IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs, Case No. 17-cv-264

v.

STATE OF WISCONSIN DEPARTMENT
OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

DECLARATION OF MICHAEL R. GODBE

I, Michael R. Godbe, certify under penalty of perjury that the following is true and correct to the best of my knowledge and recollection:

1. I am an attorney licensed to practice in the state of Wisconsin and am one of the attorneys representing the Plaintiffs in the above-captioned matter.

2. The parties in this case have engaged in discovery. Attached to this Declaration are true and correct copies of the following documents produced in discovery:

a. Attached hereto as **Exhibit A** is a true and correct copy of Defendants' Responses to Plaintiffs' Second Set of Requests for Admission and Interrogatory;

b. Attached hereto as **Exhibit B** is a true and correct copy of "It's Your Choice" Access Health Plan, Bates labelled ETF000084;

c. Attached hereto as **Exhibit C** is a true and correct copy of Excerpts From 2016 Contract & Uniform Benefits, Bates labelled ETF00727;

d. Attached hereto as **Exhibit D** is a true and correct copy of July 21, 2016 Emails between Tara Pray and Michael McNally, Bates labelled ETF02204;

e. Attached hereto as **Exhibit E** is a true and correct copy of 2017 Benefit Uniform Benefits, revised 2/1/2017, Bates labelled ETF00023;

f. Attached hereto as **Exhibit F** is a true and correct copy of excerpts from the Alina Boyden ETF Written Complaint File, Bates labelled ETF00002;

g. Attached hereto as **Exhibit G** is a true and correct copy of excerpts from the Shannon Andrews ETF Written Complaint File, Bates labelled ETF00003;

h. Attached hereto as **Exhibit H** is a true and correct copy of the January 31, 2017 ETF Memo to Health Plans, Bates labelled ETF00125;

i. Attached hereto as **Exhibit I** is a true and correct copy of June 22, 2016 GIB Correspondence Memorandum, Bates labelled ETF00562;

j. Attached hereto as **Exhibit J** is a true and correct copy of September 8, 2006 emails between Bill Kox and Jeff Bogardus and the attachment contained therein, the 2005-2007 Bargaining Demands, Bates labelled ETF02026;

k. Attached hereto as **Exhibit K** is a true and correct copy of October 22, 2008 emails between Linda Owens and Jeff Bogardus and the attachment contained therein, the 2009-2011 Bargaining Demands, Bates labelled ETF03934;

l. Attached hereto as **Exhibit L** is a true and correct copy of April 27, 2015 emails between Jeff Bogardus, Arlene Larson, and Tara Pray and the attachment contained therein, the 2015 Pray Study Group Memorandum, Bates labelled ETF01815;

m. Attached hereto as **Exhibit M** is a true and correct copy of the July 12, 2016 GIB Open Meeting Minutes, Bates labelled BoydenProd6_000100;

n. Attached hereto as **Exhibit N** is a true and correct copy of June 29, 2016 emails between Kirsten Schatten and Lisa Ellinger and the attachment contained therein, the March 3, 2014 Segal Maryland Coverage Estimate Memorandum, Bates labelled ETF02293;

o. Attached hereto as **Exhibit O** is a true and correct copy of January 30, 2017 emails between Joan Steele and Arlene Larson and the attachment contained therein, the January 27, 2017 Segal Transgender Cost Estimate Memorandum, Bates labelled ETF01893;

p. Attached hereto as **Exhibit P** is a true and correct copy of the August 12, 2016 ETF Memo to GIB, Bates labelled ETF00091;

q. Attached hereto as **Exhibit Q** is a true and correct copy of the January 31, 2017 email from Sara Brockman to GIB Members and an attachment contained therein, the December 13, 2016 GIB Open Meeting Meetings, Bates labelled GIB00711;

r. Attached hereto as **Exhibit R** is a true and correct copy of a December 29, 2016 email between Jeff Bogardus and Steven Alexander, Shannon Tischer, and Pam Olson, Bates labelled ETF02184;

s. Attached hereto as **Exhibit S** is a true and correct copy of the December 30, 2016 GIB Open Meeting Minutes, Bates labelled ETF00141;

t. Attached hereto as **Exhibit T** is a true and correct copy of February 6, 2017 emails between Tara Pray and Lisa Ellinger, Bates labelled BoydenProd7_000174;

u. Attached hereto as **Exhibit U** is a true and correct copy of the February 8, 2017 GIB Open Meeting Minutes, Bates labelled BoydenProd6_000050;

v. Attached hereto as **Exhibit V** is a true and correct copy of the May 24, 2017 GIB Open Meeting Minutes, Bates labelled ETF00156;

w. Attached hereto as **Exhibit W** is a true and correct copy of Defendant's Responses to Plaintiff's First Set of Discovery Requests; and

x. Attached hereto as **Exhibit X** is a true and correct copy of the May 2, 2018 Stipulation between the parties.

3. I declare under penalty of perjury that the foregoing is true and correct.

Executed this 8th day of June, 2018.

/s/ Michael R. Godbe
Michael R. Godbe

Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs, Case No. 17-cv-264

v.

STATE OF WISCONSIN DEPARTMENT
OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

STATE DEFENDANTS' RESPONSES AND OBJECTIONS TO PLAINTIFFS' SECOND SET OF REQUESTS FOR ADMISSION AND INTERROGATORY TO STATE DEFENDANTS

Pursuant to Federal Rules of Civil Procedure 33 and 36, Defendants State of Wisconsin Department of Employee Trust Funds, State of Wisconsin Group Insurance Board, Robert J. Conlin, Secretary of the Department of Employee Trust Funds (ETF), Board of Regents of the University of Wisconsin System, Raymond W. Cross, President of the University of Wisconsin System, Rebecca M. Blank, Chancellor of the University of Wisconsin-Madison, University of Wisconsin School of Medicine and Public Health, and Robert N. Golden, M.D., Dean of the University of Wisconsin School of Medicine and Public Health (the "State Defendants"), by their counsel, hereby object and respond to Plaintiffs Second Set of Requests for Admission and Interrogatory to State Defendants.

GENERAL OBJECTIONS

The State Defendants assert and incorporate by reference the same General Objections set forth in State Defendants' Responses and Objections to Plaintiffs' First Set of Requests for Admission, Interrogatories, and Requests for Production of Documents and Things.

SPECIFIC OBJECTIONS AND RESPONSES TO REQUESTS FOR ADMISSION

REQUEST FOR ADMISSION NO. 1: Admit that Alina Boyden is eligible for group health insurance coverage provided by Defendants ETF and GIB because she is employed by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 1: The State Defendants object that the term "provided by" is vague and ambiguous. Subject to and without waiving that objection, ADMIT that that Alina Boyden is eligible for State of Wisconsin Group Health Insurance Program coverage in part because she is employed by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 2: Admit that Alina Boyden has received group health insurance coverage, and currently receives group health insurance coverage, provided by Defendants ETF and GIB through her employment by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 2: The State Defendants object that the term "provided by" is vague and ambiguous.

Subject to and without waiving that objection, ADMIT that Alina Boyden has received State of Wisconsin Group Health Insurance Program coverage, and currently receives State of Wisconsin Group Health Insurance Program coverage through her employment by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 3: Admit that Shannon Andrews is eligible for group health insurance coverage provided by Defendants ETF and GIB because she is employed by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 3: The State Defendants object that the term "provided by" is vague and ambiguous. Subject to and without waiving that objection, ADMIT that that Shannon Andrews is eligible for State of Wisconsin Group Health Insurance Program coverage because she is employed by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 4: Admit that Shannon Andrews has received group health insurance coverage, and currently receives group health insurance coverage, provided by Defendants ETF and GIB through her employment by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 4: The State Defendants object that the term "provided by" is vague and ambiguous. Subject to and without waiving that objection, ADMIT that Shannon

Andrews has received State of Wisconsin Group Health Insurance Program coverage, and currently receives State of Wisconsin Group Health Insurance Program coverage through her employment by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 5: Admit that Alina Boyden has received health insurance coverage, and currently receives health insurance coverage through the State of Wisconsin Group Health Insurance Program because she is employed by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 5: ADMIT that Alina Boyden has received State of Wisconsin Group Health Insurance Program coverage, and currently receives State of Wisconsin Group Health Insurance Program coverage in part because she is employed by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 6: Admit that Shannon Andrews has received health insurance coverage, and currently receives health insurance coverage through the State of Wisconsin Group Health Insurance Program because she is employed by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 6: ADMIT.

REQUEST FOR ADMISSION NO. 7: Admit that State of Wisconsin employees who are defined as "eligible employees" under Wis. Stat. § 40.02(25)(b) may receive health insurance coverage through the State of

Wisconsin Group Health Insurance Program.

RESPONSE TO REQUEST FOR ADMISSION NO. 7: ADMIT.

