BOARD may offer different copayment and deductible schedules for OUT-OF-NETWORK providers, except in the case of emergency, urgent care or when the services are not reasonably available IN-NETWORK.

If the PARTICIPANT resides in a CONTRACTOR'S service area, the PPO must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty IN-NETWORK provider when determining if that provider is reasonably available.

220G Medicare

The CONTRACTOR will provide BENEFITS and services as described in Uniform Benefits to PARTICIPANTS enrolled in Medicare with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS.

The CONTRACTOR must notify the DEPARTMENT in writing if Medicare does not allow an enrollment due to a PARTICIPANT'S residence in a given area or other reason as specified by Medicare. The notification must be provided within five (5) BUSINESS DAYS of the later of receipt of the DEPARTMENT'S enrollment file or notification by Medicare.

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 EMPLOYEE, 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. The PREMIUM rate will be the non-Medicare rate during this period. Medicare becomes the primary payer after this thirty (30)-month period upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty (30) -month period during which the HEALTH BENEFIT PROGRAM will again be the primary payer. No reduction in PREMIUM is available for active EMPLOYEES under this section.

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, change from or to the IYC HDHP).

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:

1) If a PARTICIPANT changes benefit plans.

2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER (or combination of spouse-to-DOMESTIC PARTNER) transfer resulting in a change of SUBSCRIBER, but does not change benefit plans.

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.

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. For HDHPs, medical and pharmacy accumulations are combined.

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.

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 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 audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year, which includes 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 commercially insured adult 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.

c) The results of the survey shall be used for the measurement of PARTICIPANT satisfaction as specified in the performance standards in Section 315G.

4) The DEPARTMENT will monitor health care quality and/or customer satisfaction using performance measures available in the data warehouse and visual business intelligence tool, and will establish performance metrics, baseline results, and target performance levels. The DEPARTMENT will publish measure results and also establish financial incentives to encourage performance improvement.

   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.

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 and HOSPITALS are compensated under the HEALTH BENEFIT PROGRAM, including a description of any and all incentives involved. If providers are financially compensated by the CONTRACTOR, the CONTRACTOR must disclose how 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.

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.

The 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 their provider network for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150.

The DEPARTMENT will use this data to ensure provider access standards are met. 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 (33%) percent 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 the following minimum requirements:

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 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 the access standards above, including accepting 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. 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 Claims

The CONTRACTOR shall process claims for BENEFITS and services as described in Uniform Benefits with the exception of the statewide/nationwide CONTRACTOR who will provide BENEFITS and services as described in the IYC Medicare Plus certificate for Medicare PARTICIPANTS. Targets for claims processing performance standards and associated penalties are specified in Section 315C.

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. The CONTRACTOR shall pay claims of providers according to a time standard mutually established by the CONTRACTOR and the DEPARTMENT.

Upon request of the DEPARTMENT or the PARTICIPANT, the CONTRACTOR shall provide the total dollar amount of claims paid by the HEALTH BENEFIT PROGRAM.

In accordance with state statute, the CONTRACTOR must maintain individual documentation used for claim adjudication for a minimum of seven (7) years.

240 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 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.

245 Grievances

245A Grievance Process Overview

The CONTRACTOR must have an internal grievance process that complies with the HHS-administered federal external review in accordance with federal law, except as otherwise provided in this AGREEMENT. The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and external review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval during the implementation process and upon request by the DEPARTMENT. See Sections 245E, 245F, and 265A.

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 245A – H.

1) Claim review (optional for PARTICIPANT);

2) PARTICIPANT notice;

3) Investigation and resolution;

4) Notification of DEPARTMENT Administrative Review Rights (not all grievances eligible): Administrative review by DEPARTMENT staff, and/or the DEPARTMENT appeals process including filing an appeal with the BOARD, an administrative appeal hearing, consideration of the appeal by the BOARD, right to appeal the BOARD's final decision to circuit court; or,

5) Federal external review (not all grievances eligible).

245B 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.

245C 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.

245D 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.

245E Notification of Department Administrative Review Rights

In the final grievance decision letters, the CONTRACTOR shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. In all final grievance decision letters, the CONTRACTOR shall cite the specific Uniform Benefits contractual provision(s) upon which the CONTRACTOR bases its decision and relies on to support its decision with the exception of the statewide/nationwide CONTRACTOR who will cite the specific IYC Medicare Plus contractual provision(s) for Medicare PARTICIPANTS.

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 HHS-administered federal external review process.

Following a determination by the DEPARTMENT, a PARTICIPANT may submit an appeal to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code ETF 11.01 (3). This process includes an administrative hearing. The CONTRACTOR shall, upon the DEPARTMENT'S request, participate in all administrative hearings requested by PARTICIPANTS or the CONTRACTOR, as determined by the DEPARTMENT. The hearings shall be conducted in accordance with guidelines and rules and regulations promulgated by the DEPARTMENT.

BOARD decisions can only be further reviewed as provided by Wis. Stat. § 40.08 (12) and Wis. Adm. Code ETF 11.15.

245F External Review

The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an 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.

245G 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.

245H 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.

245I 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.

245J 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.

250 Cancellation of Participant Coverage

Coverage terminates at the end of the month in which a notice of cancellation of coverage is received by the EMPLOYER (for EMPLOYEES), or by the DEPARTMENT (for ANNUITANTS and CONTINUANTS), upon date of death, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. No refund of PREMIUM may be granted for the month in which the coverage ends. If the deceased subscriber has covered dependents, see Section 260D.

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.

255 Direct Pay Premium Process

The CONTRACTOR must collect direct pay PREMIUMS for certain SUBSCRIBERS as identified by the DEPARTMENT. PREMIUMS billed and received by the CONTRACTOR shall be credited to the DEPARTMENT no later than the second Wednesday of the month following receipt. It is acceptable to credit the collected direct pay PREMIUM amount on the administrative monthly invoice provided that it contains itemized SUBSCRIBER level detail.

Direct pay PREMIUMS may be submitted to the CONTRACTOR via electronic funds transfer or 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.

260 Continuation

260A 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.

260B 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.

260C Conversion / Marketplace

The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment.

260D 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.

265 Miscellaneous Program Requirements

265A 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.

The CONTRACTOR is required to perform and/or manage the following activities by the date indicated:

Implementation Requirements Timeline

Activity	Due Dates
Implementation Plan: The CONTRACTOR submits an updated implementation plan in a mutually agreed upon format and timeline to the DEPARTMENT Program Manager or designee.	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
Fraud and Abuse Review Plan: The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT	Within thirty (30) DAYS of execution of this CONTRACT
Nondiscrimination Testing Plan: The CONTRACTOR works with the DEPARTMENT to establish a plan for annual nondiscrimination testing. The DEPARTMENT will establish the first-year due date in accordance with this plan.	Within thirty (30) DAYS of execution of this CONTRACT
Transition Plan: The transition plan is established in a mutually agreed upon format and submitted to the DEPARTMENT Program Manager or designee for review.	Within thirty (30) DAYS of execution of this CONTRACT
Program Information: All program informational materials for the 2018 benefit period have been submitted to the DEPARTMENT Program Manager or designee for review and approval.	August 18, 2017
Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE ENROLLMENT period for review and approval.	September 1, 2017
Employer Meeting: The CONTRACTOR attends the It's Your Choice EMPLOYER Kick-Off meeting.	Fall 2017 (Date TBD)
Customer Service: The CONTRACTOR'S dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained.	September 30, 2017
Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched.	September 30, 2017
Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period.	September 2017 (Date TBD)
Employer Health Fairs: The CONTRACTOR shall participate in IT'S YOUR CHOICE OPEN ENROLLMENT health fairs sponsored by EMPLOYERS in their service area.	October – November 2017
Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation.	November 16, 2017

Activity	Due Dates
Financial Administration: Financial administration requirements are operational, including but not limited to: • Establishment of bank account(s) for funds for claims payments, and determine bank account(s) ownership. • Establishment of mutually agreed upon written procedures related to managing the bank account(s) and invoicing (including data fields to be included). • Direct pay invoicing process. • ACH mechanism for EFT of claims payments and direct pay PREMIUMS.	November 30, 2017
Grievance Procedure: The CONTRACTOR must submit its grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, for the DEPARTMENT'S review and approval.	November 30, 2017
ID Cards: The CONTRACTOR issues welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018.	December 15, 2017
Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM are fully operational.	January 1, 2018
Web-Portal: The CONTRACTOR'S web-portal tracking PARTICIPANT level information is launched.	January 1, 2018
Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly.	January 15, 2018
Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly.	January 31, 2018
Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	February 28, 2018
Claims Data: The claims data transfer process to the DEPARTMENT'S data warehouse has been established, tested, and working correctly.	March 31, 2018

265B Account Management and Staffing

Upon execution of this CONTRACT, the CONTRACTOR shall designate an Account Manager and a backup, assigned to the DEPARTMENT for the life of the CONTRACT, who is accountable for and has the authority to:

1) Manage the entire range of services specified in the CONTRACT;

2) Respond to DEPARTMENT requests and inquiries;

3) Provide daily operational support;

4) Implement the DEPARTMENT changes to benefit plan design and procedures; and,

5) Resolve general administrative problems identified by the DEPARTMENT.

The Account Manager or backup must be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the contract. The Account Manager or backup must provide an initial response to DEPARTMENT requests and inquiries within one (1) BUSINESS DAY. The CONTRACTOR shall resolve DEPARTMENT issues within five (5) BUSINESS DAYS of receipt, unless otherwise approved by the DEPARTMENT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR must have a designated Information Technology contact and a backup Information Technology contact who will have overall responsibility for the information technology aspects of the CONTRACT. The Information Technology contact shall be available for consultation with the DEPARTMENT during the hours of 8:00 a.m. to 4:30 p.m. CST/CDT, Monday through Friday, as required to fulfill the scope of services specified in the CONTRACT. The CONTRACTOR will provide the DEPARTMENT with an emergency contact number in case issues arise that need to be resolved outside of the aforementioned business hours.

The CONTRACTOR shall provide and maintain key, qualified staff at a level that enables the CONTRACTOR to fulfil the requirements of the CONTRACT. The CONTRACTOR shall ensure that all persons, including independent contractors, subcontractors and consultants assigned to perform under the CONTRACT, have the experience and credentials necessary to perform the work required. The CONTRACTOR shall provide the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS.

The CONTRACTOR shall notify the DEPARTMENT if the Account Manager (within one (1) BUSINESS DAY), backup or key staff (within three (3) BUSINESS DAYS) changes. The DEPARTMENT reserves the right to deny the CONTRACTOR'S designees.

The CONTRACTOR must also provide a central point of contact for EMPLOYER issues related to the HEALTH BENEFIT PROGRAM. The CONTRACTOR must acknowledge receipt of the inquiry from the benefit/payroll processing centers and/or EMPLOYER benefit/payroll staff within two (2) BUSINESS DAYS of the inquiry and actively communicate on issue resolution status with the payroll processing centers and/or other payroll.

The CONTRACTOR shall provide onsite staff attendance at the annual IYC EMPLOYER Kick-Off Meeting and other EMPLOYER sponsored meetings, such as health fairs, throughout the state for the annual IT'S YOUR CHOICE OPEN ENROLLMENT period.

The CONTRACTOR will ensure that staff providing services under the CONTRACT have received comprehensive orientation and ongoing training, understand applicable requirements of the CONTRACT, and are knowledgeable about the CONTRACTOR'S operations and policies.

The CONTRACTOR must participate in meetings as requested by the DEPARTMENT. This may include QUARTERLY coordination meetings with other stakeholders of the 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 5 point survey tool) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.), and notification of changes impacting HEALTH BENEFIT PROGRAM services.

265C Customer Service

The CONTRACTOR shall operate a dedicated 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 315D 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, EMPLOYER group);

5) The representative that handled the inquiry;

6) For phone inquiries, the length of call; and,

7) The resolution of the inquiry (including a resolution code using a coding scheme).

Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request.

At the DEPARTMENT'S request, the CONTRACTOR must provide the policies and procedures related to the operation of the customer service department. The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.

The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each 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.

265D 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.).

265E 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.

265F 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 or the IYC Medicare Plus certificate administered by the statewide/nationwide CONTRACTOR.

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.

265G 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 "personal information", as those terms are respectively defined in Wis. Admin. Code ETF 10.01 (3m) and ETF 10.70 (1), that are included in such information;

2) Not make any disclosure of such information without providing advance notice to the DEPARTMENT; and,

3) Include a liability clause for damages in the event the CONTRACTOR makes any disclosure of personal information or any medical record that would violate Wis. Stat. § 40.07 (1) or (2), respectively, if the disclosure was made by the DEPARTMENT.

265H 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.

265I Subrogation and Other Payers

The CONTRACTOR shall correspond with PARTICIPANTS to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other payers such as worker's compensation, insurance contracts, or government-sponsored benefit programs.

The CONTRACTOR shall have authority to retain any attorneys or law firms regarding such subrogation rights and lawsuits involving such rights to represent the BOARD to pursue the BOARD'S subrogation rights in accordance with this AGREEMENT. Any subrogation settlement agreed to by the CONTRACTOR shall be deemed acceptable by the BOARD. The CONTRACTOR may forego subrogation where, at the CONTRACTOR'S discretion, the circumstances in a particular subrogation matter warrant such a decision.

With respect to these subrogation cases, the CONTRACTOR will hire outside legal counsel or utilize in-house counsel to provide the BOARD with subrogation litigation services on the BOARD'S behalf at a contingency fee not to exceed thirty (30%) percent for outside legal counsel or twenty (20%) percent for in-house counsel of net dollars recovered by such counsel, with those attorneys' fees being subject to, and being paid consistent with, the Wisconsin Rules of Professional Conduct for Attorneys, the code of professional ethics and performance standards established by the Wisconsin Supreme Court for attorneys practicing law in the State of Wisconsin.

For such subrogation matters, the BOARD shall not pay or provide any additional reimbursement for the outside legal counsel's or in-house counsel's legal fees, expenses, costs and disbursements incurred by such counsel while providing subrogation-related legal services and such legal fees, expenses, costs and disbursements are included in, and will be paid out of, the maximum thirty (30%) percent contingency fee that is paid to the outside legal counsel or twenty (20%) percent fee paid to in-house counsel as set forth in this subsection. The CONTRACTOR will not be paid or receive any portion of the contingency fee that is paid to the outside legal counsel if outside legal counsel is hired. The BOARD shall be solely responsible and liable for paying the contingency fee to outside legal counsel for its attorneys' fees, legal costs and disbursements incurred by the outside legal counsel representing the BOARD in subrogation cases, not the CONTRACTOR. The CONTRACTOR is not responsible or liable for paying the contingency fee or any outside counsel attorneys' fees, legal costs and disbursements.

265J 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.

265K Other

The CONTRACTOR shall not provide claims or other rating information to individual LOCAL EMPLOYERS participating in the HEALTH BENEFIT PROGRAM.

265L 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.

265M Conflict of Interest

During the term of this AGREEMENT, the CONTRACTOR shall have no interest, direct or indirect, that would conflict in any manner or degree with the performance of services required under this AGREEMENT.

Without limiting the generality of the preceding paragraph, the CONTRACTOR agrees that it shall not, during the initial AGREEMENT period and any extension thereof, acquire or hold any business interest that conflicts with the CONTRACTOR'S ability relating to its performance of its services under this AGREEMENT.

The CONTRACTOR shall not engage in any conduct which violates, or induces others to violate, the provision of the Wisconsin statutes regarding the conduct of public employees. If a BOARD member or an organization in which a BOARD member holds at least ten (10%) percent interest is a party to this AGREEMENT, then this AGREEMENT is voidable by the BOARD unless appropriate disclosure has been made to the Wisconsin Ethics Commission.

300 DELIVERABLES

305 Reporting Requirements

As required by the CONTRACT, the CONTRACTOR must submit reports to the DEPARTMENT. Reports must be submitted by SECURE email to the DEPARTMENT, the DEPARTMENT'S sFTP site, or other method as specified by the DEPARTMENT, in the format and timeframe specified by the DEPARTMENT. The DEPARTMENT reserves the right to modify reporting requirements as deemed necessary to monitor the CONTRACT and programs.

Instructions and specific due dates will be provided by the DEPARTMENT annually.

Unless otherwise requested by the DEPARTMENT, each report must be specific to data from the 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 Invoicing	The CONTRACTOR notifies the DEPARTMENT every calendar week during the term of this AGREEMENT and informs the DEPARTMENT in writing by submission of an invoice showing the amount due from the DEPARTMENT to the CONTRACTOR. *(See Section 135A, 1, a.)*	Weekly
3) Administrative Fee Invoice	The CONTRACTOR submits to the DEPARTMENT an administrative monthly invoice that is based on PARTICIPANT counts as of the first calendar DAY of the month as determined by DEPARTMENT enrollment records. *(See Section 135A, 2, a.)*	Monthly
4) 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, 1.)*	Monthly
5) Bank Reconciliation Report	The CONTRACTOR shall perform a monthly bank reconciliation and provide to the DEPARTMENT within 20 BUSINESS DAYS following month-end. *(See Section 135A, 1, c.)*	Monthly
6) Claims Invoice Reconciliation Report	The CONTRACTOR submits a claims invoice reconciliation report each month for the prior month. The report reconciles the weekly claims invoice into a monthly report that will match the claims data reported each month to the DEPARTMENT'S data warehouse. *(See Section 135A, 1, d.)*	Monthly

Report	Description	Frequency
7) 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 265C.)*	Monthly
8) 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, 2..)*	Monthly
9) Fraud and Abuse Review Results	The CONTRACTOR performs QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provides results of material findings to the DEPARTMENT. *(See Section 155F, 2.)*	Quarterly
10) Hospital Bill Audit	The CONTRACTOR performs a HOSPITAL bill audit process for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand ($200,000) dollars per CONFINEMENT and provides results of material findings to the DEPARTMENT. *(See Section 155C.)*	Quarterly
11) 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
12) Performance Standards Reports	The CONTRACTOR submits all data and reports as required to measure performance standards specified in Section 315.	Quarterly, unless otherwise noted
13) DEPARTMENT Initiatives	The CONTRACTOR implements and reports on the DEPARTMENT Initiatives as detailed in the most recent Guidance for DEPARTMENT Initiatives document. 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, High Tech Radiology, Low Back Surgery, Shared Decision Making, and Advance Care Planning. *(See Section 215B.)*	Semi-annually
14) 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 215C.)*	Semi-annually
15) 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.)*	Semi-annually

Report	Description	Frequency
16) 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
17) CAHPS Survey Results Report	The CONTRACTOR submits the results of its annual CAHPS survey to the DEPARTMENT. *(See Section 225, 3, b.)*	Annually
18) 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
19) 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
20) 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.)*	Annually
21) 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
22) 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
23) HEDIS Results Report	The CONTRACTOR submits audited HEDIS data results to the DEPARTMENT for its commercial membership for the previous calendar year. *(See Section 225, 3, a.)*	Annually
24) Provider Contract Certification	The CONTRACTOR must certify that their provider contracts meet the requirements in Section 230.	Annually