REQUEST FOR ADMISSION NO. 8: Admit that Alina Boyden has received health insurance coverage, and currently receives health insurance coverage, administered by the Wisconsin Department of Employee Trust Funds and the Group Insurance Board because she is employed by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 8: The State Defendants object that the term "administered by" is vague and ambiguous. Subject to and without waiving that objection, ADMIT that Alina Boyden has received State of Wisconsin Group Health Insurance Program coverage, and currently receives State of Wisconsin Group Health Insurance Program coverage, administered by the Wisconsin Department of Employee Trust Funds in part because she is employed by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 9: Admit that Shannon Andrews has received health insurance coverage, and currently receives health insurance coverage administered by the Wisconsin Department of Employee Trust Funds and the Group Insurance Board because she is employed by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 9: The State Defendants object that the term "administered by" is vague and ambiguous. Subject to and without waiving that objection, ADMIT that Shannon Andrews has received State of Wisconsin Group Health Insurance Program coverage, and currently receives State of Wisconsin Group Health Insurance Program coverage, administered by the Wisconsin Department of Employee Trust Funds because she is employed by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 10: Admit that Alina Boyden has received health insurance coverage, and currently receives health insurance coverage whose terms are set by the Wisconsin Group Insurance Board, because she is employed by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 10: The State Defendants object that the term "terms" and the phrase "set by" are vague and ambiguous. Subject to and without waiving this objection, ADMIT that Alina Boyden has received State of Wisconsin Group Health Insurance Program ("Program") coverage, and currently receives Program coverage, whose terms with respect to the Uniform Benefits of the Program are in part set by the Wisconsin Group Insurance Board, in part because she is employed by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 11: Admit that Shannon Andrews has received health insurance coverage, and currently receives health insurance coverage whose terms are set by the Wisconsin Group Insurance Board, because she is employed by the Defendant, Board of Regents.

RESPONSE TO REQUEST FOR ADMISSION NO. 11: The State Defendants object that the term "terms" and the phrase "set by" are vague and ambiguous. Subject to and without waiving this objection, ADMIT that Shannon Andrews has received State of Wisconsin Group Health Insurance Program ("Program") coverage, and currently receives Program coverage, whose terms with respect to the Uniform Benefits of the Program are in part set by the Wisconsin Group Insurance Board, because she is employed by the Defendant, Board of Regents; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 12: Admit that the State of Wisconsin Group Health Insurance Program is administered by the Wisconsin Department of Employee Trust Funds and the Group Insurance Board.

RESPONSE TO REQUEST FOR ADMISSION NO. 12: The State Defendants object that the term "administered by" is vague and ambiguous. Subject to and without waiving that objection, ADMIT that the State of Wisconsin Group Health Insurance Program is administered in part by the

Wisconsin Department of Employee Trust Funds; DENY the remainder of this request.

REQUEST FOR ADMISSION NO. 13: Admit that the terms of the State of Wisconsin Group Health Insurance Program are set by the Group Insurance Board.

RESPONSE TO REQUEST FOR ADMISSION NO. 13: The State Defendants object that the term "terms" and the phrase "set by" are vague and ambiguous. Subject to and without waiving this objection, ADMIT that the terms with respect to the Uniform Benefits of the State of Wisconsin Group Health Insurance Program are set by the Wisconsin Group Insurance Board; DENY the remainder of this Request.

REQUEST FOR ADMISSION NO. 14: Admit that the United States District Court for the Western District of Wisconsin has subject-matter jurisdiction over this Matter.

RESPONSE TO REQUEST FOR ADMISSION NO. 14: The State Defendants object that this Request seeks a legal conclusion without application to relevant facts.

REQUEST FOR ADMISSION NO. 15: Admit that the United States District Court for the Western District of Wisconsin has jurisdiction over this Matter pursuant to Article III of the United States Constitution; 28 U.S.C. §§ 1331, 1343; and 42 U.S.C. § 2000e-5(f)(3).

RESPONSE TO REQUEST FOR ADMISSION NO. 15: The State Defendants object that this Request seeks a legal conclusion without application to relevant facts.

REQUEST FOR ADMISSION NO. 16: Admit that the United States District Court for the Western District of Wisconsin has personal jurisdiction over Defendants, State of Wisconsin Department of Employee Trust Funds, State of Wisconsin Group Insurance Board, Robert J. Conlin, Secretary of the Department of Employee Trust Funds, Board of Regents of the University of Wisconsin System, Raymond W. Cross, President of the University of Wisconsin System, Rebecca M. Blank, Chancellor of the University of Wisconsin-Madison and Robert N. Golden, M.D., Dean of the University of Wisconsin School of Medicine and Public Health, because Defendants' principal offices are located in this District.

RESPONSE TO REQUEST FOR ADMISSION NO. 16: ADMIT.

REQUEST FOR ADMISSION NO. 17: Admit that Venue for this Matter is appropriate in the Western District of Wisconsin under 42 U.S.C. § 2000e-5(f)(3) and 28 U.S.C. § 1391.

RESPONSE TO REQUEST FOR ADMISSION NO. 17: ADMIT.

INTERROGATORY

INTERROGATORY NO. 1: To the extent that any of Plaintiffs' Requests for Admission above is denied or qualified in any way such that your answer is anything other than an unqualified admission, set forth in detail for each such denial or qualification all factual bases for the denial or qualification, and identify all documents that support in any way the refusal to admit unequivocally, together with the identity of the custodian(s) of any such document(s).

RESPONSE TO INTERROGATORY NO. 1:

Request for Admission No. 1**:** The State Defendants deny that either ETF or GIB "provides" group health insurance coverage, to the best of their understanding of the term "provides." Wisconsin Stat. § 40.03(6)(a)1. provides only that GIB "shall, on behalf of the state, enter into a contract or contracts with one or more insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans provided for by this chapter." The State Defendants further deny that Alina Boyden is eligible for group health insurance coverage solely because she is employed by the Defendant, Board of Regents, since Boyden, as a teaching assistant, still must be employed "on at least a one-third full-time basis," Wis. Stat. § 40.02(25)(b)1.–2.

Request for Admission No. 2: The State Defendants deny that either ETF or GIB "provides" group health insurance coverage, to the best of their understanding of the term "provides." Wisconsin Stat. § 40.03(6)(a)1. provides only that GIB "shall, on behalf of the state, enter into a contract or contracts with one or more insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans provided for by this chapter."

Request for Admission No. 3: The State Defendants deny that either ETF or GIB "provides" group health insurance coverage, to the best of their understanding of the term "provides." Wisconsin Stat. § 40.03(6)(a)1. provides only that GIB "shall, on behalf of the state, enter into a contract or contracts with one or more insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans provided for by this chapter."

Request for Admission No. 4: The State Defendants deny that either ETF or GIB "provides" group health insurance coverage, to the best of their understanding of the term "provides." Wisconsin Stat. § 40.03(6)(a)1. provides only that GIB "shall, on behalf of the state, enter into a contract or contracts with one or more insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans provided for by this chapter."

Request for Admission No. 5: The State Defendants deny that Alina Boyden received and receives health insurance coverage solely because she is employed by the Defendant, Board of Regents, since Boyden, as a teaching assistant, still must be employed "on at least a one-third full-time basis," Wis. Stat. § 40.02(25)(b)1.–2.

Request for Admission No. 8: The State Defendants deny that GIB administers health insurance coverage. The State Defendants further deny that Boyden received and receives health insurance coverage solely because she is employed by the Defendant, Board of Regents, since Boyden, as a teaching assistant, still must be employed "on at least a one-third full-time basis," Wis. Stat. § 40.02(25)(b)1.–2.

Request for Admission No. 9: The State Defendants deny that GIB administers health insurance coverage.

Request for Admission No. 10: The State Defendants deny that Boyden received and receives health insurance coverage solely because she is employed by the Defendant, Board of Regents, since Boyden, as a teaching assistant, still must be employed "on at least a one-third full-time basis," Wis. Stat. § 40.02(25)(b)1.–2. The State Defendants further allege that certain Program contract terms aside from the Uniform Benefits (for example, premiums) are subject to negotiation between GIB and participating health plans and others are set by the Wisconsin Legislature

(for example, those regarding eligibility); such terms are not "set by" GIB, to the best of the State Defendants' understanding of the phrase "set by." For further detail, see Wis. Stat. §§ 40.51, 631.95, 632.746(1)–(8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.885, 632.89, 632.895(11)–(17), and 632.897.

Request for Admission No. 11: The State Defendants allege that certain Program contract terms aside from the Uniform Benefits (for example, premiums) are subject to negotiation between GIB and participating health plans and others are set by the Wisconsin Legislature (for example, those regarding eligibility); such terms are not "set by" GIB, to the best of the State Defendants' understanding of the phrase "set by." For further detail, see Wis. Stat. §§ 40.51, 631.95, 632.746(1)–(8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.885, 632.89, 632.895(11)–(17), and 632.897.

Request for Admission No. 12: The State Defendants deny that GIB administers health insurance coverage. The State Defendants further allege that participating health plans and the pharmacy benefits manager also administer aspects of the Wisconsin Group Health Insurance Program.