Report	Description	Frequency
25) Rate Renewal Reports	To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports. *(See Section 130.)*	Annually
26) 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 16 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 DEPARTMENT Program Manager or designee. *(See Section 265A.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
2) Emergency Contact Numbers	The CONTRACTOR provides the DEPARTMENT with an emergency contact number for the Implementation Manager and Account Manager or backup in case issues arise that need to be resolved outside of the aforementioned business hours. *(See Sections 265A and 265B.)*	Within ten (10) BUSINESS DAYS of execution of this CONTRACT
3) Fraud and Abuse Review Plan	The CONTRACTOR submits a fraud and abuse review plan to the DEPARTMENT. *(See Section 155F, 2 and Section 265A.)*	Within thirty (30) DAYS of execution of this CONTRACT
4) Identification (ID) Card Issuance Delays	The CONTRACTOR notifies the DEPARTMENT Program Manager of any delays with issuing the ID cards. *(See Section 205B, 2.)*	Upon identification of issue
5) ID Card Confirmation	The CONTRACTOR sends a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the ID cards were issued. *(See Section 205B, 2.)*	January
6) Key Contacts Listing (ET-1728)	The CONTRACTOR provides the DEPARTMENT with contact information for the key staff, which the DEPARTMENT will share with EMPLOYERS. *(See Section 265B.)*	April August

Deliverable	Description	Frequency
7) Provider Network Submission for Upcoming Benefit Period	The CONTRACTOR provides an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. *(See Section 230A.)*	June
8) It's Your Choice Information	The CONTRACTOR submits the following information to the DEPARTMENT, in the format as determined by the DEPARTMENT, for inclusion in the communications from the DEPARTMENT for the IT'S YOUR CHOICE OPEN ENROLLMENT period: • CONTRACTOR information, including address, toll-free customer service telephone number, twenty-four (24)-hour nurse line telephone number, and web site address. • Content for the CONTRACTOR'S plan description page, including available features. • Information for PARTICIPANTS to access the CONTRACTOR'S provider directory on its web site, including a link to the provider directory. *(See Section 140B, 2.)*	July
9) It's Your Choice Informational Materials Review	The CONTRACTOR submits all informational materials intended for distribution to PARTICIPANTS during the IT'S YOUR CHOICE OPEN ENROLLMENT period to the DEPARTMENT for review and approval. *(See Section 140B, 3.)*	July
10) Copies of Materials	The CONTRACTOR submits three (3) hard copies of all IT'S YOUR CHOICE OPEN ENROLLMENT materials in final form to the DEPARTMENT at least two (2) weeks prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 140B, 4.)*	September
11) SUBSCRIBER Notification of Changes	The CONTRACTOR submits the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEATLH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
12) SUBSCRIBER Notification Confirmation	The CONTRACTOR submits a written confirmation to the DEPARTMENT Program Manager indicating the date(s) the written notice described in item 11) above was issued. *(See Section 140B, 1.)*	October
13) Enrollment Discrepancy Tracker	The CONTRACTOR maintains an exception report spreadsheet that includes the error details and final resolution, and submits it to the DEPARTMENT. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
14) Enrollment Reconciliation Report *Full File Compare (FFC)*	The CONTRACTOR assists with a FFC of enrollment by submitting a file to the DEPARTMENT containing current enrollment data. *(See Section 150A, 4, b.)*	As directed by the DEPARTMENT
15) Web Content and Web-Portal Design and Changes	The CONTRACTOR submits the web content and web-portal design for review, as directed by the DEPARTMENT. The CONTRACTOR notifies the DEPARTMENT Program Manager of any substantial changes being made to the website prior to implementation. *(See Sections 265D, 1a and 1p.)*	As directed by the DEPARTMENT
16) Major Administrative and Operative System Changes	The CONTRACTOR submits written notice to the DEPARTMENT at least one hundred 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
17) Notification of Account Manager or Key Staff Changes	The CONTRACTOR notifies the DEPARTMENT if the Account Manager, backup or key staff changes. *(See Section 265B.)*	As needed
18) Recovery of Overpayments	The CONTRACTOR notifies the DEPARTMENT of each uncollectible overpayment of fifty ($50.00) dollars or more within ten (10) BUSINESS DAYS following the CONTRACTOR'S determination that such overpayment is uncollectible after using such recovery and collection procedures. *(See Section 135F.)*	As needed
19) Notification of Legal Action	If a PARTICIPANT files a lawsuit naming the CONTRACTOR as a defendant, the CONTRACTOR notifies the DEPARTMENT'S chief legal counsel within ten (10) BUSINESS DAYS of notification of the legal action. *(See Section 245K.)*	As needed

Deliverable	Description	Frequency
20) Notification of Legal Action Against PARTICIPANT in Dispute over Charges	If no settlement is reached in a dispute over charges and a lawsuit is brought against a PARTICIPANT, the PARTICIPANT contacts the DEPARTMENT or the CONTRACTOR within fourteen (14) DAYS of the date on which the lawsuit is received by the PARTICIPANT. Within two (2) BUSINESS DAYS of the CONTRACTOR becoming aware of a lawsuit, the CONTRACTOR notifies the DEPARTMENT about the lawsuit. The CONTRACTOR provides the DEPARTMENT with monthly reports giving each lawsuit's status in a mutually agreeable format. *(See Section 135F.)*	As needed
21) Notification of 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 personal 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 155G.)*	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 245F.)*	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, activities, and information that will be provided to the succeeding vendor when relinquishing responsibilities at termination of the CONTRACT. *(See Section 155J.)*	During the implementation period, upon DEPARTMENT request, and prior to CONTRACT termination

310B Deliverables to Participants

Deliverable	Description	Frequency
1) ID cards	The CONTRACTOR provides PARTICIPANTS with ID cards indicating, at a minimum, the EFFECTIVE DATE of coverage, and the emergency room and office visit copayment amounts. *(See Section 205B.)*	Upon enrollment and BENEFIT changes that impact the information printed on the ID cards
2) PARTICIPANT Enrollment Information	The CONTRACTOR provides the following information, at a minimum, to PARTICIPANTS upon enrollment: • Information about PARTICIPANT requirements, including prior authorizations and referrals. • The HEALTH BENEFIT PROGRAM provider directory or directions on how to request a printed copy of the provider directory. • Directions on how to access the HEALTH BENEFIT PROGRAM provider directory on the CONTRACTOR'S website. • Directions on how to change their Primary Care Provider. • The CONTRACTOR'S contact information, including the dedicated toll-free customer service phone number, business hours, twenty-four (24)-hour nurse line, and website address. *(See Section 205C.)*	Upon enrollment
3) SUBSCRIBER Notification of Changes	The CONTRACTOR issues written notice to PARTICIPANTS enrolled in its benefit plan(s) prior to the IT'S YOUR CHOICE OPEN ENROLLMENT period identifying those providers that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. *(See Section 140B, 1.)*	September

Deliverable	Description	Frequency
4) PARTICIPANT Notification of Terminated Provider Agreement	At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR sends written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: • How to find a new IN-NETWORK provider or facility, • The continuity of care provision as it relates to this situation, and • Contact information for questions. *(See Section 230C.)*	See description
5) PARTICIPANT Notification of Grievance Rights	The CONTRACTOR provides the PARTICIPANT with notice of their grievance rights and a period of one hundred eighty (180) calendar DAYS to file a grievance after written denial of a BENEFIT or other occurrence of the cause of the grievance along with the Uniform Benefit contractual provision(s) upon which the denial is based. *(See Section 245B.)*	See description
6) PARTICIPANT Notification of DEPARTMENT Administrative Review Rights	In the final grievance decision letters, the CONTRACTOR informs PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision and their right to request an HHS-administered federal external review in accordance with federal law, using the language approved by the DEPARTMENT. *(See Section 245D.)*	See description
7) SUBSCRIBER Notification Upon Termination of Employment	The CONTRACTOR provides the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment. *(See Section 260C.)*	See description
8) Assignment of Primary Care Provider (PCP)	If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR assigns a PCP, notifies the PARTICIPANT in writing, and provides instructions for changing the assigned PCP. *(See Section 210.)*	As needed
9) Summary of Benefits and Coverage	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual IT'S YOUR CHOICE OPEN ENROLLMENT materials mailing process. *(See Section 205C.)*	As needed
10) 1095-C	The DEPARTMENT reserves the right to require the CONTRACTOR to assist with developing and mailing the federally required 1095-Cs. *(See Section 205C.)*	As needed

315 Performance Standards and Penalties

Performance standards are specific to data from the HEALTH BENEFIT PROGRAM, not general data from the CONTRACTOR'S book-of-business. The CONTRACTOR must track performance using the template provided by the DEPARTMENT. The CONTRACTOR must submit reports and supporting documentation for validation as mutually agreed upon with the DEPARTMENT. The CONTRACTOR shall notify the DEPARTMENT upon realization that a standard will not be met, prior to the deadline.

The penalties assessed in Section 150B and Section 315 shall not exceed twenty-five (25%) percent of the CONTRACTOR'S total administrative fee in any given quarter. After implementation, all performance standards will be measured by the DEPARTMENT on a QUARTERLY basis and assessed based on PARTICIPANT counts as of the first calendar DAY of the quarter, as determined by DEPARTMENT enrollment records. The DEPARTMENT reserves the right to waive a penalty in certain circumstances when the DEPARTMENT determines it is warranted. The performance categories and associated penalty are shown below and explained in greater detail in the tables that follow:

Section	Performance Category	Maximum Penalty
315A	Implementation	Three (3%) percent
315B	Account Management	Three (3%) percent
315C	Claims Processing	Four (4%) percent
315D	Customer Service	Four (4%) percent
315E	Data Management	Four (4%) percent
315F	Enrollment	Four (4%) percent
315G	Other	Three (3%) percent
	TOTAL	Twenty-five (25%) percent

315A Implementation

The CONTRACTOR shall complete the task by the date specified below. If an alternate date is approved by the DEPARTMENT in the implementation plan, the CONTRACTOR shall complete the task by the alternate date. The total penalties for this performance category shall not exceed three (3%) percent of the total estimated administrative fee for year one (1) of the CONTRACT.

Performance Standards – three (3%) percent Penalty	Penalties
1) Program Information: All program informational materials for the 2018 calendar year benefit period have been submitted to the DEPARTMENT Program Manager or designee by September 1, 2017 for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

Performance Standards – three (3%) percent Penalty	Penalties
2) Web Content: The CONTRACTOR must provide the DEPARTMENT Program Manager or designee no later than September 16, 2017, the customized web pages dedicated to the program and for the upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period for review and approval. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
3) Customer Service: The CONTRACTOR's dedicated toll-free customer service telephone number is operational and customer service staff for the HEALTH BENEFIT PROGRAM are trained no later than September 30, 2017. (*See Section 265A.)*	
4) Web Content Launch: The web content dedicated to the HEALTH BENEFIT PROGRAM and upcoming IT'S YOUR CHOICE OPEN ENROLLMENT period is completed, as determined by the DEPARTMENT Program Manager or designee, and launched no later than September 30, 2017. *(See Section 265A.)*	
5) Informational Mailing: The CONTRACTOR shall send an informational mailing with materials approved by the DEPARTMENT Program Manager or designee to eligible program households one (1) week prior to the start of the IT'S YOUR CHOICE OPEN ENROLLMENT period. *(See Section 265A.)*	
6) Enrollment File: The daily and full file compare of the DEPARTMENT HIPAA 834 enrollment files have been fully tested and are ready for program operation as determined by the DEPARTMENT no later than November 16, 2017. *(See Section 265A.)*	
7) Financial Administration: Financial administration requirements are operational no later than November 30, 2017. *(See Section 265A.)*	
8) Grievance Procedure: The CONTRACTOR has submitted the grievance procedure, including the DEPARTMENT administrative and independent review rights and sample grievance decision letters, by November 30, 2017, for the DEPARTMENT'S review and approval. *(See Section 265A.)*	
9) ID Cards: No later than December 15, 2017, the CONTRACTOR has issued welcome packets that contain ID cards for SUBSCRIBERS with coverage effective January 1, 2018. *(See Section 265A.)*	
10) Claims Administrative Services: All medical claims administrative services for the HEALTH BENEFIT PROGRAM shall be fully operational as determined by the DEPARTMENT no later than January 1, 2018. *(See Section 265A.)*	

Performance Standards – three (3%) percent Penalty	Penalties
11) Pharmacy Data: The pharmacy data transfer process is established, tested, and working correctly no later than January 15, 2018. *(See Section 265A.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
12) Wellness and Disease Management Data: The wellness and disease management data transfer process is established, tested, and working correctly no later than January 31, 2018. *(See Section 265A.)*	
13) Provider Data: The provider data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than February 28, 2018. *(See Section 265A.)*	
14) Claims Data Transfer: The claims data transfer process to the DEPARTMENT'S data warehouse is established, tested, and working correctly no later than March 31, 2018. *(See Section 265A.)*	

315B Account Management

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) CONTRACTOR Services: The CONTRACTOR shall achieve a ninety-five (95%) percent satisfaction or better (defined as "top two-box" satisfaction/approval using an approved standard five (5) point survey tool with five (5) being the highest satisfaction/approval rating) on a survey developed and administered by the DEPARTMENT to DEPARTMENT staff, benefit/payroll staff, and other parties that work with the CONTRACTOR to assess the quality of services provided by the CONTRACTOR. The survey will include assessments in areas that include, but are not limited to, professionalism, responsiveness, communication, technical knowledge, and notifications in disruption of any service (e.g., customer service telephone outage, website outage, etc.). *(*See *Section 265B.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey

Performance Standards	Penalties
2) **Approval of Communications:** All materials and communications shall be pre-approved by the DEPARTMENT prior to distribution to PARTICIPANTS, potential PARTICIPANTS, and EMPLOYERS of the HEALTH BENEFIT PROGRAM. This includes website content that shall be approved by the DEPARTMENT prior to launch. This also includes written and electronic communication, such as marketing, informational, standard letters, explanation of BENEFITS, summary plan descriptions, claim denials and appeals, and summary of BENEFITS and coverage. *(See Sections 140A, 1 and 265D, 1.)*	Five thousand ($5,000) dollars per incident

315C Claims Processing

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Financial Accuracy:** At least ninety-nine (99%) percent level of financial accuracy. Financial accuracy means the claim dollars paid in the correct amount divided by the total claim dollars paid. *(See Section 235.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month
2) **Processing Accuracy:** At least ninety-seven (97%) percent level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed. *(See Section 235.)*	
3) **Claims Processing Time:** At least ninety-five (95%) percent of all claims received must be processed within fifteen (15) BUSINESS DAYS of receipt of all necessary information, except for those claims for which the HEALTH BENEFIT PROGRAM is the secondary payer. *(See Section 235.)*	

315D Customer Service

The CONTRACTOR shall report monthly values on a QUARTERLY basis for these standards. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) **Call Answer Timeliness**: At least eighty (80%) percent of calls received by the organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)

Performance Standards	Penalties
2) Call Abandonment Rate: Less than three (3%) percent of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. *(See Section 265C.)*	Five thousand ($5,000) dollars for each percentage point for which the standard is not met in each month)
3) Open Call Resolution Turn-Around-Time: At least ninety (90%) percent of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. *(See Section 265C.)*	
4) Inquiry Resolution Tracking Document/Log: Inquiries not resolved within two (2) BUSINESS DAYS must be added to a tracking document/log that must summarize the issue and the current resolution status. This tracking document/log must be kept current and must be provided to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY of the DEPARTMENT'S request. *(See Section 265C.)*	
5) Electronic Written Inquiry Response: At least ninety-eight (98%) percent of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. *(See Section 265C.)*	

315E Data Management

The DEPARTMENT will specify the timetable and dates for which the claims and provider data transfers must be provided. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Claims Data Transfer: The CONTRACTOR must submit on a monthly basis to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Claims Data Specifications document, all claims processed for PARTICIPANTS. *(See Section 150A, 5, a and 150B, 1.)*	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, 2.)*	

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 155G.)*	

315F Enrollment

The CONTRACTOR shall report QUARTERLY any DAY for which any of the following standards are not met. The total penalties for this performance category shall not exceed four (4%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Enrollment File: The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. Delays in processing the 834 file must be communicated to the DEPARTMENT Program Manager or designee within one (1) BUSINESS DAY. *(See Section 150A, 4, a and c.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Enrollment Discrepancies: The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR's database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR. *(See Section 150A, 4, a.)*	
3) ID Cards: The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 4) below. *(See Section 205B, 1.)*	
4) ID Cards for elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT Period: The CONTRACTOR shall issue ID cards by December 15 (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.)*	

Performance Standards	Penalties
5) Direct Pay Terminations: The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of premium, whichever occurs first. *(See Section 255.)*	One thousand ($1,000) dollars per DAY for which the standard is not met

315G Other

The total penalties for this performance category shall not exceed three (3%) percent of the total administrative fee for the quarter.

Performance Standards	Penalties
1) Audit: The CONTRACTOR shall address any areas of improvement as identified in the audit in the timeframe as determined by the DEPARTMENT. *(See Section 155E.)*	One thousand ($1,000) dollars per DAY for which the standard is not met
2) Grievance Resolution: Investigation and resolution of any grievance will be initiated within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within seventy-two (72) hours of the CONTRACTOR'S receipt of the grievance. *(See Section 245C.)*	
3) Major System Changes and Conversions: The CONTRACTOR shall verify and commit that during the length of the contract, it shall not undertake a major system change or conversion for, or related to, the system used to deliver services for the HEALTH BENEFIT PROGRAM without specific prior written notice of at least one hundred-eighty (180) days to the DEPARTMENT. *(See Section 145, 8.)*	
4) PARTICIPANT Satisfaction Surveys: The CONTRACTOR shall achieve at or above a ninety (90%) percent satisfaction rating (defined as “top three-boxes” using a zero (0) to ten (10) rating scale with ten (10) being the highest ranking) on the health plan rating question on the CAHPS survey tool or other survey instrument as approved by the DEPARTMENT. *(See Section 225, 3, c.)*	Ten thousand ($10,000) dollars for each percentage point for which the standard is not met, per survey
5) Non-Disclosure: The CONTRACTOR shall not use or disclose names, addresses, or other data for any purpose other than specifically provided for in the CONTRACT. *(See Section 115, 19.)*	Five thousand ($5,000) dollars per incident

Performance Standards	Penalties
6) Reporting and Deliverables Requirements: The CONTRACTOR must submit the reports and deliverables as outlined in Sections 305 and 310. Each report submitted by the CONTRACTOR to the DEPARTMENT must: • Be verified by the CONTRACTOR for accuracy and completeness prior to submission; • Be delivered on or before scheduled due dates; • Be submitted as directed by the DEPARTMENT; • Fully disclose all required information in a manner that is responsive and with no material omission; and • Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report. *(See Section 155A, 2.)*	Twenty–five hundred ($2,500) dollars per report or deliverable for which the standard is not met

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 2018.

These are the Uniform Benefits or "Summary Plan Description" offered under the Health Benefit Program.

This portion of the Agreement is often excerpted and provided to PARTICIPANTS as their Summary Plan Description.

The contractor shall not alter the language, benefits or exclusions and limitations, herein.