Request for Admission No. 13: The State Defendants allege that certain State of Wisconsin Group Health Insurance Program contract terms aside from the Uniform Benefits (for example, premiums) are subject to negotiation between

GIB and participating health plans and others are set by the Wisconsin Legislature (for example, those regarding eligibility); such terms are not "set by" GIB, to the best of their understanding of the phrase "set by." For further detail, see Wis. Stat. §§ 40.51, 631.95, 632.746(1)–(8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.885, 632.89, 632.895(11)–(17), and 632.897.

Dated April 27, 2018.

Respectfully submitted,

BRAD D. SCHIMEL
Wisconsin Attorney General

/s/ Colin T. Roth
COLIN T. ROTH
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State Bar #1103985

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VERIFICATION OF INTERROGATORY RESPONSES

I, Michael S. Farrell, Chairperson of the State of Wisconsin Group Insurance Board, believe based on reasonable inquiry that the foregoing responses regarding Interrogatory No. 1 (Requests for Admission Nos. 1 (first sentence), 2, 3, 4, 8 (first sentence), 9, 10 (second sentence), 11, 12, and 13) are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 4/26/18

MICHAEL S. FARRELL
Chairperson, State of Wisconsin Group Insurance Board

On behalf of Defendant State of Wisconsin Group Insurance Board

VERIFICATION OF INTERROGATORY RESPONSES

I, Eileen K. Mallow, Director of the Office of Strategic Health Policy for the State of Wisconsin Department of Employee Trust Funds, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories No. 1 (Requests for Admission Nos. 1, 2, 3, 4, 5, 8 (second sentence), 10, 11, 12, and 13) are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 4/27/18

Eileen K Mallow

EILEEN K. MALLOW
Director of the Office of Strategic Health Policy, State of Wisconsin Department of Employee Trust Funds

On behalf of Defendant State of Wisconsin Department of Employee Trust Funds

VERIFICATION OF INTERROGATORY RESPONSES

I, Jessica Lathrop, Executive Director and Corporate Secretary for the Board of Regents of the University of Wisconsin System, believe based on reasonable inquiry that the foregoing responses regarding Interrogatory No. 1 (Requests for Admission Nos. 1 (second sentence), 5, 8 (second sentence), and 10 (first sentence)) are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 24 April, 2018

JESSICA LATHROP
Executive Director and Corporate Secretary,
Board of Regents of the University of
Wisconsin System

VERIFICATION OF INTERROGATORY RESPONSES

I, Diane S. Blaskowski, Director of Employee Services for the University of Wisconsin–Madison, believe based on reasonable inquiry that the foregoing responses regarding Interrogatory No. 1 (Requests for Admission Nos. 1 (second sentence), 5, 8 (second sentence), and 10 (first sentence)) are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 4/27/2018

Diane S. Blaskowski

DIANE S. BLASKOWSKI
Director of Employee Services, University of Wisconsin–Madison

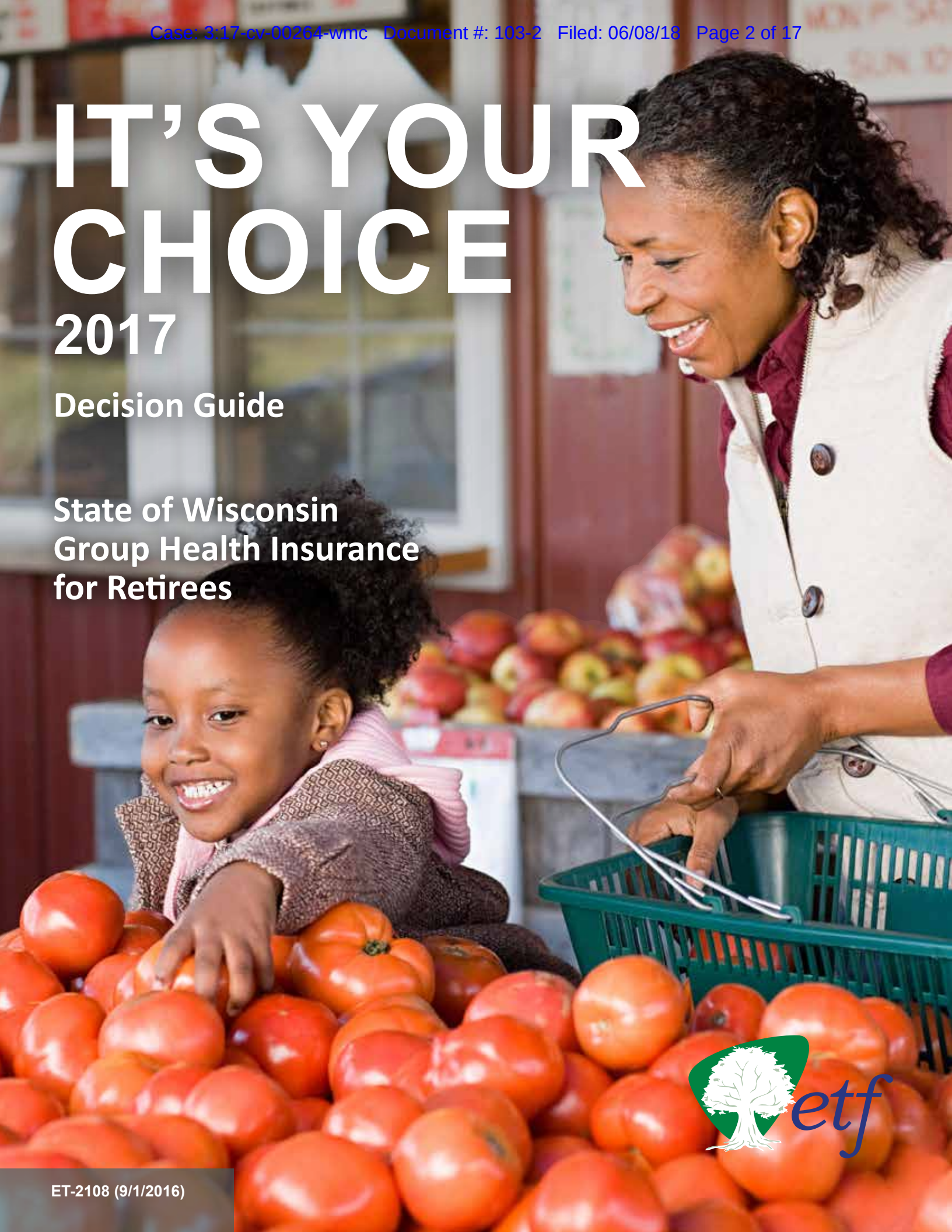
On behalf of Defendant Board of Regents

Exhibit B

IT'S YOUR CHOICE 2017

Decision Guide

State of Wisconsin Group Health Insurance for Retirees



etf

ET-2108 (9/1/2016)

KNOW YOUR BENEFIT ENROLLMENT POINTS

There are certain times throughout the year when you may enroll for health and supplemental insurance benefits, or change your coverage. Visit It's Your Choice 2017 at etf.wi.gov/IYC2017 to learn more about the choices available to you.

OPEN ENROLLMENT: OCT 17- NOV 11

The It's Your Choice 2017 open enrollment period is **October 17, 2016 through November 11, 2016**. This is your opportunity to change health plans, change from family to single coverage, enroll if you had previously deferred coverage, cancel coverage for yourself or an adult dependent child and more.

Open enrollment is available to all who are eligible under the State of Wisconsin Group Health Insurance Program. This includes employees, retirees, currently insured COBRA continuants, surviving spouses and dependents. Changes in coverage become effective January 1, 2017.

Due to November 11 being a federal holiday, mailed applications must be postmarked by November 10, 2016. ETF offices will be open to accept applications.

NEW RETIREE

When you retire, your health insurance plan (if you are enrolled) will automatically continue in most circumstances. If you terminate employment after 20 years of creditable service but are not eligible for an immediate annuity, you may continue your coverage by filing a *Continuation-Conversion Notice* (ET-2311) form with ETF within 90 days of your employment termination date. This form is available online or by contacting ETF.

If you are enrolled in any optional insurance plans that you wish to continue, you must return a continuation form directly to the insurance vendor.

NEW TO MEDICARE

If you are eligible for Medicare, you and your Medicare-eligible dependents must be enrolled in the hospital (Part A) and medical (Part B) portions of Medicare at the time of your retirement, as soon as you turn age 65 or have another Medicare enrollment opportunity. You will then automatically be enrolled in the prescription drug (Part D) plan, Navitus MedicareRx (PDP), offered by Navitus and underwritten by Dean Health Insurance Inc. Because all It's Your Choice plans have coverage options that are coordinated with Medicare, you will remain covered by your health plan even after you enroll in Medicare. Please contact ETF if you do not receive the required *Medicare Eligibility Statement* (ET-4307) at least one month before your 65th birthday, or if you have been on Social Security disability for 24 months.