These Uniform Benefits are provided to SUBSCRIBERS via the It's Your Choice materials as their Summary Plan Description. The language in this section is written to the audience of the PARTICIPANT. Included in this section is a set of definitions which is specific to Uniform Benefits. The contractor does not need to recreate the description of benefits nor distribute it to PARTICIPANTS.

These Uniform Benefits are provided to a SUBSCRIBER who is a retired public employee under Wis. Stat. § 40.02 (25) (b) 11, or any DEPENDENT of such an employee, and, if eligible, has acted under Wis. Stat. § 40.51 (10) to elect group health insurance coverage. SUBSCRIBERS or DEPENDENTS who are ineligible and unenrolled in Medicare may join Program Option 16. SUBSCRIBERS or DEPENDENTS who are eligible and enrolled in Medicare may join Program Option 12. Benefits will be provided to SUBSCRIBERS via the Local Annuitant Health Program (LAHP) materials.

I. Schedule of Benefits

All benefits are paid according to the terms of this contract between the THIRD PARTY ADMINISTRATOR(S) (TPA), the PBM, and the Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the contract. The SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, EMERGENCY services received from an OUT-OF-NETWORK PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE.

The Group Insurance Board contracts with a PBM to provide prescription drug benefits. The PBM is responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are COVERED under the State of Wisconsin Health Benefit Program.

This Summary Plan Description applies to services received from IN-NETWORK PROVIDERS. If any OUT-OF-NETWORK benefits are available, YOU will be provided with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by OUT-OF-NETWORK PROVIDERS. OUT-OF-NETWORK DEDUCTIBLE amounts do not accumulate to the IN-NETWORK OUT-OF-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 TPA before such services are obtained.

The covered benefits are subject to the following:

1) DEDUCTIBLES, COINSURANCE and COPAYMENTS as described in this schedule:

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Annual medical DEDUCTIBLE	$250 individual/$500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	None.	$1,500 per individual plan / $3,000 per family plan The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the plan pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).
Annual medical COINSURANCE	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies OOPL except as described below.	BENEFIT PLAN pays 100% except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL.
Annual medical OUT-OF-POCKET LIMIT (OOPL)	$1,250 PARTICIPANT / $2,500 aggregate family limit except as described below.[1]	None except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLAN pays 80% to OOPL.[1]	After DEDUCTIBLE: $2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN pays 100%.	Covered 100%.	BENEFIT PLAN pays 100%.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT Applies to: • Specialists • URGENT CARE	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $75 COPAYMENT (counts towards to OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	MEDICARE/BENEFIT PLAN pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit).[2]	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	MEDICARE/BENEFIT PLAN pays 100% HOSPITAL, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. §632.895 (16), covered 100%.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	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 and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). 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 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	MEDICARE/BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.

Benefits for State of Wisconsin	PARTICIPANTS who do not have MEDICARE as the primary payor[3]	MEDICARE prime PARTICIPANTS	PARTICIPANTS enrolled in the High DEDUCTIBLE Health Plan (HDHP)[3]
Prescription Drugs	See below.	See below.	After DEDUCTIBLE: subject to medical DEDUCTIBLE above. After DEDUCTIBLE, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2]Federally required preventive services are covered at 100%.

[3] State of Wisconsin MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the MEDICARE Prime Uniform Benefits SCHEDULE OF BENEFITS.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical DEDUCTIBLE	None.	$250 individual / $500 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). After an individual within a family plan meets the $250 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to office visit COPAYMENTS, preventive services* or prescription drugs.	$500 individual / $1,000 family. DEDUCTIBLE applies to annual OUT-OF-POCKET LIMIT (OOPL). When an individual within a family plan meets the $500 DEDUCTIBLE, COINSURANCE will apply to covered medical services. Medical DEDUCTIBLE does not apply to preventive services* or prescription drugs.	$1,500 per individual plan / $3,000 per family plan. The DEDUCTIBLE must be met before coverage begins; for family coverage, the full family DEDUCTIBLE must be met before the BENEFIT PLAN pays, except for preventive services*. The DEDUCTIBLE includes prescription drugs and applies to annual OUT-OF-POCKET LIMIT (OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
Annual Medical COINSURANCE	BENEFIT PLAN/MEDICARE pays 100% except as described below for: DURABLEMEDICAL EQUIPMENT, cochlear implants and hearing aids.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visits, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.	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.	After DEDUCTIBLE: BENEFIT PLAN pays 90% / 10% applies to medical services except for office visits, and as described below. COINSURANCE applies to OOPL except as described below.
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]	$1,250 individual / $2,500 aggregate family limit except as described below.[1]	After DEDUCTIBLE, none except as described below for: DURABLE MEDICAL EQUIPMENT, cochlear implants and hearing aids. Then, BENEFIT PLANS pays 80% to OOPL.[1]	$2,500 per individual plan / $5,000 per family plan.
*Routine, preventive services as required by federal law	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.	BENEFIT PLAN/ MEDICARE pays 100%.	BENEFIT PLAN pays 100%.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
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	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $15, DEDUCTIBLE need not be met first. COPAYMENT applies towards meeting the annual OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $15 per visit. COPAYMENT applies towards meeting the annual OOPL.
Specialist COPAYMENT applies to: • Specialists • URGENT CARE	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays $25 per visit, DEDUCTIBLE need not be met first. COPAYMENTS count towards meeting the OOPL, but not the DEDUCTIBLE.	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	PARTICIPANT pays the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: PARTICIPANT pays $25 per visit. COPAYMENT applies towards meeting the annual OOPL.

Benefits for Participating Local / Wisconsin Public Employers (WPE)	**WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17**	**WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE** [3]	**WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE**	**WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE**[3]
ILLNESS/INJURY related services beyond the office visit COPAYMENT (if applicable)	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100%; no medical COPAYMENTS.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Emergency Room COPAYMENT (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	PARTICIPANT pays $60 COPAYMENT.	PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). After COPAYMENT and DEDUCTIBLE: BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). BENEFIT PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT and Durable Diabetic Equipment and Related Supplies	BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	After DEDUCTIBLE: BENEFIT PLAN/ MEDICARE pays 80% (20% PARTICIPANT cost to $500 OOPL per PARTICIPANT; no aggregate family limit.[2]	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
Cochlear Implants for PARTICIPANTS age 18 and older	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	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).	After DEDUCTIBLE: BENEFIT PLAN pays 90% HOSPITAL CHARGES (10% PARTICIPANT cost to OOPL). BENEFIT PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants for PARTICIPANTS under age 18	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLANS pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).	BENEFIT PLAN/ MEDICARE pays 100% HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use.	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), BENEFIT PLAN pays 90% for HOSPITAL CHARGES, device, surgery for implantation and follow-up sessions to train on use (10% PARTICIPANT cost to OOPL).

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
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). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum BENEFIT PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL). 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), BENEFIT PLANS pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).	As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 100%.	After DEDUCTIBLE: As required by Wis. Stat. § 632.895 (16), BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical	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.	After DEDUCTIBLE: BENEFIT PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as DURABLE MEDICAL EQUIPMENT. Other services BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum BENEFIT PLAN payment of $1,250 for diagnostic procedures and nonsurgical

Benefits for Participating Local / Wisconsin Public Employers (WPE)	WPE eligible PARTICIPANTS enrolled in Program Option (PO) 2/12 & those enrolled in MEDICARE and PO6/16 or PO7/17	WPE eligible PARTICIPANTS enrolled in PO6/16 who are not enrolled in MEDICARE [3]	WPE eligible PARTICIPANTS enrolled in PO4/14 including those enrolled in MEDICARE	WPE eligible PARTICIPANTS enrolled in PO7/17 - High DEDUCTIBLE Health Plan (HDHP) who are not enrolled in MEDICARE[3]
		treatment per PARTICIPANT per calendar year.		treatment per PARTICIPANT per calendar year.
Dental Implants	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	BENEFIT PLAN pays 100% following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: BENEFIT PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum BENEFIT PLAN payment of $1,000 per tooth.
Prescription Drugs	See below.	See below.	See below.	After DEDUCTIBLE: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

Under no circumstances will YOU pay beyond the federal Maximum Out-of-Pocket (MOOP) limit which is $6,850 single / $13,700 family for federally required essential health benefits.

[1] Level 3 prescription drug COINSURANCE will continue to be paid by YOU past the OOPL, to the federal MOOP, see more information below.

[2] Federally required preventive services are covered at 100%.

[3] Wisconsin Public Employer MEDICARE eligible annuitants and their MEDICARE eligible DEPENDENTS are limited to participation under the PO2 Uniform Benefits SCHEDULE OF BENEFITS.

1) Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE

2) Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.

3) Diagnostic Services Limitations: PRIOR AUTHORIZATION may be required.

4) Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): Covered up to 50 visits per PARTICIPANT for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional MEDICALLY NECESSARY visits may be available when PRIOR AUTHORIZED by the TPA, up to a maximum of 50 additional visits per therapy per PARTICIPANT per calendar year.

5) Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when MEDICALLY NECESSARY and PRIOR AUTHORIZED by the TPA; and HOSPITAL CHARGES. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for PARTICIPANTS under 18 years of age are payable as described in the preceding grid.

6) Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The PARTICIPANT'S out-of-pocket costs are not applied to the annual OOPL. As required by Wis. Stat. §632.895 (16), hearing aids for PARTICIPANTS under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.

7) Home Care Benefits Maximum: 50 visits per PARTICIPANT per calendar year. 50 additional MEDICALLY NECESSARY visits per PARTICIPANT per calendar year may be available when authorized by the TPA.

8) HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the TPA.

9) Transplants: Limited to transplants listed in Benefits and Services Section.

10) Licensed Skilled Nursing Home Maximum: 120 days per BENEFIT PERIOD payable for SKILLED CARE.

11) Mental Health/Alcohol/Drug Abuse Services: Annual dollar and day limit maximums for mental health/alcohol/drug abuse services are suspended as required by the Federal Mental Health Parity Act.

12) Vision Services: One routine exam per PARTICIPANT per calendar year. Non-routine eye exams are covered as MEDICALLY NECESSARY. (Contact lens fittings are not part of the routine exam and are not covered.)

13) Oral Surgery: Limited to procedures listed in Benefits and Services Section.

14) Temporomandibular Disorders as required by Wis. Stat. §632.895 (11): The maximum benefit for diagnostic procedures and non-surgical treatment is $1,250 per PARTICIPANT per calendar year. Intraoral splints are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

15) Dental Services: No coverage provided under Uniform Benefits except as specifically listed in Benefits and Services Section.

The benefits that are administered by the PHARMACY BENEFIT MANAGER (PBM) are subject to the following:

1) Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):

a) Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.

b) Preventive Prescription Drugs:

i) Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.

ii) Under the HDHP, preventive prescription drugs are not subject to the DEDUCTIBLE; however, if the preventive prescription drug is not covered at 100% as required by federal law, a COPAYMENT will be required according to the provisions of this program's benefits.

iii) The PBM will publish a list of prescriptions drugs affected by these provisions.

Prescription Drug Copayments:
Level 1 COPAYMENT: $5.00
The Level 1 COPAYMENT applies to Preferred GENERIC DRUGS and certain lower-cost Preferred BRAND NAME DRUGS.

Prescription Drug Coinsurance:
Level 2 COINSURANCE: 20% ($50 max)
The Level 2 COINSURANCE applies to Preferred BRAND NAME DRUGS, and certain higher-cost Preferred GENERIC DRUGS.

Level 3 COINSURANCE: 40% ($150 max)
The Level 3 COINSURANCE applies to Non-Preferred BRAND NAME DRUGS and certain high-cost, GENERIC DRUGS for which alternative and/or equivalent Preferred GENERIC DRUGS and Preferred BRAND NAME DRUGS are available and covered.

Level 1/Level 2 Annual OOPL:
Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $600 per individual or $1,200 per family for all PARTICIPANTS.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): no annual OOPL.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

2) SPECIALTY MEDICATIONS
Specialty Drug Cost Share:
Level 4 COPAYMENT: $50
The Level 4 COPAYMENT applies when Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 COINSURANCE: 40% ($200 max)
The Level 4 COINSURANCE applies when any SPECIALTY MEDICATION is obtained from a PARTICIPATING PHARMACY other than a PREFERRED SPECIALTY PHARMACY and when Non-Preferred SPECIALTY MEDICATIONS are obtained from a PREFERRED SPECIALTY PHARMACY.

Level 4 Annual OOPL:
There is no OOPL for Non-Preferred SPECIALTY MEDICATIONS. YOU must continue to pay Level 4 COINSURANCE for Non-Preferred SPECIALTY MEDICATIONS until YOU meet the Federal MOOP of $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:

a) IYC Health Plan, IYC MEDICARE, MEDICARE Advantage, MEDICARE Plus, IYC Local Traditional (PO2/12), IYC Local DEDUCTIBLE (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family.

b) IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $2,500 for single coverage, or $5,000 for family coverage.

When the OOPL is met, YOU pay no more out-of-pocket expenses for covered medical services or prescription drugs.

3) **Certain grandfathered erectile dysfunction medication as defined by the PBM (Viagra and Caverject Injection):** the 40% Level 4 COINSURANCE ($200 max) applies to these prescription medications. However, the COINSURANCE does not accumulate toward any OOPL. YOU must continue to pay Level 4 COINSURANCE for these drugs even after other annual OOPLs have been met.

4) **Disposable Diabetic Supplies and Glucometers:** 20% PARTICIPANT COINSURANCE applies to the prescription drug Level 1/Level 2 annual OOPL.

5) **Smoking Cessation:** One consecutive three-month course of pharmacotherapy covered per calendar year. PRIOR AUTHORIZATION is required if the first quit attempt is extended by the prescriber.

II. Definitions

The following terms, when used and capitalized in this Uniform Benefits description, are defined and limited to that meaning only:

ADVANCE CARE PLANNING: A process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. ADVANCE CARE PLANNING includes:

1) Understanding YOUR health care treatment options.

2) Clarifying YOUR health care goals.

3) Weighing YOUR options about what kind of care and treatment YOU would want or not want.

4) Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive.

5) Communicating YOUR wishes and any documents with YOUR family, friends, clergy, other advisors and physician and other health care professionals.

BED AND BOARD: Means all usual and customary HOSPITAL CHARGES for: (a) Room and meals; and (b) all general care needed by registered bed patients.

BENEFIT PERIOD: Means the total duration of CONFINEMENTS that are separated from each other by less than 60 days.

BENEFIT PLAN: Means the BENEFIT PLAN design option that the SUBSCRIBER is enrolled in under the State of Wisconsin Group Benefit Program.

BRAND NAME DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and GENERIC DRUG classifications.

CHARGE: An amount for a health care service from a PROVIDER that is reasonable, as determined by the TPA. The TPA considers, as part of determination of CHARGE:

1) Amounts charged for similar health care services in the same general area under comparable circumstances,

2) the TPA's methodology guidelines,

3) pricing guidelines of any third party responsible for pricing a claim,

4) the negotiated rate determined between the TPA and an IN-NETWORK PROVIDER, and

5) other factors.

The term “area” means a county or other geographical area which the TPA determines is appropriate to obtain a representative cross section of amounts. For example, the “area” may be an entire state.

In some cases the amount the TPA determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the health care service. CHARGE includes all taxes for which a PARTICIPANT can legally be charged, including but not limited to, sales tax.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a HOSPITAL, covered residential center, SKILLED NURSING FACILITY or licensed ambulatory surgical center on the advice of YOUR physician; and discharge therefrom, or (b) the time spent receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY. If the PARTICIPANT is transferred or discharged to another facility for continued treatment of the same or related condition, it is one CONFINEMENT. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT.

CONGENITAL: Means a condition which exists at birth.

COINSURANCE: A specified percentage of the CHARGES that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

COPAYMENT: A specified dollar amount that the PARTICIPANT or family must pay each time those covered services are provided, subject to any limits specified in the SCHEDULE OF BENEFITS.

CUSTODIAL CARE: Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of an IN-NETWORK PROVIDER, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered CUSTODIAL CARE if the PARTICIPANT is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the PARTICIPANT to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the IN-NETWORK PROVIDER, that the medical or surgical treatment will enable that person to live outside an institution. CUSTODIAL CARE also includes rest cures, respite care, and home care provided by family members.

DEDUCTIBLE: The amount YOU owe for health care services YOUR BENEFIT PLAN covers before YOUR BENEFIT PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR BENEFIT PLAN will not pay anything until YOU have incurred $1,500 in out-of-pocket expenses for covered health care services subject to the DEDUCTIBLE. The DEDUCTIBLE may not apply to all services.

DEPARTMENT: Means the Wisconsin DEPARTMENT of Employee Trust Funds.

DEPENDENT: Means, as provided herein, the SUBSCRIBER'S:

1) Spouse.[1]

2) DOMESTIC PARTNER, if elected.[2]

3) Child.[3, 4, 5]

4) Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19. [3, 4, 5]

5) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.[3, 4, 5]

6) Stepchild.[1, 3, 4, 5]

7) Child of the DOMESTIC PARTNER insured on the policy.[2, 3, 4, 5]

8) Grandchild if the parent is a DEPENDENT child.[3, 4, 5, 6]

[1] A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

[2] A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

[3] All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, 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.

[4] A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

[5] A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an ELIGIBLE EMPLOYEE.

[6] A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

DOMESTIC PARTNER: Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

1) Each individual is at least 18 years old and otherwise competent to enter into a contract.

2) Neither individual is married to, or in a domestic partnership with, another individual.

3) The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.

4) The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY.

5) The two individuals agree to be responsible for each other's basic living expenses.

6) The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

   a) Only one of the individuals has legal ownership of the residence.

   b) One or both of the individuals have one or more additional residences not shared with the other individual.

   c) One of the individuals leaves the common residence with the intent to return.

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 TPA and/or PBM, on which the PARTICIPANT becomes enrolled and entitled to the benefits specified in the contract.

ELIGIBLE EMPLOYEE: As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.

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 TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

EXPERIMENTAL: The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY that, as determined by the TPA and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY for a PARTICIPANT'S ILLNESS or INJURY. The criteria that the TPA and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, MEDICAID and other insurers and self-insured plans.

FORMULARY: Means a list of prescription drugs, developed by a committee established by the PBM. The committee is made up of physicians and pharmacists. The PBM may require PRIOR AUTHORIZATION for certain Preferred and NON-PREFERRED DRUGS before coverage applies. Drugs that are not included on the FORMULARY are not covered by the benefits of this program.

GENERIC DRUGS: Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.

GENERIC EQUIVALENT: Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.

GRIEVANCE: Means a written complaint filed with the TPA and/or PBM concerning some aspect of the TPA and/or PBM. Some examples would be a rejection of a claim, denial of a formal REFERRAL, etc.

HABILITATION SERVICES: Means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A benefit plan that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OOPL set by the IRS. An HDHP does not pay any health care costs until the annual DEDUCTIBLE has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The HDHP is designed to offer a lower monthly premium in turn for more shared health care costs.

HOSPICE CARE: Means services provided to a PARTICIPANT whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the PARTICIPANT as comfortable as possible. HOSPICE CARE must be provided through a licensed HOSPICE CARE PROVIDER approved by the TPA.