LIFE CHANGE EVENT

Did you recently have a change in marital status, enter into a domestic partnership, have an eligible move to a new county or have another life change event? You may have the opportunity to enroll or change your coverage outside of the open enrollment period. There are various rules related to life change events. Check out the *Life Changes and Coverage Changes* chart on the Helpful Info tab at etf.wi.gov/IYC2017 to see what your options are and how long you have to submit an application to enroll or make a change.

WHAT IS CHANGING IN 2017

This section highlights the most significant changes for 2017. Visit etf.wi.gov/IYC2017 for complete information.

WELL WISCONSIN PROGRAM

The $150 Well Wisconsin incentive will continue to be available to you and your enrolled spouse or domestic partner. Starting in 2017, all aspects of the Well Wisconsin Program, including payment of the incentive, will be administered by StayWell®, not your health plan.

Note: Individuals enrolled in the IYC Medicare Advantage Plan are not eligible for the Well Wisconsin incentive, but will have access to the online wellness tools and services.

HEALTH PLAN CHANGES TO NOTE

- A new offering by Security Health Plan in the Fox Valley, called Security Health Plan - Valley
- WEA Trust South Central, covering Dane County, will no longer be available
- Anthem Blue Preferred Southeast will no longer be available
- Arise Health Plan - Aspirus Arise will no longer be available
- HealthPartners Health Plan will no longer be covering Grant or Vernon counties
- State Maintenance Plan (SMP) will no longer be available in Vilas County

If you are enrolled in one of the health plans that will no longer be available, you will need to choose a different plan during It's Your Choice open enrollment. Check out the Compare Plans tab at etf.wi.gov/IYC2017 to help you select a new health plan.

PROVIDER NETWORK CHANGES

Network Health will no longer cover services by ThedaCare providers.

Health plans can change provider networks each year. Check out the interactive map at etf.wi.gov/IYC2017 to confirm your health plan service area and provider network is available for 2017.

MEDICAL BENEFITS

There will no longer be an exclusion related to benefits or services based on gender identity.

Note: It's Your Choice Medicare Plus pays only for services that Medicare covers. Please contact WPS at 1-800-634-6448 if you have a specific question about benefits.

INCREASED HSA CONTRIBUTION LIMIT

The individual contribution limit will increase by $50, to $3,400. The family contribution limit will not change. The annual catch-up contribution limit for those between 55-65 years old will not change.

OPTIONAL PLANS

EPIC Dental Wisconsin and EPIC Benefits+ will both offer special enrollment for retirees during IYC in 2017.

EPIC Dental Wisconsin, EPIC Benefits+ and Anthem DentalBlue have rate changes for 2017.

$150 WELL WISCONSIN INCENTIVE - NEW VENDOR

StayWell® and Well Wisconsin

Starting in 2017, the State of Wisconsin Group Health Insurance Program will be contracting with StayWell® for administration of the Well Wisconsin Program and new disease management programs. The mobile-friendly StayWell® wellness portal will provide you with access to the tools and resources you need to earn the $150 incentive and support your health goals, including health coaching and integration with your fitness tracker. Watch for more information from StayWell® on how to access the new portal and earn your 2017 incentive. StayWell® is a registered trademark of StayWell® Company, LLC.

Visit wellwisconsin.wi.gov for more information.

All health and wellness incentives paid to ETF members by the health plan or StayWell® are considered taxable income to the subscriber and are reported to your employer. Health information, including individual responses to the health survey, are protected by federal law and will not be shared with ETF or your employer.

WELL WISCONSIN
Healthier starts with you

HOW TO CHOOSE YOUR HEALTH PLAN

Now that you know when you can enroll and make changes, take these steps for choosing a plan.

STEP 1. CHOOSE A PLAN DESIGN

Consider the different plan design options below.

STEP 2. FIND PLANS IN YOUR AREA

Use the interactive health plan map at It's Your Choice 2017 at etf.wi.gov/IYC2017 or the table on Page 5 to determine which plans and providers are available in your county.

STEP 3. CHOOSE A HEALTH PLAN

Check out each plan's overall performance rating (Page 4), and compare benefits and your premium and out-of-pocket costs (Pages 7-13). Also learn about ways to supplement your coverage on Page 6.

STEP 4. ENROLL OR MAKE A CHANGE

Visit It's Your Choice 2017 at etf.wi.gov/IYC2017 for information on how to enroll online. A paper *Health Insurance Application/Change* (ET-2301) form is also available online, or from ETF.

PLAN DESIGN OPTIONS

Below are the health plan designs you have to choose from. Take a moment to read about these options and see which one is best for you. Not everyone is eligible for a high deductible health plan; see etf.wi.gov/IYC2017 for eligibility information.You can find helpful comparison charts on Pages 7-13.

RETIREES WITH MEDICARE

IT'S YOUR CHOICE HEALTH PLAN MEDICARE

This plan offers uniform benefits and is coordinated with your Medicare coverage, allowing you to choose from a variety of health plan providers.

IT'S YOUR CHOICE MEDICARE ADVANTAGE

This plan is offered by Humana and allows members to use any health care provider in the United States that accepts Medicare. Benefits are the same in- and out-of-network. If you decide to seek care from an out-of-network provider, your share of the costs may be slightly higher for medical equipment or supplies.

IT'S YOUR CHOICE MEDICARE PLUS

This is a fee-for-service Medicare supplement plan administered by WPS. This plan is available to eligible retirees enrolled in Medicare Parts A and B and generally only pays Medicare deductibles and coinsurance. It's Your Choice Medicare Plus permits you and your eligible dependents to receive care from any qualified health care provider nationwide, or during worldwide travel, for treatment covered by the plan.

RETIREES WITHOUT MEDICARE

IT'S YOUR CHOICE HEALTH PLAN

This plan allows you to choose from a variety of health plan providers that offer the same uniform benefits package.

IT'S YOUR CHOICE HIGH DEDUCTIBLE HEALTH PLAN

This plan is available to retirees younger than age 65. It provides you with the same uniform benefits package and health plan providers as the It's Your Choice Health Plan. The difference is that this plan has a higher deductible and out-of-pocket limits. In exchange for the increased cost sharing, this plan offers a lower monthly premium cost and is paired with a required Health Savings Account (HSA). If you decide to enroll in this plan, you must open and contribute to the HSA. (You can find more information on page 6.)

IT'S YOUR CHOICE ACCESS HEALTH PLAN

This plan provides freedom of choice of doctors and hospitals across the country. In exchange for the increased flexibility in medical providers, your monthly premium cost is higher.

IT'S YOUR CHOICE ACCESS HIGH DEDUCTIBLE HEALTH PLAN

This plan is available to retirees younger than age 65. It provides freedom of choice of doctors and hospitals across the country, along with a higher deductible and out-of-pocket limits. In exchange for the increased cost sharing, this plan offers a lower monthly premium cost and is paired with a Health Savings Account (HSA). If you decide to enroll in this plan, you must open and contribute to the HSA. (You can find more information on Page 6.)

PLAN RATINGS

The overall performance ratings chart below is based on several quality measures. Visit It's Your Choice 2017 at etf.wi.gov/IYC2017 to see detailed health plan report cards.

HEALTH PLAN PROVIDER RATINGS Health Plan Options	Overall Performance Rating (5 ★ is highest)
Anthem Blue	★★★☆☆
Arise Health Plan	★★☆☆☆
Dean Health Insurance	★★★★★
GHC of Eau Claire	★★★☆☆
GHC of South Central Wisconsin	★★★☆☆
Gundersen Health Plan	★★★★☆
Health Tradition Health Plan	★★★☆☆
HealthPartners Health Plan	★★★★★
Humana	★★☆☆☆
Medical Associates Health Plans	★★☆☆☆
MercyCare Health Plans	★★★☆☆
Network Health	★☆☆☆☆
Physicians Plus	★★★☆☆
Security Health Plan	★★★★☆
State Maintenance Plan	Not available
UnitedHealthcare of Wisconsin	★☆☆☆☆
Unity Health Insurance	★★★☆☆
WEA Trust	★★★☆☆

For health plans available in your county* and more details, visit It's Your Choice 2017 at
etf.wi.gov/IYC2017

*See the It's Your Choice health plan providers table on Page 5 or the interactive health plan map at etf.wi.gov/IYC2017 to see which plans are available in your county.

QUESTIONS AND ANSWERS

Q DO I NEED TO DO ANYTHING DURING OPEN ENROLLMENT?

A Yes! Review important changes for 2017 and your:

- ✓ health plan provider network
- ✓ health plan service area
- ✓ plan design options
- ✓ dental options
- ✓ options to supplement your coverage

For more information, or if you want to make changes, visit etf.wi.gov/IYC2017.

Generally, if you are not changing coverage, you don't need to do anything during open enrollment. You should still be sure you understand how your coverage may change in 2017.

Q HOW DO I STAY INFORMED ABOUT IMPORTANT UPDATES?

A Sign up for It's Your Choice e-alerts on health and wellness benefits, and related topics of interest. Visit etf.wi.gov and look for ETF E-mail Updates.

Q WHAT IF I DO NOT HAVE ACCESS TO THE INTERNET?

A You can contact ETF using the contact information on the back of this guide to request printed information to be mailed to you.

Q HOW DO I ENROLL OR MAKE CHANGES?

A Visit It's Your Choice 2017 at etf.wi.gov/IYC2017 to find out how you can enroll or make changes online or download a *Health Insurance Application/Change* (ET-2301) form anytime at etf.wi.gov/publications/et2301.pdf or request this form by contacting ETF.

Q WHERE CAN I FIND NOTICES?

A Visit etf.wi.gov/IYC2017 for EEOC, COBRA, ACA marketplace and more federal and state notices.

Visit It's Your Choice 2017 at etf.wi.gov/IYC2017 for more FAQs

WHAT HEALTH PLAN PROVIDERS ARE NEAR ME?

The table below shows health plan availability by county; health plans in red have limited provider availability in that area.

It's Your Choice Access, Medicare Advantage and Medicare Plus plans are available in all counties.

Visit It's Your Choice 2017 at etf.wi.gov/IYC2017 for an interactive health plan map.

Health Plan Codes

AE	Anthem Blue Preferred - Northeast	**HE**	Humana - Eastern	**SMP**	State Maintenance Plan - WPS
AH	Arise Health Plan	**HW**	Humana - Western	**UH**	UnitedHealthcare of Wisconsin
D	Dean Health Insurance	**MA**	Medical Associates Health Plans	**UC**	Unity Health Insurance - Community
D3	Dean Health Insurance - Prevea360	**MC**	MercyCare Health Plans	**UW**	Unity Health Insurance - UW Health
GEC	GHC of Eau Claire	**NN**	Network Health Northeast	**WT**	WEA Trust - East
GSC	GHC of South Central Wisconsin	**NS**	Network Health Southeast	**WV**	WEA Trust - Northwest Chippewa Valley
G	Gundersen Health Plan	**PP**	Physicians Plus	**WM**	WEA Trust - Northwest Mayo Clinic Health System
HT	Health Tradition Health Plan	**SC**	Security Health Plan - Central		
HP	HealthPartners Health Plan	**SV**	Security Health Plan - Valley		

ADAMS D, PP, SC, UC, WT	**FLORENCE** SMP, AH	**MARATHON** AH, GEC, HP, SC, WT	**RUSK** SC, WV, HP
ASHLAND GEC, HP, SC, WV	**FOND DU LAC** AE, AH, D, HE, NN, UC, UH, WT	**MARINETTE** AE, AH, HE, UH, D3, NN	**SAUK** D, G, GSC, HT, PP, UC
BARRON HP, HW, SC, WM, WV	**FOREST** SMP, AH, SC	**MARQUETTE** SMP, AH, D, PP, SV, UC, UH, WT	**SAWYER** GEC, HP, SC
BAYFIELD SMP, GEC, HP, SC, WV	**GRANT** D, G, HT, MA, PP, UC, AH	**MENOMINEE** SMP, AH, WT	**SHAWANO** AE, AH, HE, SV, UH, WT, NN, SC
BROWN AE, AH, D3, HE, NN, SV, UH, WT	**GREEN** D, HE, PP, UC, MC	**MILWAUKEE** AH, HE, NS, UH, WT	**SHEBOYGAN** AE, AH, D3, HE, NN, UH, WT
BUFFALO SMP, HT, WM	**GREEN LAKE** AE, AH , HE, SV, UH, WT, D, NN, PP	**MONROE** G, HP, HT, WM, AH	**ST. CROIX** HP, HW, WV, WM
BURNETT GEC, HP, SC	**IOWA** D, MA, PP, UC	**OCONTO** AE, AH, D3, HE, NN, SV, UH, WT	**TAYLOR** AH, GEC, SC, HP
CALUMET AE, HE, NN, UH, AH, WT	**IRON** SMP, GEC, WV	**ONEIDA** GEC, HP, SC, AH	**TREMPEALEAU** AH, G, HT, HP, SC, WM
CHIPPEWA G, HP, HW, SC, WM, WV	**JACKSON** G, HP, HT, SC, WV	**OUTAGAMIE** AE, AH, HE, NN, SV, UH, WT, D3	**VERNON** G, HT, UC, WM, AH, D, PP
CLARK GEC, HP, SC, WV, AH, G	**JEFFERSON** D, HE, MC, PP, UC, UH, WT, AH	**OZAUKEE** AH, HE, NS, UH, WT	**VILAS** SC, AH, GEC, HP
COLUMBIA D, GSC, PP, UC, WT, AH	**JUNEAU** G, HT, PP, SC, UC, WT, AH, D	**PEPIN** SMP, HT, HW, HP, SC, WV	**WALWORTH** AH, HE, MC, UC, UH, WT, D, PP
CRAWFORD G, HP, HT, MA, AH, WM UC	**KENOSHA** AH, HE, UH	**PIERCE** HP, WV, HW, WM	**WASHBURN** GEC, HP, SC, WV
DANE D, GSC, PP, UW	**KEWAUNEE** AE, AH, UH, WT, D3, HE, NN, SV	**POLK** HP, HW, WV	**WASHINGTON** AH, HE, NS, UH, WT
DODGE AH, D, HE, NN, PP, UH, UC, WT	**LA CROSSE** G, HP, HT, WM, AH	**PORTAGE** HP, SC, WT, AH, NN	**WAUKESHA** AH, D, HE, NS, UC, UH, WT, PP
DOOR AE, AH, HE, NN, UH, WT, D3	**LAFAYETTE** MA, PP, D, UC	**PRICE** GEC, SC, AH, HP	**WAUPACA** AE, AH, HE, SV, UH, WT, NN, SC
DOUGLAS GEC, HP, HW, SC, WV	**LANGLADE** AH, GEC, SC, HP	**RACINE** HE, NS, UH, AH	**WAUSHARA** AH, AE, HE, PP, SV, UH, WT, NN
DUNN HP, HW, WM, WV	**LINCOLN** GEC, HP, SC, AH	**RICHLAND** D, G, HT, PP, UC	**WINNEBAGO** AE, AH, HE, NN, UH, WT, SV
EAU CLAIRE G, HP, HW, SC, WM, WV, AH	**MANITOWOC** AE, AH, D3, HE, NN, UH, WT	**ROCK** D, HE, MC, UC, UH, WT, PP	**WOOD** AH, SC, WT, HP, PP, UC

OPTIONS TO SUPPLEMENT YOUR COVERAGE

More choices mean more opportunities for better health and wellness. Visit It's Your Choice 2017 at etf.wi.gov/IYC2017 to see if you are eligible and when you can enroll. If you are currently enrolled, your enrollment will continue unless you cancel during It's Your Choice open enrollment.

Anthem DentalBlue *Enroll if a qualifying event occurs* ***No open enrollment for 2017***	Dental coverage plan options to supplement Uniform Dental Benefits. A variety of provider and pricing options, including major procedures. Waiting periods may apply.
Mutual of Omaha *Enroll year-round*	Long-term care insurance for you, spouses, domestic partners and parents.
VSP *Enroll during open enrollment*	Vision services from a nationwide network of doctors. Annual frame replacement for children.
EPIC Benefits+ *Will offer new enrollment during 2017 open enrollment for retirees. Coverage will continue for those who are currently enrolled.*	Basic and major dental coverage (not preventive care), hospital and surgical indemnity, and optional vision benefits.
EPIC Dental Wisconsin *Will offer new enrollment during 2017 open enrollment for retirees. Coverage will continue for those who are currently enrolled.*	Dental coverage options to supplement Uniform Dental Benefits. Members can see any dentist. Includes major procedures. Waiting periods may apply.

PRE-TAX SAVINGS

FOR RETIREES ENROLLED IN ONE OF THE HIGH DEDUCTIBLE HEALTH PLANS

HEALTH SAVINGS ACCOUNT (HSA)

Keep more money in your pocket! An HSA is an individually-owned savings account that you ***must*** enroll in if you are enrolled in one of the High Deductible Health Plans. This benefit is established exclusively for the purpose of paying qualified medical expenses.

What are the benefits of an HSA?

- HSA contributions are tax deductible
- Money used for qualified medical expenses is tax-free
- Unused funds roll over year to year
- Interest earned in an HSA is tax-free

Visit etf.wi.gov/IYC2017 for more information on HSA eligibility and enrollment. If you are already enrolled in the HSA, you ***must*** re-enroll each year to continue participation. Elections do not carry forward from year to year.

2017 MEDICAL BENEFITS AT A GLANCE

With Medicare

This comparison chart is not intended to be a complete description of coverage. The Certificate of Coverage found at etf.wi.gov/IYC2017 includes a detailed benefit description. Only medically necessary services and equipment are paid by your health plan. Custodial care is excluded.

Your out-of-pocket costs are indicated in the "You pay" line.