HOSPITAL: Means an institution that:

1) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to HOSPITALS; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, INJURY and ILLNESS; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses, or

2) qualifies as a psychiatric or tuberculosis HOSPITAL; (b) is a MEDICARE PROVIDER; and (c) is accredited as a HOSPITAL by the Joint Commission of Accreditation of HOSPITALS.

The term HOSPITAL does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal HOSPITAL.

HOSPITAL CONFINEMENT or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a HOSPITAL on the advice of an IN-NETWORK PROVIDER; or (b) receiving EMERGENCY care for ILLNESS or INJURY in a HOSPITAL. HOSPITAL swing bed CONFINEMENT is considered the same as CONFINEMENT in a SKILLED NURSING FACILITY.

ILLNESS: Means a bodily disorder, bodily INJURY, disease, mental disorder, or pregnancy. It includes ILLNESSES which exist at the same time, or which occur one after the other but are due to the same or related causes.

IMMEDIATE FAMILY: Means the DEPENDENTS, parents, brothers and sisters of the PARTICIPANT and their spouses or DOMESTIC PARTNERS.

INJURY: Means bodily damage that results directly and independently of all other causes from an accident.

IN-NETWORK PROVIDER: A PROVIDER who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to PARTICIPANTS. The PROVIDER'S written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. The TPA agrees to give YOU lists of affiliated PROVIDERS. Some PROVIDERS require PRIOR AUTHORIZATION by the TPA in advance of the services being provided.

LEVEL "M" DRUG: Means an injectable, prescription medication covered by MEDICARE Parts B and D when the MEDICARE PRESCRIPTION DRUG PLAN is the primary payer. LEVEL M DRUGS are required to be on the MEDICARE PRESCRIPTION DRUG PLAN'S MEDICARE Part D FORMULARY but are not included on the commercial coverage FORMULARY. Claims associated with LEVEL M DRUGS, along with the costs to administer the injection, are adjudicated by the PBM, not the TPA.

MAINTENANCE CARE: Means ongoing care delivered after an acute episode of an ILLNESS or INJURY has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "MAINTENANCE CARE" is made by the TPA after reviewing an individual's case history or treatment plan submitted by a PROVIDER.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT: Means items which are, as determined by the TPA:

1) Used primarily to treat an ILLNESS or INJURY, and

2) generally not useful to a person in the absence of an ILLNESS or INJURY, and

3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and

4) prescribed by a PROVIDER.

MEDICALLY NECESSARY: A service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, physician or other health care PROVIDER that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by the TPA and/or PBM:

1) Consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY, and

2) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY, and

3) not solely for the convenience of the PARTICIPANT, physician, HOSPITAL or other health care PROVIDER, and

4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

MEDICARE: Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MEDICARE PRESCRIPTION DRUG PLAN: Means the prescription drug coverage provided by the PBM to Covered Individuals who are enrolled in MEDICARE Parts A and B, and eligible for MEDICARE Part D; and who are covered under a MEDICARE coordinated contract in the State of Wisconsin or Wisconsin Public Employers group health insurance programs.

MEDICAID: Means a program instituted as required by Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.

MISCELLANEOUS HOSPITAL EXPENSE: Means usual and customary HOSPITAL ancillary CHARGES, other than BED AND BOARD, made on account of the care necessary for an ILLNESS or other condition requiring inpatient or outpatient hospitalization for which benefits are available under this TPA.

NATURAL TOOTH: Means a tooth that would not have required restoration in the absence of a PARTICIPANT’S trauma or INJURY, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

NON-PARTICIPATING PHARMACY: Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM’S directory of PARTICIPATING PHARMACIES.

NON-PREFERRED DRUG: Means a drug the PBM has determined offers less value and/or cost-effectiveness than PREFERRED DRUGS. This would include Non-Preferred GENERIC DRUGS, Non-Preferred BRAND NAME DRUGS and Non-Preferred SPECIALTY MEDICATIONS included on the FORMULARY, which are covered by the benefits of this program with a higher COPAYMENT.

NUTRITIONAL COUNSELING: This counseling consists of the following services:

1) Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician.

2) Re-assessment and intervention (individual and group).

3) Diabetes outpatient self-management training services (individual and group sessions).

4) Dietitian visit.

OUT-OF-AREA SERVICE: Means any services provided to PARTICIPANTS outside the SERVICE AREA.

OUT-OF-NETWORK PROVIDER: A PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the TPA'S professional directory of providers. Care from an OUT-OF-NETWORK PROVIDER may require PRIOR-AUTHORIZATION from the TPA unless it is EMERGENCY or URGENT CARE.

OUT-OF-POCKET LIMIT (OOPL): The most YOU pay during a policy period (usually a calendar year) before YOUR BENEFIT PLAN begins to pay 100% of the allowed amount. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR BENEFIT PLAN does not cover. Note: payments for out-of-network services or other expenses do not accumulate toward this limit.

PARTICIPANT: The SUBSCRIBER or any of his/her DEPENDENTS who have been specified for enrollment and are entitled to benefits.

PARTICIPATING PHARMACY: Means a pharmacy who has agreed in writing to provide the services to PARTICIPANTS that are administered by the PBM and covered under the policy. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a PARTICIPANT. The PBM agrees to give YOU lists of PARTICIPATING PHARMACIES.

PHARMACY BENEFIT MANAGER (PBM): The PBM is a THIRD PARTY ADMINISTRATOR that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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 TPA before obtaining the services. Unless otherwise indicated by YOUR TPA, PRIOR AUTHORIZATION is required for care from any OUT-OF-NETWORK PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONS are at the discretion of the TPA and are described in the It's Your Choice materials. Some prescriptions may also require PRIOR AUTHORIZATION, which must be obtained from the PBM and are at its discretion.

PROVIDER: Means (a) a doctor, HOSPITAL, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more benefits.

REFERRAL: When a PARTICIPANT'S PRIMARY CARE PROVIDER sends him/her to another PROVIDER for covered services. In many cases, the REFERRAL must be in writing and on the TPA PRIOR AUTHORIZATION form and approved by the TPA in advance of a PARTICIPANT'S treatment or service. REFERRAL requirements are determined by each TPA and are described in the It's Your Choice materials. The authorization from the TPA will state: a) the type or extent of treatment authorized; and b) the number of PRIOR AUTHORIZED visits and the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the TPA before services are rendered.

REHABILITATION SERVICES: Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-

language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

SCHEDULE OF BENEFITS: The document that is issued to accompany this document which details specific benefits for covered services provided to PARTICIPANTS by the BENEFIT PLAN YOU elected.

SELF-ADMINISTERED 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 TPA to provide professional services to PARTICIPANTS covered by the Health Benefit Program.

SHARED DECISION MAKING (SDM): Means a program offered by a TPA or health care PROVIDER that PARTICIPANTS must complete when considering whether to undergo certain medical or surgical interventions. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that PARTICIPANTS can decide the best possible course of treatment. The TPA or health care PROVIDER will provide the PARTICIPANT with written Patient Decisions Aids (PDAs) as part of the SDM program.

SKILLED CARE: Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving SKILLED CARE are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, SKILLED CARE is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, DOMESTIC PARTNERS, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require SKILLED CARE and are considered CUSTODIAL CARE.

SKILLED NURSING FACILITY: Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a SKILLED NURSING FACILITY.

SPECIALTY MEDICATIONS: Means medications that are used to treat complex chronic and/or life threatening conditions; are more costly to obtain and administer; may not be available from all PARTICIPATING PHARMACIES; require special storage, handling and administration; and involve a significant degree of patient education, monitoring and management.

SUBSCRIBER: An ELIGIBLE EMPLOYEE or annuitant who is enrolled for (a) single coverage; or (b) family coverage and whose DEPENDENTS are thus eligible for benefits.

THIRD PARTY ADMINISTRATOR (TPA): The THIRD PARTY ADMINISTRATOR who is under contract with the Group Insurance Board to provide benefits and services to PARTICIPANTS of the State of Wisconsin Health Benefit Program.

URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.

USUAL AND CUSTOMARY CHARGE: An amount for a treatment, service or supply provided by an OUT-OF-NETWORK PROVIDER that is reasonable, as determined by the TPA, when taking into consideration, among other factors determined by the TPA, amounts charged by health care PROVIDERS for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care PROVIDER as full payment for similar treatment, services and supplies. In some cases the amount the TPA determines as reasonable may be less than the amount billed. In these situations the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(S), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. TPA approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES. EMERGENCY or urgent services from an OUT-OF-NETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES, however, the TPA must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL/dental services.

YOU/YOUR: The SUBSCRIBER and his or her covered DEPENDENTS.

III. Benefits and Services

The benefits and services provided under the Health Benefit Program are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of IN-NETWORK chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

HOSPITAL services must be provided by an IN-NETWORK HOSPITAL. In the case of non-EMERGENCY care, the TPA reserves the right to determine in a reasonable manner the PROVIDER to be used. In cases of EMERGENCY or URGENT CARE services, IN-NETWORK PROVIDERS and HOSPITALS must be used whenever possible and reasonable (see item A, 1 and item A, 2 below).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the TPA's written PRIOR AUTHORIZATION for covered services from an OUT-OF-NETWORK PROVIDER or YOU will be financially responsible for the services. The TPA may also require PRIOR AUTHORIZATION for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached SCHEDULE OF BENEFITS, a PARTICIPANT, in consideration of the employer's payment of the applicable TPA and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any COPAYMENT, COINSURANCE and other limitations shown in the SCHEDULE OF BENEFITS; and (b) all other terms and conditions outlined in this Uniform Benefits description. All services must be MEDICALLY NECESSARY, as determined by the TPA and/or PBM.

A. Medical/Surgical Services

1) EMERGENCY Care

a) Medical care for an EMERGENCY, as defined in Section II. Refer to the SCHEDULE OF BENEFITS for information on the EMERGENCY room COPAYMENT.

b) YOU should use IN-NETWORK HOSPITAL EMERGENCY rooms whenever possible. If YOU are not able to reach YOUR IN-NETWORK PROVIDER, go to the nearest appropriate medical facility. If YOU must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU call the TPA by the next business day or as soon as possible and tell the TPA where YOU received EMERGENCY care. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA. In addition to the cost sharing described in the SCHEDULE OF BENEFITS, EMERGENCY care from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.

c) It is recommended, to expedite claims processing, that YOU (or another individual on YOUR behalf) notify the TPA of EMERGENCY or URGENT CARE OUT-OF-NETWORK HOSPITAL admissions or facility CONFINEMENTS by the next business day after admission or as soon

as reasonably possible. This will help to expedite claims payment. OUT-OF-AREA SERVICE means medical care received outside the defined SERVICE AREA.

d) EMERGENCY services include reasonable accommodations for repair of DURABLE MEDICAL EQUIPMENT as MEDICALLY NECESSARY.

e) Some examples of EMERGENCIES are:

i) Acute allergic reactions,

ii) Acute asthmatic attacks,

iii) Convulsions,

iv) Epileptic seizures,

v) Acute hemorrhage,

vi) Acute appendicitis,

vii) Coma,

viii) Heart attack,

ix) Attempted suicide,

x) Suffocation,

xi) Stroke,

xii) Drug overdoses,

xiii) Loss of consciousness, and

xiv) Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the EMERGENCY room.

2) URGENT CARE

a) Medical care received in an URGENT CARE situation as defined in Section II. URGENT CARE is not EMERGENCY care. It does not include care that can be safely postponed until the PARTICIPANT can receive care from an IN-NETWORK PROVIDER.

b) YOU must receive URGENT CARE from an IN-NETWORK PROVIDER if YOU are in the SERVICE AREA, unless it is not reasonably possible. If YOU are out of the SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If YOU must go to an

OUT-OF-NETWORK PROVIDER for care, it is recommended that YOU contact YOUR TPA by the next business day or as soon as possible and tell the TPA where YOU received URGENT CARE; this will expedite claims payment. URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the TPA or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the TPA.

c) Some examples of URGENT CARE cases are:

i) Most broken bones,

ii) Minor cuts,

iii) Sprains,

iv) Most drug reactions,

v) Non-severe bleeding, and

vi) Minor burns.

3) Surgical Services
Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include:

a) PREOPERATIVE and POSTOPERATIVE CARE, and

b) Needed services of assistants and consultants.

This does not include oral surgery procedures, which are covered as described under item 16 of this section.

PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the TPA for any PARTICIPANT who has not completed an optimal regimen of conservative care for low back pain (LBP). PRIOR AUTHORIZATION is not required for a PARTICIPANT who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PARTICIPANTS seeking surgical treatment of LBP must participate in a credible SHARED DECISION MAKING (SDM) program provided by the TPA or its contracted PROVIDERS consistent with the PRIOR AUTHORIZATION requirement.

4) Reproductive Services and Contraceptives
The following services do not require a REFERRAL to an IN-NETWORK PROVIDER who specializes in obstetrics and gynecology, however, the TPA may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

a) Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a DEPENDENT daughter who is covered under this program as a PARTICIPANT. However, this does not extend coverage to the newborn if the DEPENDENT daughter is age 18 or older at the time of the birth. In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is MEDICALLY NECESSARY. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.

b) Elective sterilization.

c) Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:

   i) Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the prescription drug benefit 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 TPA terminates, the PARTICIPANT will continue to have access to the PROVIDER until completion of postpartum care for the woman and infant. A PRIOR AUTHORIZATION is not required for the delivery, but the TPA may request notification of the inpatient stay prior to the delivery or shortly thereafter.

5) Medical Services
MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an IN-NETWORK PROVIDER (or a PROVIDER that was PRIOR AUTHORIZED by YOUR TPA).

a) Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.

b) Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.

c) Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

d) Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).

e) MEDICALLY NECESSARY travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the PARTICIPANT by the TPA. It does not apply to travel required for work. (See Exclusions, Section IV, A, 2, e.)

f) Injectable and infusible medications, except for SELF-ADMINISTERED INJECTABLE medications.

g) NUTRITIONAL COUNSELING provided by a participating registered dietician or an IN-NETWORK PROVIDER.

h) A second opinion from an IN-NETWORK PROVIDER or when PRIOR AUTHORIZED by the TPA.

i) Preventive services as required by the federal Patient Protection and Affordable Care Act.

6) Anesthesia Services
Covered when provided in connection with other medical and surgical services covered under these Uniform Benefits. It will also include anesthesia services for dental care as provided under item B, 1, c of this section.

7) Radiation Therapy and Chemotherapy
Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an IN-NETWORK PROVIDER.

8) Detoxification Services
Covers MEDICALLY NECESSARY detoxification services provided by an IN-NETWORK PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an IN-NETWORK PROVIDER.

9) Ambulance Service
Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the TPA) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the TPA'S SERVICE AREA, the TPA or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or urgent transportation is obtained.

10) Diagnostic Services
MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if

correction is needed; annual routine mammography screening when ordered and performed by an IN-NETWORK PROVIDER. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

PRIOR AUTHORIZATIONS are required for high-tech radiology tests, including MRI, CT scan, and PET scans.

11) Outpatient Rehabilitation, Physical, Speech and Occupation Therapy
MEDICALLY NECESSARY HABILITATION or REHABILITATION SERVICES and treatment as a result of ILLNESS or INJURY, provided by an IN-NETWORK PROVIDER. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be PRIOR AUTHORIZED by the TPA if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12) Home Care Benefits
Care and treatment of a PARTICIPANT under a plan of care. The IN-NETWORK PROVIDER must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

All home care must be MEDICALLY NECESSARY as part of the home care plan. Home care means one or more of the following:

a) Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.

b) Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.

c) Physical, occupational and speech therapy. (These apply to the therapy maximum.)

d) MEDICAL SUPPLIES, drugs and medicines prescribed by an IN-NETWORK PROVIDER; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.

e) NUTRITIONAL COUNSELING. A registered dietician must give or supervise these services.

f) The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

Home care will not be covered unless the attending physician certifies that:

a) HOSPITAL CONFINEMENT or CONFINEMENT in a SKILLED NURSING FACILITY would be needed if home care were not provided.

b) The PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT, cannot provide the needed care and treatment without undue hardship.

c) A state licensed or MEDICARE certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A PARTICIPANT may have been CONFINED IN A HOSPITAL just before home care started. If so, the home care plan must be approved, at its start, by the PROVIDER who was the primary PROVIDER of care during the HOSPITAL CONFINEMENT.

Home care benefits are limited to the maximum number of visits specified in the SCHEDULE OF BENEFITS, although up to 50 additional home care visits per calendar year may be PRIOR AUTHORIZED by the TPA if the visits continue to be MEDICALLY NECESSARY and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating YOUR needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13) Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the TPA. HOSPICE CARE, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. HOSPICE CARE includes, but is not limited to, MEDICAL SUPPLIES and services, counseling, bereavement counseling for one year after the PARTICIPANT'S death, DURABLE MEDICAL EQUIPMENT rental, home visits, and EMERGENCY transportation. Coverage may be continued beyond a 6-month period if authorized by the TPA.

Covers ADVANCE CARE PLANNING after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

Covers a one-time in-home palliative consult after the PARTICIPANT receives a terminal diagnosis regardless of whether his or her life expectancy is 6 months or less.

HOSPICE CARE is available to a PARTICIPANT who is CONFINED. Inpatient CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in a TPA-approved or MEDICARE-certified HOSPICE CARE facility.

When benefits are payable under both this HOSPICE CARE benefit and the Home Care Benefits, benefits payable under this subsection shall not reduce any benefits payable under the home care subsection.

14) Phase II Cardiac Rehabilitation

Services must be approved by the TPA and provided in an outpatient department of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of:

a) A heart attack (myocardial infarction),

b) Coronary bypass surgery,

c) Onset of angina pectoris,

d) Heart valve surgery,

e) Onset of decubital angina,

f) Onset of unstable angina,

g) Percutaneous transluminal angioplasty, or

h) Heart transplant.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

15) Extraction of NATURAL TEETH and/or Replacement with Artificial Teeth Because of Accidental Injury

Total extraction and/or total replacement (limited to, bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the TPA before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

16) Oral Surgery

PARTICIPANTS should contact the TPA prior to any oral surgery to determine if PRIOR AUTHORIZATION by the TPA is required. When performed by IN-NETWORK PROVIDERS, approved surgical procedures are as follows:

a) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.

b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

c) Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)

d) Surgical procedures required to correct accidental INJURIES to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such INJURIES are incurred while the PARTICIPANT is continuously covered under this contract or a preceding contract provided through the Group Insurance Board.

e) Apicoectomy. (Excision of apex of tooth root.)

f) Excision of exostoses of the jaws and hard palate.

g) Intraoral and extraoral incision and drainage of cellulitis.

h) Incision of accessory sinuses, salivary glands or ducts.

i) Reduction of dislocations of, and excision of, the temporomandibular joints.

j) Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related MEDICALLY NECESSARY guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.

k) Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when MEDICALLY NECESSARY following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

17) Treatment of Temporomandibular Disorders
As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and PRIOR AUTHORIZED MEDICALLY NECESSARY surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a) A CONGENITAL, developmental or acquired deformity, disease or INJURY caused the condition.

b) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care PROVIDER rendering the service.

c) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the DURABLE MEDICAL EQUIPMENT COINSURANCE as outlined in the SCHEDULE OF BENEFITS. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to $1,250 per calendar year.

18) Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be PRIOR AUTHORIZED by the TPA in order to be a covered transplant. Donor expenses are covered when included as part of the PARTICIPANT'S (as the transplant recipient) bill.

a) Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:

i) Aplastic anemia

ii) Acute leukemia

iii) Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

iv) Wiskott-Aldrich syndrome

v) Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)

vi) Hodgkins and non-Hodgkins lymphoma

vii) Combined immunodeficiency

viii) Chronic myelogenous leukemia

ix) Pediatric tumors based upon individual consideration

x) Neuroblastoma

xi) Myelodysplastic syndrome

xii) Homozygous Beta-Thalassemia

xiii) Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)

xiv) Multiple Myeloma, Stage II or Stage III

xv) Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b) Parathyroid transplantation

c) Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d) Corneal transplantation (keratoplasty) limited to:

   i) Corneal opacity

   ii) Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens

   iii) Corneal ulcer

   iv) Repair of severe lacerations

e) Heart transplants will be limited to the treatment of:

   i) Congestive Cardiomyopathy

   ii) End-Stage Ischemic Heart Disease

   iii) Hypertrophic Cardiomyopathy

   iv) Terminal Valvular Disease

   v) CONGENITAL Heart Disease, based upon individual consideration

   vi) Cardiac Tumors, based upon individual consideration

   vii) Myocarditis

   viii) Coronary Embolization

   ix) Post-traumatic Aneurysm

f) Liver transplants will be limited to the treatment of:

   i) Extrahepatic Biliary Atresia

   ii) Inborn Error of Metabolism

      (1) Alpha -1- Antitrypsin Deficiency

      (2) Wilson's Disease

(3) Glycogen Storage Disease

(4) Tyrosinemia

iii) Hemochromatosis

iv) Primary Biliary Cirrhosis

v) Hepatic Vein Thrombosis

vi) Sclerosing Cholangitis

vii) Post-necrotic Cirrhosis, Hbe Ag Negative

viii) Chronic Active Hepatitis, Hbe Ag Negative

ix) Alcoholic Cirrhosis, abstinence for six or more months

x) Epithelioid Hemangioepithelioma

xi) Poisoning

xii) Polycystic Disease

g) Kidney with pancreas, heart with lung, and lung transplants as determined to be MEDICALLY NECESSARY by the TPA.

h) In addition to the above-listed diagnoses for covered transplants, the TPA may PRIOR AUTHORIZE a transplant for a non-listed diagnosis if the TPA determines that the transplant is a MEDICALLY NECESSARY and a cost effective alternate treatment.

i) Kidney Transplants. See item 19 below.

19) Kidney Disease Treatment
Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum - see Transplants 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 TPA.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by an IN-NETWORK PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The TPA may require that the hospitalization be PRIOR AUTHORIZED.

1) Inpatient Care
   a) HOSPITALS and specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and MEDICALLY NECESSARY MISCELLANEOUS HOSPITAL EXPENSES, including prescription drugs administered during the CONFINEMENT. A private room is payable only if MEDICALLY NECESSARY for isolation purposes as determined by the TPA.

   b) Licensed SKILLED NURSING FACILITY: Must be admitted within 24 hours of discharge from a general HOSPITAL for continued treatment of the same condition. Only SKILLED CARE is covered. CUSTODIAL CARE is excluded. Benefits are limited to the number of days specified in the SCHEDULE OF BENEFITS. Benefits include prescription drugs administered during the CONFINEMENT. CONFINEMENT in a swing bed in a HOSPITAL is considered the same as a SKILLED NURSING FACILITY CONFINEMENT.

   c) HOSPITAL and ambulatory surgery center CHARGES and related anesthetics for dental care: Covered if services are provided to a PARTICIPANT who is under 5 years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2) Outpatient Care
   EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up

care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical care: Covered.

C. Other Medical Services

1) Mental Health Services/Alcohol and Drug Abuse
PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA.

   a) Outpatient Services
   Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. "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 TPA within 72 hours after the initial provision of service.

   d) Other
   Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section 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 TPA.

(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 TPA:

a) Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

b) Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

c) Rental or, at the option of the TPA, purchase of equipment including, but not limited to, wheelchairs and HOSPITAL-type beds.

d) An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).

e) IUDs and diaphragms.

f) Elastic support hose, for example, JOBST, which are prescribed by an IN-NETWORK PROVIDER. Limited to two pairs per calendar year.

g) Cochlear implants, as described in the SCHEDULE OF BENEFITS.

h) One hearing aid, as described in the SCHEDULE OF BENEFITS. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.

i) Ostomy and catheter supplies.

j) Oxygen and respiratory equipment for home use when authorized by the TPA.

k) Other medical equipment and supplies as approved by the TPA. Rental or purchase of equipment/supplies is at the option of the TPA.

l) When PRIOR AUTHORIZED as determined by the TPA, repairs, maintenance and replacement of covered MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, including replacement of batteries. When determining whether to repair or replace the MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT, the TPA will consider whether:

   i) The equipment/supply is still useful or has exceeded its lifetime under normal use, or

   ii) The PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OOPL.

4) Out-of-Network Coverage for Full-Time Students
If a DEPENDENT is a full-time student attending school outside of the SERVICE AREA, the following services will be covered:

a) EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered, and

b) Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by an OUT-OF-NETWORK PROVIDER when PRIOR AUTHORIZED by the TPA. If outpatient services are recommended, coverage will be provided for 5 visits outside of the SERVICE AREA when PRIOR AUTHORIZED by the TPA. Additional visits may be approved by the TPA. If the student is unable to maintain full-time student status, he/she must obtain services from an IN-NETWORK PROVIDER for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities
As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any TPA under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and

dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6) Coverage of Treatment for Autism Spectrum Disorders
Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following IN-NETWORK PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those 4 types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for 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 TPA.

1) Prescription Drugs
Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed ILLNESS or INJURY; and are purchased from a PBM Network Pharmacy after a COPAYMENT or COINSURANCE amount, as described in the SCHEDULE OF BENEFITS. A COPAYMENT will be applied to each prescription dispensed. The PBM may lower the COPAYMENT amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual OOPL applies to PARTICIPANTS' COPAYMENTS for Level 1 and Level 2 Preferred prescription drugs as described on the SCHEDULE OF BENEFITS. When any PARTICIPANT meets the annual OOPL, when applicable, as described on the SCHEDULE OF BENEFITS, that PARTICIPANT'S Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if family PARTICIPANTS combined have paid in a year the family annual OOPL as described in the SCHEDULE OF BENEFITS, even if no one PARTICIPANT has met his or her individual annual OOPL, all family PARTICIPANTS will have satisfied the annual OOPL for that calendar year. The PARTICIPANT'S cost for Level 3 drugs will not be applied to the annual OOPL. If the cost of a prescription drug is less than the applicable COPAYMENT, the PARTICIPANT will pay only the actual cost and that amount will be applied to the annual OOPL for Level 1 and Level 2 Preferred prescription drugs.

The TPA, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, EMERGENCY room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED 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 TPA or a contracted PROVIDER administers the injection. If the TPA or a contracted PROVIDER is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

a) In maximum quantities not to exceed a 30 consecutive day supply per COPAYMENT.

b) The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns or cost).

c) Single packaged items are limited to two items per COPAYMENT or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.

d) Oral contraceptives are not subject to the 30-day supply and will be dispensed at one COPAYMENT per package or a 28-day supply, whichever is less.

e) Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the FORMULARY. These require a prescription from a physician and must be filled at a PARTICIPATING PHARMACY. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug COPAYMENT and annual OOPL. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the PARTICIPANT obtains PRIOR AUTHORIZATION for a limited extension.

f) PRIOR AUTHORIZATION from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring PRIOR AUTHORIZATION is available from the PBM.

g) Cost-effective GENERIC EQUIVALENTS will be dispensed unless the IN-NETWORK PROVIDER specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the COPAYMENT specified in the FORMULARY.

h) Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Preferred prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two COPAYMENTS will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. SELF-ADMINISTERED 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 TPAs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that Subsection 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 TPA and/or PBM.

1) Surgical Services

   a) Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.

   b) Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

   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 TPA.

b) Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits and Services Section.

4) Therapies

a) Vocational rehabilitation including work hardening programs.

b) Except for services covered under the HABILITATION SERVICES therapy benefit, 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 TPA.

c) Purchase price of bone marrow, organ or tissue that is sold rather than donated.

d) All separately billed donor-related services, except for kidney transplants.

e) Non-human organ transplants or artificial organs.

7) Reproductive Services

a) Infertility services which are not for treatment of ILLNESS or INJURY (i.e., that are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an ILLNESS.

b) Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.

c) Services for storage or processing of semen (sperm); donor sperm.

d) Harvesting of eggs and their cryopreservation.

e) Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.

f) Surrogate mother services.

g) Maternity services received out of the SERVICE AREA one month prior to the estimated due date, unless PRIOR AUTHORIZED (PRIOR AUTHORIZATION will be granted only if the situation is out of the PARTICIPANT'S control, for example, family EMERGENCY).

h) Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

i) Services of home delivery for childbirth.

j) Laboratory services provided in conjunction with infertility services after the diagnosis of infertility is confirmed.

8) HOSPITAL Inpatient Services

a) Take home drugs and supplies dispensed at the time of discharge, which can reasonably be purchased on an outpatient basis.

b) HOSPITAL stays, which are extended for reasons other than MEDICAL NECESSITY, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c) A continued HOSPITAL stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, SKILLED NURSING FACILITY.

9) Durable Medical or Diabetic Equipment and Supplies

a) All DURABLE MEDICAL EQUIPMENT purchases or rentals unless PRIOR AUTHORIZED as required by the TPA.

b) Repairs and replacement of DURABLE MEDICAL EQUIPMENT/supplies unless PRIOR AUTHORIZED by the TPA.

c) MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d) Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as PRIOR AUTHORIZED by the TPA.

e) Equipment, models or devices that have features over and above that which are MEDICALLY NECESSARY for the PARTICIPANT will be limited to the standard model as determined by the TPA. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the PARTICIPANT'S condition nor is the existing equipment, models or devices in need of repair or replacement.

f) Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.

g) Customization of buildings for accommodation (for example, wheelchair ramps).

h) Replacement or repair of DURABLE MEDICAL EQUIPMENT/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10) Outpatient Prescription Drugs – Administered by the PBM

a) Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.

b) Charges for prescription drugs which require PRIOR AUTHORIZATION unless approved by the PBM.

c) Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

d) Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).

e) Anorexic agents.

f) Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.

g) All over-the-counter drug items, except those designated as covered by the PBM.

h) Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.

i) Charges for injectable medications, except for SELF-ADMINISTERED 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 TPA and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

g) Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.

h) Treatment, services or supplies used in educational or vocational training.

i) Treatment or service in connection with any ILLNESS or INJURY caused by a PARTICIPANT (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.

j) 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 TPA and/or PBM, or services received after the TPA and/or PBM coverage or eligibility terminates. Except when

a PARTICIPANT'S coverage terminates because of SUBSCRIBER cancellation or nonpayment of premium, benefits shall continue to the PARTICIPANT if he or she is CONFINED as an inpatient on the coverage termination date but only until the attending physician determines that CONFINEMENT is no longer MEDICALLY NECESSARY; the contract maximum is reached; the end of 12 months after the date of termination; or CONFINEMENT ceases, whichever occurs first. If the termination is a result of a SUBSCRIBER changing coverage under TPAs during a prescribed enrollment period as determined by the Board, benefits after the EFFECTIVE DATE with the succeeding TPA will be the responsibility of the succeeding TPA unless the facility in which the PARTICIPANT is CONFINED is not part of the succeeding TPA's network. In this instance, the liability will remain with the previous TPA.

p) Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.

q) Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and MEDICALLY NECESSARY or not required in accordance with accepted standards of medical, surgical or psychiatric practice.

r) Charges for any missed appointment.

s) EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the TPA and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t) Services provided by members of the SUBSCRIBER'S IMMEDIATE FAMILY or any person residing with the SUBSCRIBER.

u) Services, including non-physician services, provided by OUT-OF-NETWORK PROVIDERS. Exceptions to this exclusion:

   i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

   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 TPA.

v) Services of a specialist without an IN-NETWORK PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the TPA. Any HOSPITAL or medical care or service not provided for in this document unless authorized by the TPA.

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 TPA 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 TPA. The treatment of the complication must be a covered benefit of the TPA and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any TPA as part of this program.

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 TPA to determine medical appropriateness and whether services can be provided by IN-NETWORK PROVIDERS.

4) Major Disaster or Epidemic: If a major disaster or epidemic occurs, IN-NETWORK PROVIDERS and HOSPITALS must render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its PARTICIPATING PHARMACIES. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

5) Circumstances Beyond the TPA's and/or PBM's Control: If, due to circumstances not reasonably within the control of the TPA and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the TPA and/or PBM, disability of a significant part of HOSPITAL or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the TPA, IN-NETWORK PROVIDERS and/or PBM will use their best efforts to provide services and other

benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from OUT-OF-NETWORK PROVIDERS and/or NON-PARTICIPATING PHARMACIES.

6) Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by an IN-NETWORK PROVIDER for determining the need for correction.

7) Outpatient Rehabilitation, Physical, Occupational and Speech Therapy: These therapies are benefits only for treatment of those conditions which are expected to yield significant patient improvement within two months after the beginning of treatment.

V. Coordination of Benefits and Services

A. Applicability

1) This Coordination of Benefits (COB) provision applies to THIS PLAN when a PARTICIPANT has health care coverage under more than one PLAN at the same time. "PLAN" and "THIS PLAN" are defined below.

2) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of THIS PLAN are determined before or after those of another PLAN. The benefits of THIS PLAN:

   a) Shall not be reduced when, under the order of benefit determination rules, THIS PLAN determines its benefits before another PLAN, but

   b) May be reduced when, under the order of benefit determination rules, another PLAN determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of THIS PLAN.

B. Definitions

In this Section 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 TPA has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under THIS PLAN must give the TPA any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another PLAN may include an amount which should have been paid under THIS PLAN. If it does, the TPA may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under THIS PLAN. The TPA will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by the TPA is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1) The persons it has paid or for whom it has paid,

2) Insurance companies, or

3) Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. Miscellaneous Provisions

A. Right to Obtain and Provide Information

Each PARTICIPANT agrees that the TPA and/or PBM may obtain from the PARTICIPANT'S health care PROVIDERS the information (including medical records) that is reasonably necessary, relevant and appropriate for the TPA and/or PBM to evaluate in connection with its treatment, payment, or health care operations. Each person claiming benefits must, upon request by the TPA, provide any relevant and reasonably available information which the TPA believes is necessary to determine benefits payable. Failure to provide such information may result in denial of the claim at issue.

Each PARTICIPANT agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the TPA and/or PBM but also disclosures to:

1) Health care PROVIDERS as necessary and appropriate for treatment,

2) Appropriate DEPARTMENT employees as part of conducting quality assessment and improvement activities, or reviewing the TPA's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations,

3) The tribunal, including an external review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The TPA, at its own expense, shall have the right and opportunity to examine the person of any PARTICIPANT when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under the Health Benefit Program (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the TPA, each PARTICIPANT shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The TPA may employ a professional staff to provide case management services. As part of this case management, the TPA or the PARTICIPANT'S attending physician may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:

1) The recommended treatment offers at least equal medical therapeutic value, and

2) The current treatment program may be changed without jeopardizing the PARTICIPANT'S health, and

3) The CHARGES (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the TPA agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the TPA's recommendation, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the TPA. The PBM may establish similar case management services.

D. Disenrollment

No person other than a PARTICIPANT is eligible for health benefits. The SUBSCRIBER'S rights to group health benefits coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice open enrollment period. Re-enrollment options may be limited under the Board's authority.

The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the TPA or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage and enrollment options may be limited by the Board.

E. Recovery of Excess Payments

The TPA and/or PBM might pay more than the TPA and/or PBM owes under the policy. If so, the TPA and/or PBM can recover the excess from YOU. The TPA and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the TPA and/or PBM.

Each PARTICIPANT agrees to reimburse the TPA and/or PBM for all payments made for benefits to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by the TPA and/or PBM. At the option of the TPA and/or PBM, benefits for future CHARGES may be reduced by the TPA and/or PBM as a set-off toward reimbursement.

F. Limit on Assignability of Benefits

This is YOUR personal policy. YOU cannot assign any benefit to other than a physician, HOSPITAL or other PROVIDER entitled to receive a specific benefit for YOU.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each PARTICIPANT agrees that the payer under these Uniform Benefits, whether that is a TPA or the DEPARTMENT, shall be subrogated to a PARTICIPANT'S rights to damages, to the extent of the benefits the TPA provides under the policy, for ILLNESS or INJURY a third party caused or is liable for. It is only necessary that the ILLNESS or INJURY occur through the act of a third party. The TPA'S or DEPARTMENT'S rights of full recovery may be from any source, including but not limited to:

1) The third party or any liability or other insurance covering the third party.

2) The PARTICIPANT'S own uninsured motorist insurance coverage.

3) Under-insured motorist insurance coverage.

4) Any medical payments, no-fault or school insurance coverages which are paid or payable.

PARTICIPANT'S rights to damages shall be, and they are hereby, assigned to the TPA or DEPARTMENT to such extent.

The TPA'S or DEPARTMENT'S subrogation rights shall not be prejudiced by any PARTICIPANT. Entering into a settlement or compromise arrangement with a third party without the TPA'S or DEPARTMENT'S prior written consent shall be deemed to prejudice the TPA'S or DEPARTMENT'S rights. Each PARTICIPANT shall promptly advise the TPA or DEPARTMENT in writing whenever a claim against another party is made on behalf of a PARTICIPANT and shall further provide to the TPA or DEPARTMENT such additional information as is reasonably requested by the TPA or DEPARTMENT. The PARTICIPANT agrees to fully cooperate in protecting the TPA'S or DEPARTMENT'S rights against a third party. The TPA or DEPARTMENT has no right to recover from a PARTICIPANT or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the PARTICIPANT'S or insured's comparative negligence. If a dispute arises between the TPA or DEPARTMENT and the PARTICIPANT over the question of whether or not the PARTICIPANT has been "made whole", the TPA or DEPARTMENT reserves the right to a judicial determination whether the insured has been "made whole."

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the TPA or DEPARTMENT provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the TPA or DEPARTMENT the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the TPA or DEPARTMENT in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the TPA or DEPARTMENT shall be responsible for all actual attorney's fees and expenses incurred in

making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the TPA or DEPARTMENT for all amounts theretofore or thereafter paid by the TPA or DEPARTMENT which would have otherwise been recoverable under such acts and the TPA or DEPARTMENT shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the TPA or DEPARTMENT immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof of Claim

As a PARTICIPANT, it is YOUR responsibility to notify YOUR PROVIDER of YOUR participation in the TPA and PBM.

Failure to notify an IN-NETWORK PROVIDER of YOUR membership in the BENEFIT PLAN may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

If YOU received allowable covered services (in most cases only EMERGENCIES or URGENT CARE) from an OUT-OF-NETWORK PROVIDER outside the SERVICE AREA, obtain and submit an itemized bill and submit to the TPA, clearly indicating the PROVIDER'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the TPA and/or PBM does not receive the claim within 12 months, or if later, as soon as reasonably possible, after the date the service was received, the TPA and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating TPAs and the PBM are required to make a reasonable effort to resolve PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the TPA and/or PBM. Contact the TPA and/or PBM for specific information on its GRIEVANCE procedures.

If YOU exhaust the TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the TPA and/or PBM. The TPA and/or PBM will advise YOU of YOUR

right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the TPA and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. YOU may request an external review pursuant to federal law. In this event, YOU must notify the TPA and/or PBM of YOUR request. In accordance with federal law, any decision by an HHS-administered federal External Review is final and binding. YOU have no further right to administrative review once the external review decision is rendered.

K. Appeals to the Group Insurance Board

After exhausting the TPA's or PBM's GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT'S determination to the Group Insurance Board, unless an HHS-administered federal external review decision that is final and binding has been rendered in accordance with federal law. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process. These appeals are reviewed only to determine whether the TPA and/or PBM breached its contract with the Group Insurance Board.

EXHIBIT 2

Standard Terms And Conditions (Request For Bids / Proposals)

1.0 SPECIFICATIONS: The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid/proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 DEVIATIONS AND EXCEPTIONS: Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 QUALITY: Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 QUANTITIES: The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 DELIVERY: Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 PRICING AND DISCOUNT: The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the contractor which are demonstrated to be industrywide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 UNFAIR SALES ACT: Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 ACCEPTANCE-REJECTION: The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 METHOD OF AWARD: Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 ORDERING: Purchase orders or releases via purchasing cards shall be placed directly to the contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements

are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW AND COMPLIANCE: This contract shall be governed under the laws of the State of Wisconsin. The contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel this contract if the contractor fails to follow the requirements of s. 77.66, Wis. Stats., and related statutes regarding certification for collection of sales and use tax. The State of Wisconsin also reserves the right to cancel this contract with any federally debarred contractor or a contractor that is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

16.0 ANTITRUST ASSIGNMENT: The contractor and the State of Wisconsin recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State of Wisconsin (purchaser). Therefore, the contractor hereby assigns to the State of Wisconsin any and all claims for such overcharges as to goods, materials or services purchased in connection with this contract.

17.0 ASSIGNMENT: No right or duty in whole or in part of the contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION / AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan by the contractor. An exemption occurs from this requirement if the contractor has a workforce of less than fifty (50) employees. Within fifteen (15) working days after the contract is awarded, the contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

19.2 The contractor agrees to post in conspicuous places, available for employees and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the contractor's becoming declared an "ineligible" contractor, termination of the contract, or withholding of payment.

20.0 PATENT INFRINGEMENT: The contractor selling to the State of Wisconsin the articles described herein guarantees the articles were manufactured or produced in accordance with applicable federal labor laws. Further, that the sale or use of the articles described herein will not infringe any United States patent. The contractor covenants that it will at its own expense defend every suit which shall be brought against the State of Wisconsin (provided that such contractor is promptly notified of such suit, and all papers therein are delivered to it) for any alleged infringement of any patent by reason of the sale or use of such articles, and agrees that it will pay all costs, damages, and profits recoverable in any such suit.

21.0 SAFETY REQUIREMENTS: All materials, equipment, and supplies provided to the State of Wisconsin must comply fully with all safety requirements as set forth by the Wisconsin Administrative Code and all applicable OSHA Standards.

22.0 WARRANTY: Unless otherwise specifically stated by the bidder/proposer, equipment purchased as a result of this request shall be warranted against defects by the bidder/proposer for one (1) year from date of receipt. The equipment manufacturer's standard warranty shall apply as a minimum and must be honored by the contractor.

23.0 INSURANCE RESPONSIBILITY: The contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employees engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin public records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot be copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin public records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employees and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

31.0 PROMOTIONAL ADVERTISING / NEWS RELEASES: Reference to or use of the State of Wisconsin, any of its departments, agencies or other subunits, or any state official or employee for commercial promotion is prohibited. News releases pertaining to this procurement shall not be made without prior approval of the State of Wisconsin. Release of broadcast e-mails pertaining to this procurement shall not be made without prior written authorization of the contracting agency.

32.0 HOLD HARMLESS: The contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the contractor, or of any of its contractors, in prosecuting work under this agreement.

33.0 FOREIGN CORPORATION: A foreign corporation (any corporation other than a Wisconsin corporation) which becomes a party to this Agreement is required to conform to all the requirements of Chapter 180, Wis. Stats., relating to a foreign corporation and must possess a certificate of authority from the Wisconsin Department of Financial Institutions, unless the corporation is transacting business in interstate commerce or is otherwise exempt from the requirement of obtaining a certificate of authority. Any foreign corporation which desires to apply for a certificate of authority should contact the Department of Financial Institutions, Division of Corporation, P. O. Box 7846, Madison, WI 53707-7846; telephone (608) 261-7577.

34.0 WORK CENTER PROGRAM: The successful bidder/proposer shall agree to implement processes that allow the State agencies, including the University of Wisconsin System, to satisfy the State's obligation to purchase goods and services produced by work centers certified under the State Use Law, s.16.752, Wis. Stat. This shall result in requiring the successful bidder/proposer to include products provided by work centers in its catalog for State agencies and campuses or to block the sale of comparable items to State agencies and campuses.

35.0 FORCE MAJEURE: Neither party shall be in default by reason of any failure in performance of this Agreement in accordance with reasonable control and without fault or negligence on their part. Such causes may include, but are not restricted to, acts of nature or the public enemy, acts of the government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes and unusually severe weather, but in every case the failure to perform such must be beyond the reasonable control and without the fault or negligence of the party.

State of Wisconsin
Department of Administration
DOA-3681 (01/2001)
ss. 16, 19 and 51, Wis. Stats.

Division of Agency Services
Bureau of Procurement

EXHIBIT 3

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor; and

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential contractor shall certify in writing to the procuring agency that no relationship exists between the potential contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employee or who is retained as a contractor full-time by a State of Wisconsin agency from being retained as a contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.0831 Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

7.0 RECORDKEEPING AND RECORD RETENTION: The contractor shall establish and maintain adequate records of all expenditures incurred under the contract. All records must be kept in accordance with generally accepted accounting procedures. All procedures must be in accordance with federal, state and local ordinances.

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the contractor. The contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

8.0 INDEPENDENT CAPACITY OF CONTRACTOR: The parties hereto agree that the contractor, its officers, agents, and employees, in the performance of this agreement shall act in the capacity of an independent contractor and not as an officer, employee, or agent of the state. The contractor agrees to take such steps as may be necessary to ensure that each subcontractor of the contractor will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the state.

EXHIBIT 4

Department Terms and Conditions

1.0 ENTIRE AGREEMENT: This Contract, its exhibits, subsequent amendments and the documents incorporated by order of precedence contain the entire understanding between the parties on the subject matter hereof, and no representations, inducements, promises, or agreements, oral or otherwise, not embodied herein shall be of any force or effect. This Contract supersedes any other oral or written agreement entered into between the parties on the subject matter hereof.

This Contract may be amended at any time by written mutual agreement, but any such amendment shall be without prejudice to any claim arising prior to the date of the change. No one, except duly authorized officers or agents of the Contractor and the Department, shall alter or amend this Contract. No change in this Contract shall be valid unless evidenced by an amendment that is signed by such officers of the Contractor and the Department.

2.0 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW: In the event of a conflict between this Contract and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against employees or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state.

The Contractor shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the Department upon request.

The Contractor acknowledges that Wis. Stat. § 40.07 specifically exempts information related to individuals in the records of the Department of Employee Trust Funds from the Wisconsin Public Records Law. Contractor shall treat any such records provided to or accessed by Contractor as non-public records as set forth in Wis. Stat. § 40.07.

Contractor will comply with the provisions of Wis. Stat. § 134.98**.**

3.0 LEGAL RELATIONS: The Contractor shall at all times comply with and observe all federal and State laws, local laws, ordinances, and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct. This includes but is not limited to laws regarding compensation, hours of work, conditions of employment and equal opportunities for employment.

In carrying out any provisions of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters that the Department acts as an agent of the State.

The Contractor accepts full liability and agrees to hold harmless the State, the Department's governing boards, the Department, its employees, agents and contractors for any act or omission of the Contractor, or any of its employees, in connection with this Contract.

No employee of the Contractor may represent himself or herself as an employee of the Department or the State.

4.0 CONTRACTOR: The Contractor will be the sole point of contact with regard to contractual matters, including the performance of Services and the payment of any and all charges resulting from contractual obligations.

None of the Services to be provided by the Contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals, or other such entity without prior written notification to, and approval of, the Department.

After execution of the Contract, ETF will provide a designated contact person and commit to a timely approval process for notification of a change in subcontractor(s) and/or delegated services.

The Contractor shall be solely responsible for its actions and those of its agents, employees or subcontractors under this Contract. The Contractor will be responsible for Contract performance when subcontractors are used. Subcontractors must abide by all terms and conditions of this Contract.

Neither the Contractor nor any of the foregoing parties has the authority to act or speak on behalf of the State of Wisconsin.

The Contractor will be responsible for payment of any losses by subcontractors or agents.

Any notice required or permitted to be given shall be deemed to have been given on the date of delivery or three (3) Business Days after mailing by the United States Postal Service, certified or registered mail-receipt requested. In the event the Contractor moves or updates contact information, the Contractor shall inform the Department of such changes in writing within ten (10) Business Days. The Department shall not be held responsible for payments delayed due to the Contractor's failure to provide such notice.

5.0 **CONTRACTOR PERFORMANCE:** Work under this Contract shall be performed in a timely, professional and diligent matter by qualified and efficient personnel and in conformity with the strictest quality standards mandated or recommended by all generally-recognized organizations establishing quality standards for the work of the type to be performed hereunder. The Contractor shall be solely responsible for controlling the manner and means by which it and its employees or its subcontractors perform the Services, and the Contractor shall observe, abide by, and perform all of its obligations in accordance with all legal and Contract requirements.

Without limiting the foregoing, the Contractor shall control the manner and means of the Services so as to perform the work in a reasonably safe manner and comply fully with all applicable codes, regulations and requirements imposed or enforced by any government agencies. Notwithstanding the foregoing, any stricter standard provided in plans, specifications or other documents incorporated as part of this Contract shall govern.

The Contractor shall provide the Services with all due skill, care, and diligence, in accordance with accepted industry practices and legal requirements, and to the Department's satisfaction; the Department's decision in that regard shall be final and conclusive.

All Contractor's Services under this Contract shall be performed in material compliance with the applicable federal and state laws and regulations in effect at the time of performance, except when imposition of a newly enacted or revised law or regulation would result in an unconstitutional impairment of this Contract.

The Contractor will make commercially reasonable efforts to ensure that Contractor's professional and managerial staff maintain a working knowledge and understanding of all federal and state laws, regulations, and administrative code appropriate for the performance of their respective duties, as well as contemplated changes in such law which affect or may affect the Service under this Contract.

The Contractor shall maintain a written contingency plan describing in detail how it will continue operations and Services under the Contract in certain events including, but not limited to, strike and disaster, and shall submit it to the Department upon request.

6.0 **AUDIT PROVISION:** The Contractor and its authorized subcontractors are subject to audits by the State of Wisconsin, the Legislative Audit Bureau (LAB), an independent Certified Public Accountant (CPA), or other representatives as authorized by the State of Wisconsin. The Contractor will cooperate with such efforts and provide all requested information permitted under the law.

Authorized personnel shall have access to interview any Contractor's or subcontractor's employee or authorized agent involved with this Contract in conjunction with any audit, review, or investigation deemed necessary by the State of Wisconsin.

7.0 **CRIMINAL BACKGROUND VERIFICATION:** The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://oser.state.wi.us/docview.asp?docid=6658). The Contractor is expected to perform background checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

8.0 **COMPLIANCE WITH ON-SITE PARTY RULES AND REGULATIONS:** Contractor and the State of Wisconsin agree that their employees, while working at or visiting the premises of the other party, shall comply with all internal rules and regulations of the other party, including security procedures, and all applicable federal, state, and local laws and regulations applicable to the location where said employees are working or visiting.

The Department is responsible for allocating building and equipment access, as well as any other necessary Services available from the Department that may be used by the Contractor. Any use of the Department facilities, equipment, internet access, and/or services shall only be for project purposes as authorized by the Department. The Contractor will provide its own personal computers, which must comply with the Department security policies before connection

to the Department's local computer network.

9.0 SECURITY OF PREMISES, EQUIPMENT, DATA AND PERSONNEL: The State of Wisconsin shall have the right, acting by itself or through its authorized representatives, to enter the premises of the Contractor at mutually agreeable times to inspect and copy the records of the Contractor and the Contractor's compliance with this section. In the course of performing Services under this Contract, the Contractor may have access to the personnel, premises, equipment, and other property, including data files, information, or materials (collectively referred to as "data") belonging to the State.

The Contractor shall be responsible for damage to the State's equipment, workplace, and its contents, or for the loss of data, when such damage or loss is caused by the Contractor, contracted personnel, or subcontractors, and shall reimburse the State accordingly upon demand. This remedy shall be in addition to any other remedies available to the State by law or in equity.

10.0 BREACH NOT WAIVER: A failure to exercise any right, or a delay in exercising any right, power or remedy hereunder on the part of either party shall not operate as a waiver thereof. Any express waiver shall be in writing and shall not affect any event or default other than the event or default specified in such waiver. A waiver of any covenant, term or condition contained herein shall not be construed as a waiver of any subsequent breach of the same covenant, term or condition. The making of any payment to the Contractor under this Contract shall not constitute a waiver of default, evidence of proper Contractor performance, or acceptance of any defective item or Services furnished by the Contractor.

11.0 SEVERABILITY: The provisions of this Contract shall be deemed severable and the unenforceability of any one or more provisions shall not affect the enforceability of any of the other provisions. If any provision of this Contract, for any reason, is declared to be invalid, unenforceable, or illegal, the parties shall substitute an enforceable provision that, to the maximum extent possible in accordance with applicable law, preserves the original intentions and economic positions of the parties.

12.0 LIQUIDATED DAMAGES: The Contractor and Department acknowledge that it can be difficult to ascertain actual damages when a Contractor fails to carry out the responsibilities of this Contract. Because of that, the Contractor and Department will negotiate liquidated damages, as required by the State of Wisconsin, for this Contract. The Contractor agrees that the Department shall have the right to liquidate such damages, through deduction from the Contractor's invoices, in the amount equal to the damages incurred, or by direct billing to the Contractor.

The Department shall notify the Contractor in writing of any claim for liquidated damages pursuant to this section within thirty (30) Calendar Days after the Contractor's failure to perform in accordance with the terms and conditions of this Contract.

Notwithstanding the foregoing language, when necessary the Department will identify in the RFP specific financial penalties for failure of the Contractor to meet performance standards and guarantees that may be set forth in the RFP.

13.0 CONTRACT DISPUTE RESOLUTION: In the event of any dispute or disagreement between the parties under this Contract, whether with respect to the interpretation of any provision of this Contract, or with respect to the performance of either party hereto, except for breach of Contractor's intellectual property rights, each party shall appoint a representative to meet for the purpose of endeavoring to resolve such dispute or negotiate for and adjustment to such provision.

No legal action of any kind, except for the seeking of equitable relief in the case of the public's health, safety or welfare, may begin in regard to the dispute until this dispute resolution procedure has been elevated to the Contractor's highest executive authority and the equivalent executive authority within the Department, and either of the representatives in good faith concludes, after a good faith attempt to resolve the dispute, that amicable resolution through continued negotiation of the matter at issue does not appear likely.

The party believing itself aggrieved (the "Invoking Party") shall call for progressive management involvement in the dispute negotiation by delivering written notice to the other party. Such notice shall be without prejudice to the Invoking Party's right to any other remedy permitted by this Contract. After such notice, the parties shall use all reasonable efforts to arrange personal meetings and/or telephone conferences as needed, at mutually convenient times and places, between authorized negotiators for the parties at the following successive management levels, each of which shall have a period of allotted time as specified below which to attempt to resolve the dispute:

Level	Contractor	The Department	Allotted Time
First Second	Level 1 entity	Deputy Office Director Office	10 Business Days
	Level 2 entity	Director	20 Business Days
Third	Level 3 entity	Secretary	30 Business Days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is days from the date that the Invoking Party's notice was originally received by the other party. If the Third Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's

original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the section below. The time periods herein are in addition to those periods for a party to cure provided elsewhere in this Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

14.0 **CONTROLLING LAW:** All questions as to the execution, validity, interpretation, construction and performance of this Contract shall be construed in accordance with the laws of the State of Wisconsin, without regard to any conflicts of laws or choice of law principles. Any court proceeding arising or related to this Contract or a party's obligations hereunder shall be exclusively brought and exclusively maintained in the State of Wisconsin, Dane County Circuit Court, or in the District Court of the United States Western District (if jurisdiction is proper in federal court), or upon appeal to the appellate courts of corresponding jurisdiction, and Contractor hereby consents to the exclusive jurisdiction and exclusive venue therein and waives any right to object to such jurisdiction or venue. To the extent that in any jurisdiction Contractor may now or hereafter be entitled to claim for itself or its assets immunity from suit, execution, attachment (before or after judgment) or other legal process, Contractor, to the extent it may effectively do so, irrevocably agrees not to claim, and it hereby waives, the same.

15.0 **RIGHT TO SUSPEND OPERATIONS:** If, at any time during the period of this Contract, the Department determines that the best interest of the Department or its governing boards would be best served by the Contractor's temporarily holding of all Services, the Department will promptly notify the Contractor. Upon receipt of such notice, the Contractor shall suspend all Services.

16.0 **TERMINATION OF THIS CONTRACT:** The Department may terminate this Contract at any time at its sole discretion by delivering one-hundred eighty (180) Calendar Days written notice to the Contractor.

Upon termination, the Department's liability shall be limited to the prorated cost of the Services performed as of the date of termination plus expenses incurred with the prior written approval of the Department.

If the Contractor terminates this Contract, it shall refund all payments made hereunder by the Department to the Contractor for work not completed or not accepted by the Department. Such termination shall require written notice to that effect to be delivered by the Contractor to the Department not less than one-hundred eighty (180) Calendar Days prior to said termination.

Upon any termination of this Contract, the Contractor shall perform the Services specified in a transition plan if so requested by the Department; provided, however, that except as expressly set forth otherwise herein, the Contractor shall not be obligated to perform such Services unless all amounts due to the Contractor under this Contract, including payment for the transition Services, have been paid. Failure of the Contractor to comply with a transition plan upon request and upon payment shall constitute a separate breach for which the Contractor shall be liable.

Upon the expiration or termination for any reason, each party shall be released from all obligations to the other arising after the expiration date or termination date, except for those that by their terms survive such termination or expiration.

17.0 **TERMINATION FOR CAUSE:** If the Contractor fails to perform any material requirement of this Contract, breaches any material requirement of this Contract, or if the Contractor's full and satisfactory performance of this Contract is substantially endangered, the Department may terminate this Contract. Before terminating this Contract, the Department shall give written notice of its intent to terminate to Contractor after a thirty (30) Day written notice and cure period.