	Most Medicare members are in IYC Medicare IYC Medicare & IYC Medicare Advantage	IYC Medicare Plus[2]
Annual Medical Deductible[1]	**Medicare pays:** Allowable services after Part A ($1,288) and Part B ($166) deductibles **Plan pays:** Part A inpatient hospital deductible of $1,288 and Part B deductible of $166 **You pay:** $0	**Medicare pays:** Allowable services after Part A ($1,288) and Part B ($166) deductibles **Plan pays:** Part A inpatient hospital deductible of $1,288 and Part B deductible of $166 **You pay:** $0
Annual Medical Coinsurance[1]	**Medicare pays:** For Part A, varying coinsurance as listed below for hospital inpatient and skilled nursing facility care. After Part B deductible, 80% **Plan pays:** Part B deductible and 20% coinsurance **You pay:** $0	**Medicare pays:** For Part A, varying coinsurance as listed below for hospital inpatient and skilled nursing facility care. After Part B deductible, 80% **Plan pays:** Part B deductible and 20% coinsurance **You pay:** $0
Annual Medical Out-of-Pocket Limit (OOPL)	None	None
Outpatient illness/injury related services	**Medicare pays:** After Part B deductible, 80% **Plan pays:** Part B deductible and 20% coinsurance **You pay:** $0	**Medicare pays:** After Part B deductible, 80% **Plan pays:** Part B deductible and 20% coinsurance **You pay:** $0
Emergency Room Copay	**Medicare pays:** After Part B deductible, 80% **Plan pays:** Part B deductible and 20% coinsurance **You pay:** $60 copayment (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	**Medicare pays:** After Part B deductible, 80% **Plan pays:** Part B deductible and 20% coinsurance **You pay:** $0
Hospital Semiprivate room and board, and miscellaneous hospital services and supplies such as drugs, X-rays, lab tests and operating room. "Lifetime reserve" days are a one-time additional 60 days of hospital coverage paid by Medicare.	**Medicare pays:** After Part A deductible; full cost for the first 60 days 61st to 90th day, all but $322 per day 91st to 150th day, all but $644 per day (if using "lifetime reserve"), if "lifetime reserve" days are exhausted, $0 **Plan pays:** 100% as medically necessary, plan providers only. No day limit **You pay:** $0	**Medicare pays:** After Part A deductible; full cost for the first 60 days 61st to 90th day, all but $322 per day 91st to 150th day, all but $644 per day (if using "lifetime reserve), if "lifetime reserve" days are exhausted, $0 **Plan pays:** Initial Part A deductible of $1,288 for the first 60 days 61st to 90th day, $322 per day 91st to 150th day, $644 per day if under "lifetime reserve" period **You pay:** $0 for first 90 days of confinement, and up to 150 under "lifetime reserve." Once "lifetime reserve" is exhausted, you pay the full cost after 90 days

OOPL = out-of-pocket limit

[1]Medicare deductible and coinsurance amounts listed are from 2016. After Medicare releases the 2017 amounts in the late fall, ETF will update this chart online. Medicare deductible amounts are listed only to describe how your benefits work under the available plan designs. Your out-of-pocket costs are indicated in the "You pay" line.
[2]IYC Medicare Plus pays only for services that Medicare covers. You pay the full cost of any non-covered services.

	IYC Medicare & IYC Medicare Advantage	IYC Medicare Plus[2]
Licensed Skilled Nursing Facility Medicare covered services in a Medicare approved facility	**Medicare pays:** Requires a 3-day period of hospital stay, 100% for the first 20 days 21st to 100th days, all but $161 per day Beyond 100 days, $0 **Plan pays:** 100% as medically necessary, for the first 120 days per benefit period; plan providers only Beyond 120 days, $0 **You pay:** $0 for the first 120 days, full cost after 120 days	**Requires a 3-day period of hospital stay** **Medicare pays:** 100% for the first 20 days 21st to 100th days, all but $161 per day Beyond 100 days, $0 **Plan pays:** 21st to 100th days, $161 per day 101st to 120th days, all covered services up to a maximum of 120 days per benefit period Beyond 120 days, $0 **You pay**: $0 for the first 120 days, full cost after 120 days
Licensed Skilled Nursing Facility (Non-Medicare approved facility) If admitted within 24 hours following a hospital stay	**Medicare pays:** $0 **Plan pays:** 120 days per benefit period for skilled care in a facility licensed in a state **You pay:** Full cost after 120 days	**Medicare pays:** $0 **Plan pays:** Maximum daily rate for up to 30 days per confinement; covers only the same type of expenses normally covered by Medicare in a Medicare-approved facility **You pay:** $0 for eligible expenses for the first 30 days, full cost after 30 days
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	For Medicare-approved supplies: **Medicare pays:** After Part B deductible, 80% **Plan pays:** If you have not met the Part B deductible, 80% If you have met the Part B deductible, but you have not met the $500 OOPL per participant, 0% If you have met the Part B deductible, and also the $500 OOPL per participant, 20% **You pay:** 20% up to $500 OOPL per participant, after OOPL, $0	For Medicare-approved supplies: **Medicare pays:** After Part B deductible, 80% **Plan pays:** Part B deductible and 20% coinsurance **You pay:** $0
	For supplies NOT covered by Medicare: **Medicare pays:** None **Plan pays:** If you have not met the $500 OOPL per participant, 80% If you have met the $500 OOPL per participant, 100% **You pay:** 20% up to $500 OOPL per participant, after OOPL, $0	For supplies NOT covered by Medicare: **Medicare pays:** None **Plan pays:** None **You pay:** Full cost of supplies
Home Health Care Under an approved plan of care, part-time services of an RN, LPN or home health aide; physical, respiratory, speech or occupational therapy; medical supplies, drugs, lab services and nutritional counseling.	**Medicare pays:** 100% of charges for visits considered medically necessary by Medicare, generally 5 visits per week for 2 to 3 weeks; or 4 or fewer visits per week as long as required **Plan pays:** 100% for 50 visits per year, plan may approve an additional 50 visits IYC Medicare Advantage has no visit limits **You pay:** Full costs of visits not covered by Medicare and the plan beyond the 50 (or if approved, 100) visits per year	**Medicare pays:** 100% of charges for visits considered medically necessary by Medicare, generally 5 visits per week for 2 to 3 weeks; or 4 or fewer visits per week as long as required **Plan pays:** 100% for up to 365 visits per year **You pay:** Full costs of visits beyond 365 per year
Hearing Exam	For routine exams: **Medicare pays:** None **Plan pays:** 100% **You pay:** $0	For routine exams: **Medicare pays:** None **Plan pays:** None **You pay:** Full cost of hearing exam
	For illness or disease: **Medicare pays:** After Part B deductible, 80% **Plan pays:** Deductible and 20% coinsurance **You pay:** $0	For illness or disease: **Medicare pays:** After Part B deductible, 80% **Plan pays:** Deductible and 20% coinsurance **You pay:** $0
Hearing Aid (per ear)	**Medicare pays:** No coverage for adults **Plan pays:** 80% for adults up to plan paid $1,000 every three years (does not count toward OOPL) **You pay:** 20% coinsurance and 100% of costs exceeding plan payment of $1,000	**Medicare pays:** No coverage for adults **Plan pays:** None **You pay:** Full cost of hearing aid

MEDICAL BENEFITS AT A GLANCE

Without Medicare

The information below will help you compare the benefits available through the different

Most members are in this plan

	IYC Health Plan	IYC HDHP
Annual Medical Deductible	$250 individual / $500 family After an individual within a family plan meets the $250 deductible, benefits apply as described below Deductible applies to annual out-of-pocket limit (OOPL) Medical deductible does not apply to office visit copayments, preventive services* or prescription drugs	$1,500 individual / $3,000 family The deductible must be met before coverage begins; for family coverage, the full family deductible must be met The deductible includes prescription drugs and applies to OOPL
Primary Care Physician Office Visit Copayment includes: • Internist • General Physician • Family Practitioner • Pediatrician • Gynecologist/Obstetrician • Nurse Practitioner • Physician Assistant • Chiropractor • Physical/Occupational/Speech Therapy in an office visit setting	You pay $15 copayment per visit up to OOPL Office visit copayments are not subject to the deductible Additional services such as lab work, X-rays, etc., are subject to the deductible and coinsurance	You pay the full allowed amount of an office visit until deductible is met After deductible: You pay $15 copayment per office visit up to OOPL Coinsurance will apply to additional services such as lab work, X-rays, etc.
Specialty Office Visit Copayment includes: • Specialty Providers • Urgent Care • Vision Exam in an office visit setting	You pay $25 copayment per visit up to OOPL Office visit copayments are not subject to the deductible Additional services such as lab work, X-rays, etc., are subject to the deductible and coinsurance	You pay the full allowed amount of an office visit until deductible is met After deductible: You pay $25 copayment per office visit up to OOPL Coinsurance will apply to additional services such as lab work, X-rays, etc.
Annual Medical Coinsurance	After deductible: You pay 10% coinsurance up to OOPL Applies to medical services except for office visit or emergency room copayments and preventive services*	You pay the full allowed amount of services until deductible is met After deductible: You pay 10% coinsurance up to OOPL Applies to medical services except for office visit or emergency room copayments and preventive services*
Annual Medical Out-of-Pocket Limit (OOPL)	$1,250 individual / $2,500 family	$2,500 individual / $5,000 family For family coverage, you must meet the full family OOPL before your plan pays 100%
Routine, Preventive Services as Required by Federal Law	Plan pays 100%, not subject to deductible For details visit www.healthcare.gov/preventive-care-benefits/	Plan pays 100%, not subject to deductible For details visit www.healthcare.gov/preventive-care-benefits/
Illness/Injury Related Services Beyond the Office Visit Copayment (if applicable)	After deductible: You pay 10% coinsurance up to OOPL Applies to medical services except for office visit or emergency room copayments	You pay the full allowed amount of services until deductible is met After deductible: You pay 10% coinsurance up to OOPL Applies to medical services except for office visit or emergency room copayments
Emergency Room Copayment (waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer)	You pay $75 copayment per visit, then the deductible and coinsurance applies to services beyond the copayment up to OOPL	You pay the full allowed amount of services until deductible is met After deductible: You pay $75 copayment per visit, then coinsurance applies to services beyond the copayment up to OOPL