The State of Wisconsin reserves the right to cancel this Contract in whole or in part without penalty in one (1) or more of the following occurrences:

- **(a)** If the Contractor intentionally furnished any statement, representation, warranty, or certification in connection with its Proposal which is materially false, incorrect, or incomplete;
- **(b)** If applicable, fails to follow the sales and use tax certification requirements of Wis. Stat. § 77.66;
- **(c)** Incurs a delinquent Wisconsin tax liability;
- **(d)** Fails to submit a non-discrimination or affirmative action plan per the requirements of Wis. Stat. § 16.765 and Wisconsin's Fair Employment Law, subch. II, Chapter 111 of the Wisconsin Statutes as required herein;
- **(e)** Is presently identified on the list of parties excluded from State of Wisconsin procurement and non-procurement Contracts;
- **(f)** Becomes a state or federal debarred Contractor, or becomes excluded from state Contracts, or;
- **(g)** Fails to maintain and keep in force all required insurance, permits and licenses as required per this Contract;
- **(h)** Fails to maintain the confidentiality of the State of Wisconsin's information that is considered to be Confidential Information or Protected Health Information;
- **(i)** Files a petition in bankruptcy, become insolvent, or otherwise takes action to dissolve as a legal entity; or,
- **(j)** If at any time the Contractor's performance threatens the health or safety of a State of Wisconsin employee, citizen, or customer.
- **(k)** Violation of any requirements in Section 22 regarding Confidential Information.

In the event of a termination for cause by the State of Wisconsin, the State of Wisconsin shall be liable for payments for

any work accepted by the State of Wisconsin prior to the date of termination.

18.0 **REMEDIES OF THE STATE:** The State of Wisconsin shall be free to invoke any and all remedies permitted under Wisconsin law. In particular, if the Contractor fails to perform as specified in this Contract, the State of Wisconsin may issue a written notice of default providing for at least a seven (7) Business Day period in which the Contractor shall have an opportunity to cure, provided that cure is possible, feasible, and approved in writing by the State of Wisconsin. Time allowed for cure of a default shall not diminish or eliminate the Contractor's liability. If the default remains, after opportunity to cure, then the State of Wisconsin may: (1) exercise any remedy provided in law or in equity or (2) terminate Contractor's Services.

If the Contractor fails to remedy any delay or other problem in its performance of this Contract after receiving reasonable notice from the State of Wisconsin to do so, the Contractor shall reimburse the State of Wisconsin for all reasonable costs incurred as a direct consequence of the Contractor's delay, action, or inaction.

In case of failure to deliver Services in accordance with or Services from other sources as necessary, Contractor shall be responsible for the additional cost, including purchase price and administrative fees. This remedy shall be in addition to any other legal remedies available to the State of Wisconsin.

19.0 **TRANSITIONAL SERVICES:** Upon cancellation, termination, or expiration of this Contract for any reason, the Contractor shall provide reasonable cooperation, assistance and Services, and shall assist the State of Wisconsin to facilitate the orderly transition of the work hereunder to the State of Wisconsin and or to an alternative Contractor selected for the transition upon written notice to the Contractor at least thirty (30) business days prior to termination or cancellation, and subject to the terms and conditions set forth herein.

20.0 **ADDITIONAL INSURANCE RESPONSIBILITY:** The Contractor shall exercise due diligence in providing Services under this Contract. In order to protect the Board's governing the Department and any Department employee against liability, cost, or expenses (including reasonable attorney fees) which may be incurred or sustained as a result of Contractors errors or other failure to comply with the terms of this Contract, the selected Contractor shall maintain errors and omissions insurance including coverage for network and privacy risks, breach of privacy and wrongful disclosure of information in an amount acceptable to the Department with a minimum of **$1,000,000** and **$5,000,000** aggregate per claim in force during this Contract period and for a period of three (3) years thereafter for Services completed. Contractor shall furnish the Department with a certificate of insurance for such amount. Further, this certificate shall designate the State of Wisconsin Employee Trust Funds and its affiliated boards as additional insured parties. The Department reserves the right to require higher or lower limits where warranted.

21.0 **OWNERSHIP OF MATERIALS:** Except as otherwise provided in subsection (t) of Section 22, all information, data, reports and other materials as are existing and available from the Department and which the Department determines to be necessary to carry out the scope of Services under this Contract shall be furnished to the Contractor and shall be returned to the Department upon completion of this Contract. The Contractor shall not use it for any purpose other than carrying out the work described in this Contract.

The Department will be furnished without additional charge all data, models, information, reports, and other materials associated with and generated under this Contract by the Contractor.

The Department shall solely own all customized software, documents, and other materials developed under this Contract. Use of such software, documents, and materials by the Contractor shall only be with the prior written approval of the Department.

This Contract shall in no way affect or limit the Department's rights to use, disclose or duplicate, for any purpose whatsoever, all information and data pertaining to the Department or covered individuals and generated by the claims administration and other Services provided by Contractor under this Contract.

All files (paper or electronic) containing any Wisconsin claimant or employee information and all records created and maintained in the course of the work specified by this Contract are the sole and exclusive property of the Department. Contractor may maintain copies of such files during the term of this Contract as may be necessary or appropriate for its performance of this Contract. Moreover, Contractor may maintain copies of such files after the term of this Contract (i) for one hundred twenty (120) days after termination, after which all such files shall be transferred to the Department or destroyed by Contractor, except for any files as to which a claim has been made, and (ii) for an unlimited period of time after termination for Contractor's use for statistical purposes, if Contractor first deletes all information in the records from which the identity of a claimant or employee could be determined and certifies to the Department that all personal identifiers have been removed from the retained files.

22.0 **CONFIDENTIAL INFORMATION AND HIPAA BUSINESS ASSOCIATE AGREEMENT:** This Section is intended to cover handling of Confidential Information under state and federal law, and specifically to comply with the requirements of HIPAA, HITECH, and the Genetic Information Nondiscrimination Act (GINA) and the federal implementing regulations for those statutes requiring a written agreement with business associates.

(a) DEFINITIONS: As used in this Section, unless the context otherwise requires:

(1) Business Associate. "Business Associate" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Contractor (insert name of Contractor).

(2) Confidential Information has the meaning ascribed to it in Section 1.5 of the RFP.

(3) Covered Entity. "Covered Entity" has the meaning ascribed to it at 45 CFR 160.103 and in this Contract refers to the Department of Employee Trust Funds.

(4) HIPAA Rules. "HIPAA Rules" mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(5) Individual Personal Information "Individual Personal Information" has the meaning ascribed to it at Wis. Admin. Code ETF § 10.70 (1).

(6) Medical Record. "Medical Record" has the meaning ascribed to it at Wis. Admin. Code ETF 10.01 (3m).

(b) PROVISION OF CONFIDENTIAL INFORMATION FOR CONTRACTED SERVICES: ETF, a different business associate of ETF or a contractor performing Services for ETF may provide Confidential Information to the Contractor under this Contract as the Department determines is necessary for the proper administration of this Contract, as provided by Wis. Stat. § 40.07 (1m) (d) and (3).

(c) DUTY TO SAFEGUARD CONFIDENTIAL INFORMATION: The Contractor shall safeguard Confidential Information supplied to the Contractor or its employees under this Contract. In addition, the Contractor will only share Confidential Information with its employees on a need-to-know basis. Should the Contractor fail to properly protect Confidential Information, any cost the Department pays to mitigate the failure will be subtracted from the Contractor's invoice(s).

(d) USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor shall:

(1) Not use or disclose Confidential Information for any purpose other than as permitted or required by this Contract or as required by law. Contractor shall not use or disclose member names, addresses, or other data for any purpose other than specifically provided for in this Contract;

(2) Make uses and disclosures and requests for any Confidential Information following the minimum necessary standard in the HIPAA Rules;

(3) Use appropriate safeguards to prevent use or disclosure of Confidential Information other than as provided for by this Contract, and with respect to Protected Health Information, comply with Subpart C of 45 CFR Part 164;

(4) Not use or disclose Confidential Information in a manner that would violate Subpart E of 45 CFR Part 164 or Wis. Stat. § 40.07 if done by ETF; and

(5) If applicable, be allowed to use or disclose Confidential Information for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided the disclosures are required by law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been or is suspected of being breached.

(e) COMPLIANCE WITH ELECTRONIC TRANSACTIONS AND CODE SET STANDARDS: The Contractor shall comply with each applicable requirements of 45 C.F.R. Part 162 if the Contractor conducts standard transactions, as that term is defined in HIPAA, for or on behalf of ETF.

(f) MANDATORY REPORTING: Contractor shall report to ETF in the manner set forth in Subsection (l) any use or disclosure or suspected use or disclosure of Confidential Information not provided for by this Contract, of which it becomes aware, including breaches or suspected breaches of unsecured Protected Health Information as required at 45 CFR 164.410.

(g) DESIGNATED RECORD SET: Contractor shall make available Protected Health Information in a designated record set to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.524.

(h) AMENDMENT IN DESIGNATED RECORD SET: Contractor shall make any amendment to Protected Health Information in a designated record set as directed or agreed to by ETF pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy ETF's obligations under 45 CFR 164.526.

(i) ACCOUNTING OF DISCLOSURES: Contractor shall maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy ETF's obligations under 45 CFR 164.528.

(j) COMPLIANCE WITH SUBPART E OF 45 CFR 164: To the extent Contractor is to carry out one or more of ETF's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to a covered entity in the performance of such obligation; and

(k) INTERNAL PRACTICES: Contractor shall make its internal practices, books, and records available to the Secretary of the United States Department of Labor for purposes of determining compliance with the HIPAA Rules.

(l) CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** A list of any affected members (if available);
- **b.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **c.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **d.** The date of the discovery by Contractor;
- **e.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **f.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than one (1) business day before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

(m) CLASSIFICATION LABELS: Contractor shall ensure that all data classification labels contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed by the Department.

(n) SUBCONTRACTORS: If applicable, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit Confidential Information on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information.

(o) NOTICE OF LEGAL PROCEEDINGS: If Contractor or any of its employees, agents, or subcontractors is legally required in any administrative, regulatory or judicial proceeding to disclose any Confidential Information, contractor shall give the Department prompt notice (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

(p) MITIGATION: The Contractor shall take immediate steps to mitigate any harmful effects of the suspected or actual unauthorized use, disclosure, or loss of any Confidential Information provided to Contractor under this Contract. The Contractor shall reasonably cooperate with the Department's efforts to comply with the breach notification requirements of HIPAA, to seek appropriate injunctive relief or otherwise prevent or curtail such suspected or actual unauthorized use, disclosure or loss, or to recover its Confidential Information, including complying with a

reasonable corrective action plan, as directed by the Department.

(q) COMPLIANCE REVIEWS: The Department may conduct a compliance review of the Contractor's security procedures before and during this Contract term to protect Confidential Information.

(r) AMENDMENT: The Parties agree to take such action as is necessary to amend the Contract as necessary for compliance with the HIPAA Rules and other applicable law.

(s) SURVIVAL: The obligations of Contractor under this Section survive the termination of the underlying Contract.

(t) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION: Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

1. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to ETF or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;
4. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;
5. Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and
6. If required by ETF, transmit the Confidential Information to another contractor of ETF.

23.0 INDEMNIFICATION:

23.1 SCOPE OF INDEMNIFICATION FOR INTELLECTUAL PROPERTY RIGHTS INFRINGEMENT: In the event of a claim against the Parties for Intellectual Property Rights Infringement associated with a claim for benefits, Contractor agrees to defend, indemnify and hold harmless Board and Department ("Indemnified Parties") from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Board, Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section.

23.2 SCOPE OF OTHER INDEMNIFICATION: In addition to the foregoing Section, Contractor shall defend, indemnify and hold harmless the Indemnified Parties from and against any and all claims, actions, loss, damage, expenses, costs (including reasonable fees for Department's staff attorneys and/or attorneys from the Wisconsin Attorney General's Office) reasonable attorneys' fees otherwise incurred by Department and/or the Wisconsin Attorney General's Office, court costs, and related reasonable legal expenses whether incurred in defending against such claims or enforcing this Section, or liability arising from or in connection with the following: (a) Contractor's performance of or failure to perform any duties or obligations under any agreement between Contractor and any third party; (b) injury to persons (including death or illness) or damage to property caused by the act or omission of Contractor or Contractor Personnel; (c) any claims or losses for Services rendered by any subcontractor, person, or firm performing or supplying Services, materials, or supplies in connection with the Contractor's performance of this Contract; (d) any claims or losses resulting to any person or third party entity injured or damaged by the Contractor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under this Contract in a manner not authorized by this Contract, or by Federal or State statutes or regulations; and (e) any failure of the Contractor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

23.3 INDEMNIFICATION NOTICE: Department shall give Contractor prompt written notice of such claim, suit, demand, or action (provided that a failure to give such prompt notice will not relieve Contractor of its indemnification obligations hereunder except to the extent Contractor can demonstrate actual, material prejudice to its ability to mount a defense as a result of such failure). Department will cooperate, assist, and consult with Contractor in the defense or investigation of any claim made or suit filed against Department resulting from Contractor's performance under the Contract.

23.4 NO INDEMNIFICATION OBLIGATIONS: Contractor shall as soon as practicable, notify Department of any claim made or suit filed against Contractor resulting from Contractor's obligations under this Contract if such claim may involve the Department. Department has no obligation to provide legal counsel or defense to Contractor if a suit, claim, or action is brought against Contractor or its subcontractors as a result of Contractor's performance of its obligations under this Contract. In addition, Department has no obligation for the payment of any judgments or the settlement of any claims against Contractor arising from or related to this Contract. Department has not waived any right or entitlement to claim sovereign immunity under this Contract.

23.5 CONTRACTOR'S DUTY TO INDEMNIFY: Contractor shall comply with its obligations to indemnify, defend and hold the Indemnified Parties harmless with regard to claims, damages, losses and/or expenses arising from a claim for benefits under the Plan as provided herein. Contractor shall be entitled to control the defense of any such claim and to defend or settle any such claim, in its sole discretion, with counsel of its own choosing; however, Contractor shall consult with Department regarding its defense of any claim and not settle or compromise any claim or action in a manner that imposes restrictions or obligations on Department, requires any financial payment by Department, or grants rights or concessions to a third party without first obtaining Department's prior written consent. Contractor shall have the right to assert any and all defenses on behalf of the Indemnified parties, including sovereign immunity.

In carrying out any provision of this Contract or in exercising any power or authority granted to the Contractor thereby, there shall be no liability upon the Department, it being understood that in such matters the Department acts as an agent of the State.

The Contractor shall at all times comply with and observe all federal and state laws and regulations which are in effect during the period of this Contract and which in any manner affect the work or its conduct.

24.0 EQUITABLE RELIEF: The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury shall not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Contract or under applicable law.

25.0 RIGHT TO PUBLISH OR DISCLOSE: Throughout the term of this Contract, the Contractor must secure the Department's written approval prior to the release of any information which pertains to work or activities covered by this Contract.

The parties agree that it is a breach of this Contract to disclose any information to any person that the Department or its governing boards may not disclose under Wis. Stat. § 40.07. Contractor acknowledges that it will be liable for damage or injury to persons whose Confidential Information is disclosed by any officer, employee, agent, or subcontractor of the Contractor without proper authorization.

26.0 TIME IS OF THE ESSENCE: Timely provision of the Services required under this Contract shall be of the essence of the Contract, including the provisions of the Services within the time agreed or on a date specified herein.

27.0 IDENTIFICATION OF KEY PERSONNEL AND PERSONNEL CHANGES: The Department will designate a contract administrator, who shall have oversight for performance of the Department's obligations under this Contract. The Department shall not change the person designated without prior written notification to the Contractor.

The State of Wisconsin reserves the right to approve all individuals assigned to this project. The Contractor agrees to use its best effort to minimize personnel changes during the Contract term.

At the time of contract negotiations, the Contractor shall furnish the Department with names of all key personnel assigned to perform work under this Contract and furnish the Department with criminal background checks.

The Contractor will designate a contract administrator who shall have executive and administrative oversight for performance of the Contractor's obligations under this Contract. The Contractor shall not change this designation without prior written notice to the Department.

The Contractor may not divert key personnel for any period of time except in accordance with the procedure identified in this section. The Contractor shall provide a notice of proposed diversion or replacement to the single person of contact (SPOC) at least sixty (60) days in advance, together with the name and qualifications of the person(s) who will take the place of the diverted or replaced staff. At least thirty (30) days before the proposed diversion or replacement, the Department shall notify the SPOC whether the proposed diversion or replacement is approved or rejected, and if rejected shall provide reasons for the rejection. Such approval by the Department shall not be unreasonably withheld or delayed.

Replacement staff shall be on-site within two (2) weeks of the departure date of the person being replaced. The Contractor shall provide the Department with reasonable access to any staff diverted by the Contractor.

Replacement of key personnel shall be with persons of equal ability and qualifications. The Department has the right to conduct separate interviews of proposed replacements for key personnel. The Department shall have the right to approve, in writing, the replacement of key personnel. Such approval shall not be unreasonably withheld. Failure of the Contractor to promptly replace key personnel within thirty (30) Calendar Days after departure shall entitle the Department to terminate this Contract. The notice and justification must include identification of proposed substitute key personnel and must provide sufficient detail to permit evaluation of the impact of the change on the project and/or maintenance.

Any of the Contractor's staff that the Department deems unacceptable shall be promptly and without delay removed by the Contractor from the project and replaced by the Contractor within thirty (30) Calendar Days by another employee with acceptable experience and skills subject to the prior approval of the Department. Such approval by the Department will not be unreasonably withheld or delayed.

An unauthorized change by the Contractor of any Contracted Personnel designed as key personnel will result in the imposition of liquidated damages, as defined in this Contract.

28.0 DATA SECURITY AND PRIVACY AGREEMENT

(a) PURPOSE AND SCOPE OF APPLICATION: This Data Security and Privacy Agreement (Agreement) is designed to protect the Department of Employee Trust Fund's (ETF) Confidential Information and ETF Information Resources (defined below). This Agreement describes the data security and privacy obligations of Contractor and its sub-contractors that connect to ETF Information Resources and/or gain access to Confidential Information.

(b) DEFINED TERMS:

(1) **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) Individual Personal 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); or (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 by Contractor on FORM D –Designation of Confidential and Proprietary Information (DOA-3027). Pricing information cannot be held confidential.

(2) **ETF Information Resources** means those devices, networks and related infrastructure that ETF has obtained for use to conduct ETF business. Devices include but are not limited to, ETF-owned, managed, used through service agreements storage, processing, communications devices and related infrastructure on which ETF data is accessed, processed, stored, or communicated, and may include personally owned devices. Data includes, but is not limited to, Confidential Information, other ETF created or managed business and research data, metadata, and credentials created by or issued on behalf of ETF.

(c) ACCESS TO ETF INFORMATION RESOURCES: In any circumstance when Contractor is provided access to ETF Information Resources, it is solely Contractor's responsibility to ensure that its access does not result in any access by unauthorized individuals to ETF Information Resources. Contractors who access ETF's systems from any ETF location must at a minimum conform with ETF security standards that are in effect at the ETF location(s) where the access is provided. Any Contractor technology and/or systems that gain access to ETF Information Resources must comply with, at a minimum, the elements in the Computer System Security Requirements set forth in this Agreement.