HDHP = High Deductible Health Plan OOPL = out-of-pocket limit *Routine, preventive services as required by federal law

It's Your Choice (IYC) health plan design options for retirees without Medicare. Complete information is available online.

IYC Access Health Plan In-Network	IYC Access Health Plan Out-of-Network	IYC Access HDHP In-Network	IYC Access HDHP Out-of-Network
$250 individual / $500 family After an individual within a family plan meets the $250 deductible, coinsurance will apply to covered medical services except for office visit copayments Deductible applies to annual OOPL Medical deductible does not apply to prescription drugs	$500 individual / $1,000 family After an individual within a family plan meets the $500 deductible, coinsurance will apply to covered medical services Deductible applies to annual OOPL Medical deductible does not apply to prescription drugs	$1,700 individual / $3,400 family The deductible must be met before coverage begins; for family coverage, the full family deductible must be met The deductible includes prescription drugs and applies to OOPL	$2,000 individual / $4,000 family The deductible must be met before coverage begins; for family coverage, the full family deductible must be met The deductible includes prescription drugs and applies to OOPL
You pay $15 copayment per visit up to OOPL Office visit copayments are not subject to the deductible Additional services such as lab work, X-rays, etc., are subject to the deductible and coinsurance	After deductible: You pay 30% coinsurance up to OOPL	You pay the full allowed amount of an office visit until deductible is met After deductible: You pay $15 copayment per office visit up to OOPL Coinsurance will apply to additional services such as lab work, X-rays, etc.	You pay the full allowed amount of an office visit until deductible is met After deductible: You pay 30% coinsurance up to OOPL
You pay $25 copayment per visit up to OOPL Office visit copayments are not subject to the deductible Additional services such as lab work, X-rays, etc., are subject to the deductible and coinsurance	After deductible: You pay 30% coinsurance up to OOPL	You pay the full allowed amount of an office visit until deductible is met After deductible: You pay $25 copayment per office visit up to OOPL Coinsurance will apply to additional services such as lab work, X-rays, etc.	You pay the full allowed amount of an office visit until deductible is met After deductible: You pay 30% coinsurance up to OOPL
After deductible: You pay 10% coinsurance up to OOPL Applies to medical services except for office visit or emergency room copayments and preventive services*	After deductible: You pay 30% coinsurance up to OOPL Applies to medical services except for emergency room copayments	You pay the full allowed amount of services until deductible is met After deductible: You pay 10% coinsurance up to OOPL Applies to medical services except for office visit or emergency room copayments and preventive services*	You pay the full allowed amount of services until deductible is met After deductible: You pay 30% coinsurance up to OOPL Applies to medical services except for emergency room copayments
$1,000 individual / $2,000 family	$2,000 individual / $4,000 family	$3,500 individual / $6,550 family For family coverage, you must meet the full family OOPL before your plan pays 100%	$3,800 individual / $7,600 family For family coverage, you must meet the full family OOPL before your plan pays 100%
Plan pays 100% For details visit www.healthcare.gov/preventive-care-benefits/	Subject to the deductible and coinsurance	Plan pays 100% For details visit www.healthcare.gov/preventive-care-benefits/	Subject to the deductible and coinsurance
After deductible: You pay 10% coinsurance up to OOPL Applies to medical services except for office visit or emergency room copayments	After deductible: You pay 30% coinsurance up to OOPL Applies to medical services except for emergency room copayments	You pay the full allowed amount of services until deductible is met After deductible: You pay 10% coinsurance up to OOPL Applies to medical services except for office visit or emergency room copayments	You pay the full allowed amount of services until deductible is met After deductible: You pay 30% coinsurance up to OOPL Applies to medical services except for emergency room copayments
You pay $75 copayment per visit, then the deductible and coinsurance applies to services beyond the copayment up to OOPL	You pay $75 copayment per visit, then in-network deductible and coinsurance applies to services beyond the copayment up to OOPL	You pay the full allowed amount of services until deductible is met After deductible: You pay $75 copayment per visit, then coinsurance applies to services beyond the copayment up to OOPL	You pay the full allowed amount of services until deductible is met After deductible: You pay $75 copayment per visit, then coinsurance applies to services beyond the copayment up to OOPL

MEDICAL WITH DENTAL COVERAGE

The non-Medicare and Medicare rates below reflect health care coverage that includes medical **with dental**.
These are the total monthly premium rates that you would pay.

Health Plan Name	Non-Medicare Rates				Medicare Rates		
	IYC Health Plan		HDHP[1]		IYC Health Plan Medicare[1]		
	Single	Family	Single	Family	Medicare Single	Medicare 1[2]	Medicare 2[3]
Anthem Blue Preferred Northeast	793.86	1,960.48	688.84	1,697.88	573.94	1,351.64	1,145.66
Arise Health Plan	809.46	1,999.48	702.34	1,731.68	581.94	1,375.24	1,161.66
Dean Health Insurance	653.76	1,610.18	568.44	1,396.88	477.34	1,114.94	952.46
Dean Health Insurance - Prevea 360	713.96	1,760.68	620.14	1,526.18	527.64	1,225.44	1,053.06
GHC of Eau Claire	786.56	1,942.18	682.64	1,682.38	528.24	1,298.64	1,054.26
GHC of South Central Wisconsin	657.06	1,618.48	571.24	1,403.88	505.74	1,146.64	1,009.26
Gundersen Health Plan	819.56	2,024.68	710.94	1,753.18	496.04	1,299.44	989.86
Health Tradition Health Plan	811.66	2,004.98	704.24	1,736.38	469.04	1,264.54	935.86
HealthPartners Health Plan	736.96	1,818.18	639.94	1,575.68	545.74	1,266.54	1,089.26
Humana - Eastern	822.36	2,031.68	713.44	1,759.38	439.84	1,246.04	877.46
Humana - Western	879.76	2,175.18	762.74	1,882.68	439.84	1,303.44	877.46
IYC Access Health Plan *and* IYC Medicare Plus[4]	1,400.42	3,494.94	1,185.52	2,957.68	397.02	1,804.08	802.34
Medical Associates Health Plans	721.16	1,778.68	626.34	1,541.68	434.24	1,139.24	866.26
MercyCare Health Plans	652.26	1,606.48	567.14	1,393.68	456.34	1,092.44	910.46
Network Health Northeast	782.86	1,932.98	679.44	1,674.38	503.64	1,270.34	1,005.06
Network Health Southeast	773.56	1,909.68	671.44	1,654.38	477.64	1,235.04	953.06
Physicians Plus	692.66	1,707.48	601.84	1,480.38	465.14	1,141.64	928.06
Security Health Plan - Central	867.46	2,144.48	752.14	1,856.18	610.94	1,462.24	1,219.66
Security Health Plan - Valley	841.56	2,079.68	729.94	1,800.68	598.04	1,423.44	1,193.86
State Maintenance Plan (SMP)	868.56	2,165.18	738.06	1,838.98	397.02	1,266.14	802.34
Unitedhealthcare of Wisconsin	789.26	1,948.98	684.94	1,688.18	571.84	1,344.94	1,141.46
Unity Health Insurance - Community	765.16	1,888.68	664.24	1,636.38	505.14	1,254.14	1,008.06
Unity Health Insurance - UW Health	679.56	1,674.68	590.54	1,452.18	470.04	1,133.44	937.86
WEA Trust - East	823.26	2,033.98	714.14	1,761.18	489.14	1,296.24	976.06
WEA Trust - Northwest Chippewa Valley	864.46	2,136.98	749.64	1,849.88	503.54	1,351.84	1,004.86
WEA Trust - Northwest Mayo Clinic Health Sys.	864.46	2,136.98	749.64	1,849.88	503.54	1,351.84	1,004.86

[1]Medicare rates do not apply to the HDHP.
[2]Medicare 1 = Family coverage with at least one insured family member enrolled in Medicare Parts A, B and D.
[3]Medicare 2 = Family coverage with all insured family members enrolled in Medicare Parts A, B and D.
[4]Members with IYC Access Health Plan or SMP coverage who become enrolled in Medicare Parts A and B will automatically be moved to the IYC Medicare Plus plan. All other non-Medicare family members will remain covered under the IYC Access Health Plan or SMP.