(d) COMPLIANCE WITH APPLICABLE LAWS: Contractor agrees to comply with all applicable state and federal laws, as well as industry best practices, governing the collection, access, use, disclosure, safeguarding and destruction of Confidential Information.

(e) PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION: Contractor agrees to hold ETF's Confidential Information, and any information derived from such information, in strictest confidence. Contractor will not access, use or disclose Confidential Information other than to carry out the purposes for which ETF disclosed the Confidential Information to Contractor, except as permitted or required by applicable law, or as otherwise authorized in writing by ETF. For avoidance of doubt, this provision prohibits Contractor from using for its own benefit Confidential Information or any information derived from such information. If required by a court of competent jurisdiction or an administrative body to disclose Confidential Information, Contractor will notify ETF in writing immediately upon receiving notice of such requirement and prior to any such disclosure, to give ETF an opportunity to oppose or otherwise respond to such disclosure (unless prohibited by law from doing so).

(f) REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES: The Contractor's transmission, transportation or storage of Confidential Information outside the United States, or access of Confidential Information from outside the United States, is prohibited except on prior written authorization by ETF.

(g) SAFEGUARD STANDARD: Contractor agrees to protect the privacy and security of Confidential Information according to all applicable laws and regulations, including HIPAA, by commercially-acceptable frameworks or standards such as the ISO/IEC 27000-series, NIST, 800-53, RFC 2196, IEC 62443, and SANS CIS Top 20. ISO 270001, etc. Security Controls, and no less rigorously than it protects its own confidential information, but in no case less than reasonable care. Contractor will implement, maintain and use appropriate administrative, technical and physical security measures to preserve the confidentiality, integrity and availability of the Confidential Information. All Confidential Information stored on portable devices or media must be encrypted in accordance with the Federal Information Processing Standards (FIPS) Publication 140-2. Contractor will ensure that all security measures are regularly reviewed including ongoing monitoring, an annual penetration and vulnerability test, and an annual security incident response test, and revised, no less than annually, to address evolving threats and vulnerabilities while Contractor has responsibility for the Confidential Information under the terms of this Agreement. Prior to agreeing to the terms of this Agreement, and periodically thereafter (no more frequently than annually) at ETF's request, Contractor will provide assurance, in the form of a third-party audit report or other documentation acceptable to ETF, such as SOC2 Type II, demonstrating that appropriate information security safeguards and controls are in place.

(h) INFORMATION SECURITY PLAN:

(1) Contractor acknowledges that ETF is required to comply with information security standards for the protection of Confidential Information as required by law, regulation and regulatory guidance, as well as ETF's internal security program for information and systems protection.

(2) Contractor will establish, maintain and comply with an information security plan (Information Security Plan), which will contain, at a minimum, such elements as those set forth in this Agreement.

(3) Contractor's Information Security Plan will be designed to:

- **a.** Ensure the privacy, security, integrity, availability, and confidentiality of Confidential Information;
- **b.** Protect against any anticipated threats or hazards to the security or integrity of such information;
- **c.** Protect against unauthorized access to or use of such information that could result in harm or inconvenience to the person that is the subject of such information;
- **d.** Reduce risks associated with Contractor having access to ETF Information Resources; and
- **e.** Comply with all applicable legal and regulatory requirements for data protection.

(4) On at least an annual basis, Contractor will review its Information Security Plan, update and revise it as needed, and submit it to ETF upon request. At ETF's request, Contractor will make modifications to its Information Security Plan or to the procedures and practices thereunder to conform to ETF's security requirements as they exist from time to time. If there are any significant

modifications to Contractor's Information Security Plan, Contractor will notify ETF within a reasonable period of time, not to exceed two weeks. Any significant modification must include the same or a higher framework or information security standard maturity level than what currently exists in the Plan.

(i) RETURN OR DESTRUCTION OF CONFIDENTIAL INFORMATION:

Upon termination of this Contract for any reason, Contractor, with respect to Confidential Information received from ETF, another contractor of ETF, or created, maintained, or received by Contractor on behalf of ETF, shall:

(1) Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

(2) Where feasible, return to ETF, or, if agreed to by ETF, destroy the remaining Confidential Information that Contractor still maintains in any form;

(3) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information to prevent use or disclosure of the Protected Health Information, other than as provided for in this Subsection, for as long as Contractor retains the Protected Health Information;

(4) Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out above under Subsection (d) which applied prior to termination;

(5) Return to ETF or, if agreed to by ETF, destroy the Protected Health Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities; and

(6) If required by ETF, transmit the Confidential Information to another contractor of ETF.

(j) NOTIFICATION OF CORRESPONDENCE CONCERNING CONFIDENTIAL INFORMATION: Contractor agrees to notify ETF immediately, both orally and in writing, but in no event more than twenty-four (24) hours after Contractor receives correspondence or a complaint regarding Confidential Information, including but not limited to, correspondence or a complaint that originates from a regulatory agency or an individual.

(k) BREACHES OF CONFIDENTIAL INFORMATION:

CONTRACTOR REPORTING OF BREACH OR SUSPECTED BREACH OR DISCLOSURE TO ETF:

(1) Within twenty-four (24) hours after Contractor becomes aware of a suspected breach, impermissible use, or impermissible disclosure of ETF's Confidential Information, notify in writing the ETF Program Manager and Privacy Officer. A suspected breach, impermissible use, or impermissible disclosure is considered to be discovered as of the first day on which such occurrence is known to Contractor, or, by exercising reasonable diligence, would have been known to Contractor. The notification must contain details sufficient for the ETF Program Manager and Privacy Officer to determine ETF's agency response. Sufficient details include, without limitation:

- **a.** The nature of the unauthorized access, use or disclosure;
- **b.** A list of any affected members (if available);
- **c.** Information about the information included in the breach, impermissible use, or impermissible disclosure;
- **d.** The date or dates of the suspected breach, impermissible use, or impermissible disclosure;
- **e.** The date of the discovery by Contractor;
- **f.** A list of the pro-active steps taken by Contractor and being taken to correct breach, impermissible use or impermissible disclosure; and
- **g.** Contact information at Contractor for affected persons who contact ETF regarding the issue.

(2) Not less than twenty-four (24) hours before Contractor makes any external communications to the public, media, federal Office for Civil Rights (OCR), other governmental entity, or persons

potentially affected by the breach, impermissible use, or impermissible disclosure, provide a copy of the planned communication to the ETF Program Manager and Privacy Officer.

(3) Within thirty (30) days after Contractor makes the initial report under this section, Contractor shall research the suspected breach, impermissible use, or impermissible disclosure Confidential Information and provide a report in writing to the ETF Program Manager. The report must contain, at a minimum:

- **a.** A complete list of any affected members and contact information;
- **b.** Copies of correspondence or notifications provided to the public, media, OCR, other governmental entity, or persons potentially affected;
- **c.** Whether Contractor's Privacy Officer has determined there has been a reportable breach under HIPAA, or an unauthorized acquisition under Wis. Stat. §134.98 and the reasoning for such determination;
- **d.** If Contractor determines there has been a breach, impermissible use, or impermissible disclosure, an explanation of the root cause of the breach, impermissible use, or impermissible disclosure;
- **e.** A list of the corrective actions taken to mitigate the suspected breach, impermissible use, or impermissible disclosure; and
- **f.** A list of the corrective actions taken to prevent a similar future breach, impermissible use, or impermissible disclosure.

COORDINATION OF BREACH RESPONSE ACTIVITIES:

(4) Contractor will fully cooperate with ETF's investigation of any breach involving Contractor, including but not limited to making witnesses, documents, HIPAA logs, systems logs, video recordings, or other pertinent or useful information available immediately upon Contractor's reporting of the breach and throughout the investigation. Contractor's full cooperation will include but not be limited to Contractor:

- **a.** Immediately preserving any potential forensic evidence relating to the breach, and remedying the breach as quickly as circumstances permit
- **b.** Within forty-eight (48) hours designating a contact person to whom ETF will direct inquiries, and who will communicate Contractor responses to ETF inquiries; Contractor will designate a Privacy Officer and Security Officer to serve as contacts for ETF.
- **c.** As rapidly as circumstances permit, applying appropriate resources to remedy the breach condition, investigate, document, restore ETF service(s) as directed by ETF, and undertake appropriate response activities such as working with ETF, its representative, and law enforcement to identify the breach, identify the perpetrator(s), and take appropriate actions to remediate the security vulnerability;
- **d.** Providing status reports at least every two (2) hours until the root cause of the breach is identified and a plan is devised to fully remediate the breach;
- **e.** Once the root cause of the breach is identified and a plan is devised to fully remediate the breach, providing status reports daily or at mutually agreed upon timeframes, to ETF on breach response activities, findings, analyses, and conclusions;
- **f.** Coordinating all media, law enforcement, or other breach notifications with ETF in advance of such notification(s), unless expressly prohibited by law; and
- **g.** Ensuring that knowledgeable Contractor staff is available on short notice, if needed, to participate in ETF-initiated meetings and/or conference calls regarding the breach.

ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS:

(5) Contractor will make itself and any employees, subcontractors, or agents assisting Contractor in the performance of its obligations available to ETF at no cost to ETF to testify as witnesses, or otherwise, in the event of a breach or other unauthorized disclosure of Confidential Information caused by Contractor that results in litigation, governmental investigations, or administrative proceedings against ETF, its directors, officers, agents or employees based upon a claimed violation of laws relating to security and privacy or arising out of this Agreement or the Contract.

(l) RETENTION OF LOGS:

(1) HIPAA logs (logs of any systems that have information relating to HIPAA) must be kept for six (6) years.

(2) Firewall logs must be kept for twelve (12) months.

(m) ADDITIONAL INSURANCE: In addition to the insurance required under the Agreement, Contractor at its sole cost and expense will obtain, keep in force, and maintain an insurance policy (or policies) that provides coverage for privacy and data security breaches. This specific type of insurance is typically referred to as Privacy, Technology and Data Security Liability, Cyber Liability, or Technology Professional Liability. In some cases, Professional Liability policies may include some coverage for privacy and/or data breaches. Regardless of the type of policy in place, it needs to include coverage for reasonable costs in investigating and responding to privacy and/or data breaches with the following minimum limits unless ETF specifies otherwise: $1,000,000 Each Occurrence and $5,000,000 Aggregate.

(n) INFORMATION SECURITY PLAN REQUIREMENTS:

(1) Contractor will develop, implement, and maintain a comprehensive Information Security Plan that is written in one or more readily accessible parts and contains administrative, technical, and physical safeguards. The safeguards contained in such program must be consistent with the safeguards for protection of Confidential Information and information of a similar character set forth in any state or federal regulations by which the person who owns or licenses such information may be regulated.

(2) Without limiting the generality of the foregoing, every comprehensive Information Security Plan will include, but not be limited to:

a. Designating one or more employees to maintain the comprehensive Information Security Plan;

b. Identifying and assessing internal and external risks to the security, confidentiality, and/or integrity of any electronic, paper or other records containing Confidential Information and of ETF Information Resources, and evaluating and improving, where necessary, the effectiveness of the current safeguards for limiting such risks, including but not limited to:

c. Ongoing employee (including temporary and contract employee) training;

d. Employee compliance with policies and procedures; and

e. Means, including Contractor staff, processes, and technology, for detecting information system intrusions, data breaches, and anomalous system behavior or activity, and for preventing security breaches, intrusions, or unauthorized access to information systems or networks.

f. Developing security policies for employees relating to the storage, access and transportation of records containing Confidential Information outside of business premises.

g. Imposing disciplinary measures for violations of the comprehensive Information Security Plan rules.

h. Preventing terminated employees from accessing records containing Confidential Information and/or ETF Information Resources.

i. Overseeing service providers, by:

--Taking reasonable steps to select and retain third-party service providers that are capable of maintaining appropriate security measures to protect such Confidential Information and ETF Information Resources consistent with all applicable laws and regulations; and

-- Requiring such third-party service providers by contract to implement and maintain such appropriate security measures for Confidential Information.

j. Placing reasonable restrictions upon physical access to records containing Confidential Information and ETF Information Resources and requiring storage of such records and data in locked facilities, storage areas or containers.

k. Restrict physical access to any network or data centers that may have access to Confidential Information or ETF Information Resources.

l. Requiring regular monitoring to ensure that the comprehensive Information Security Plan is operating in a manner reasonably calculated to prevent unauthorized access to or

unauthorized use of Confidential Information and ETF Information Resources; and upgrading information safeguards as necessary to limit risks.

m. Reviewing the scope of the security measures at least annually or whenever there is a material change in business practices that may reasonably implicate the security or integrity of records containing Confidential Information and of ETF Information Resources.

n. Documenting responsive actions taken in connection with any incident involving a breach, and mandating post-incident review of events and actions taken, if any, to make changes in business practices relating to protection of Confidential Information and ETF Information Resources.

(o) COMPUTER SYSTEM SECURITY REQUIREMENTS: To the extent that Contractor electronically stores or transmits Confidential Information or has access to any ETF Information Resources, it will include in its written, comprehensive Information Security Plan the establishment and maintenance of a security system covering its computers, including any wireless system, that, at a minimum, and to the extent technically feasible, will have the following elements:

(1) Secure user authentication protocols including:

a. Control of user IDs and other identifiers;
b. A secure method of assigning and selecting passwords, or use of unique identifier technologies, such as biometrics or token devices;
c. Multi-Factor Authentication (MFA);
c. Control of data security passwords to ensure that such passwords are kept in a location and/or format that does not compromise the security of the data they protect;
d. Multi-factor authentication for system administrators and others with 'super-user' access rights;
e. Restricting access to active users and active user accounts only;
f. Blocking access to user identification after multiple unsuccessful attempts to gain access or the limitation placed on access for the particular system; and
g. Periodic review of user access, access rights and audit of user accounts.

(2) Secure access control measures that:

a. Restrict access to records and files containing Confidential Information and systems that may have access to ETF Information Resources to those who need such information to perform their job duties; and
b. Assign unique identifications plus passwords, which are not vendor supplied default passwords, to each person with computer access, which are reasonably designed to maintain the integrity of the security of the access controls.

(3) Encryption of all transmitted records and files containing Confidential Information.

(4) Adequate security of all networks that connect to ETF Information Resources or access Confidential Information, including wireless networks.

(5) Reasonable monitoring of systems, for unauthorized use of or access to Confidential Information and ETF Information Resources.

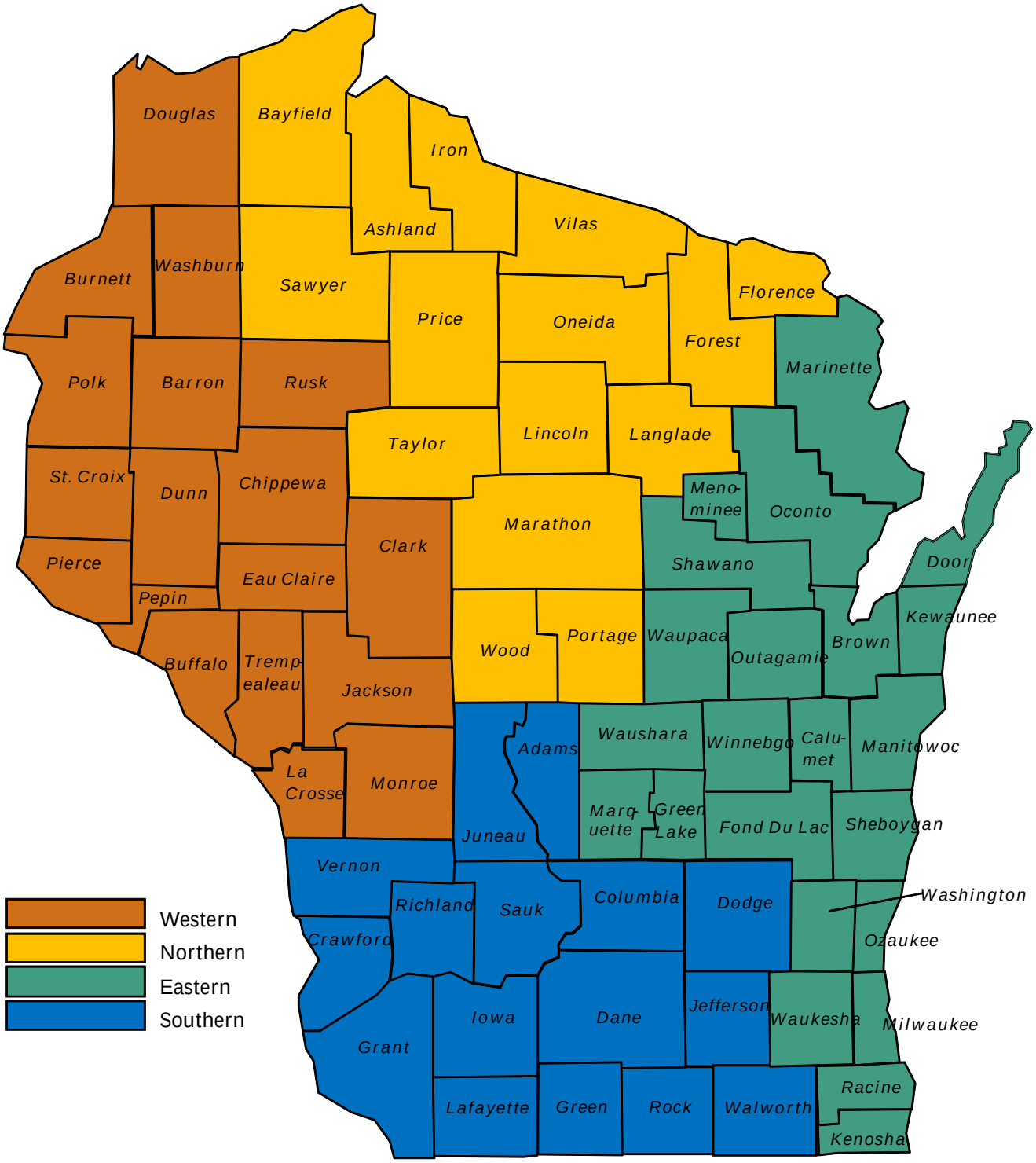
(6) Encryption of all Confidential Information stored on Contractor devices, including laptops or other portable storage devices.

(7) For files containing Confidential Information on a system that is connected to the Internet or that may have access to ETF Information Resources, reasonably up-to-date firewall, router and switch protection and operating system security patches, reasonably designed to maintain the integrity of the Confidential Information.

(8) Reasonably up-to-date versions of system security agent software, including intrusion detection systems, which must include malware protection and reasonably up-to-date patches and virus definitions, or a version of such software that can still be supported with up-to-date patches and virus definitions, and is set to receive the most current security updates on a regular basis.

(9) Education and training of employees on the proper use of the computer security system and the importance of Confidential Information and network security.

With reasonable notice to Contractor, ETF may require additional security measures which may be identified in additional guidance, contracts, communications or requirements.

State of Wisconsin
Department of Employee Trust Funds
Regional Map

RFP ETG0003
Exhibit 5: Map
Issued July 22, 2016