MEDICAL WITHOUT DENTAL COVERAGE

The non-Medicare and Medicare rates below reflect health care coverage that includes medical **without dental**. These are the total monthly premium rates that you would pay. See footnotes on Page 11.

Health Plan Name	Non-Medicare Rates				Medicare Rates		
	IYC Health Plan		HDHP[1]		IYC Health Plan Medicare[1]		
	Single	Family	Single	Family	Medicare Single	Medicare 1[2]	Medicare 2[3]
Anthem Blue Preferred Northeast	766.02	1,890.86	661.00	1,628.26	546.10	1,295.96	1,076.04
Arise Health Plan	781.62	1,929.86	674.50	1,662.06	554.10	1,319.56	1,092.04
Dean Health Insurance	625.92	1,540.56	540.60	1,327.26	449.50	1,059.26	882.84
Dean Health Insurance - Prevea 360	686.12	1,691.06	592.30	1,456.56	499.80	1,169.76	983.44
GHC of Eau Claire	758.72	1,872.56	654.80	1,612.76	500.40	1,242.96	984.64
GHC of South Central Wisconsin	629.22	1,548.86	543.40	1,334.26	477.90	1,090.96	939.64
Gundersen Health Plan	791.72	1,955.06	683.10	1,683.56	468.20	1,243.76	920.24
Health Tradition Health Plan	783.82	1,935.36	676.40	1,666.76	441.20	1,208.86	866.24
HealthPartners Health Plan	709.12	1,748.56	612.10	1,506.06	517.90	1,210.86	1,019.64
Humana - Eastern	794.52	1,962.06	685.60	1,689.76	412.00	1,190.36	807.84
Humana - Western	851.92	2,105.56	734.90	1,813.06	412.00	1,247.76	807.84
IYC Access Health Plan *and* IYC Medicare Plus[4]	1,372.58	3,425.32	1,157.68	2,888.06	369.18	1,748.40	732.72
Medical Associates Health Plans	693.32	1,709.06	598.50	1,472.06	406.40	1,083.56	796.64
MercyCare Health Plans	624.42	1,536.86	539.30	1,324.06	428.50	1,036.76	840.84
Network Health Northeast	755.02	1,863.36	651.60	1,604.76	475.80	1,214.66	935.44
Network Health Southeast	745.72	1,840.06	643.60	1,584.76	449.80	1,179.36	883.44
Physicians Plus	664.82	1,637.86	574.00	1,410.76	437.30	1,085.96	858.44
Security Health Plan - Central	839.62	2,074.86	724.30	1,786.56	583.10	1,406.56	1,150.04
Security Health Plan - Valley	813.72	2,010.06	702.10	1,731.06	570.20	1,367.76	1,124.24
State Maintenance Plan (SMP)	840.72	2,095.56	710.22	1,769.36	369.18	1,210.46	732.72
Unitedhealthcare of Wisconsin	761.42	1,879.36	657.10	1,618.56	544.00	1,289.26	1,071.84
Unity Health Insurance - Community	737.32	1,819.06	636.40	1,566.76	477.30	1,198.46	938.44
Unity Health Insurance - UW Health	651.72	1,605.06	562.70	1,382.56	442.20	1,077.76	868.24
WEA Trust - East	795.42	1,964.36	686.30	1,691.56	461.30	1,240.56	906.44
WEA Trust - Northwest Chippewa Valley	836.62	2,067.36	721.80	1,780.26	475.70	1,296.16	935.24
WEA Trust - Northwest Mayo Clinic Health Sys.	836.62	2,067.36	721.80	1,780.26	475.70	1,296.16	935.24

HOW MUCH ARE MY PRESCRIPTION DRUGS?

The 2017 Pharmacy Benefit Plan comparison table below shows what amount or percentage you would pay for prescription drugs under each plan. For example, with the It's Your Choice Health Plan the out-of-pocket limit (OOPL), or maximum, you would pay for Levels 1 and 2 drugs is $600 for an individual and $1,200 for family coverage. All covered prescription drugs (Rx) fall into one of four cost-sharing levels, including Level 1 for most generic drugs and Levels 2, 3 and 4 for most brand-name drugs. Navitus is the plan administrator.

Most members are in this plan

	IYC Health Plan	IYC HDHP	IYC Access Health Plan In-Network	IYC Access Health Plan Out-of-Network	IYC Access HDHP In-Network	IYC Access HDHP Out-of-Network
Deductible[1]						
An annual fixed dollar amount a member pays before the plan pays.						
	None	$1,500 individual / $3,000 family (combined medical & Rx)	None	None	$1,700 individual / $3,400 family (combined medical & Rx)	$2,000 individual / $4,000 family (combined medical & Rx)
Copayment/Coinsurance						
A dollar amount or percentage a member pays for each covered drug.						
Level 1	$5	$5	$5	$5	$5	$5
Level 2	20% ($50 max)	20% ($50 max)	20% ($50 max)	20% ($50 max)	20% ($50 max)	20% ($50 max)
Level 3	40% ($150 max)[2]	40% ($150 max)	40% ($150 max)[2]	40% ($150 max)[2]	40% ($150 max)	40% ($150 max)
Level 4 Preferred drugs	$50[3] or 40% ($200 max)	$50[3] or 40% ($200 max)	$50[3] or 40% ($200 max)	$50[3] or 40% ($200 max)	$50[3] or 40% ($200 max)	$50[3] or 40% ($200 max)
Level 4 Non-preferred drugs[4]	40% ($200 max)	40% ($200 max)	40% ($200 max)	40% ($200 max)	40% ($200 max)	40% ($200 max)
Out-of-Pocket Limits[5]						
The maximum amount of copayments, coinsurance or deductible that a member pays.						
Levels 1 & 2	$600 individual / $1,200 family	$2,500 individual / $5,000 family (combined medical & Rx)	$1,000 individual / $2,000 family	$1,000 individual / $2,000 family	$3,500 individual / $6,550 family (combined medical & Rx)	$3,800 individual / $7,600 family (combined medical & Rx)
Level 3	$6,850 individual / $13,700[2,6] family		$6,850 individual / $13,700[2,6] family	None		
Level 4[4]	$1,200 individual / $2,400 family		$1,200 individual / $2,400 family	$1,200 individual / $2,400 family		

[1] "Zero Dollar" preventive drugs identified by the Affordable Care Act (ACA) are paid for by the plan even if the deductible has not been met. "First Dollar" preventive drugs identified by the ACA are subject to copayment/coinsurance cost sharing, even if the deductible has not been met. After the deductible is met, the member is still responsible for the copayment/coinsurance until the OOPL is met.

[2] Level 3 coinsurance does not apply toward the group health insurance program's OOPL under a non-HDHP, only the federal maximum out-of-pocket.

[3] Reduced copayment of $50 applies only when **Preferred Specialty Drugs** are obtained from a **Preferred Specialty Pharmacy**. All other Level 4 drugs require coinsurance of 40% ($200 max).

[4] Level 4 coinsurance for **Non-preferred Specialty Drugs** does not apply to the group health insurance program's Level 4 OOPL, only the federal MOOP.

[5] Family OOPLs for non-HDHP plans are embedded. An individual within a family can reach an individual OOPL before the family OOPL is met and not have to pay any copayment/coinsurance. Family OOPLs for HDHP plans are not embedded and an individual will continue to pay until the family OOPL is met.

[6] Federal Maximum Out-of-Pocket Limit or federal maximum out-of-pocket (MOOP).

UNIFORM DENTAL BENEFITS

Administered by Delta Dental of Wisconsin

Questions? Visit www.deltadentalwi.com/state-of-wi or call Delta Dental at 1-844-337-8383.

Medical Coverage Required

Uniform Dental Benefits are ***only*** available if you enroll in medical coverage under the State of Wisconsin Group Health Insurance Program. If you elect family medical coverage with dental, you will be enrolled in the family dental coverage. Similarly, if you elect single medical coverage with dental, you will be enrolled in the single dental coverage.

Search Dental Providers

You must visit a provider in the Delta Dental PPO or Delta Dental Premier networks to receive coverage. See www.deltadentalwi.com/provider-search/ for the Provider Directory. There is no benefit for out-of-network providers.

View Your Benefits

There are no changes to the benefits for 2017. Visit Delta's website at www.deltadentalwi.com/state-of-wi for more information. Be sure to login or create an account to print ID cards, view your benefits and claims, and ask questions. Visit www.deltadentalwi.com/create-account to create your account.

To learn more about dental benefits, visit

It's Your Choice 2017 at etf.wi.gov/IYC2017

DENTAL BENEFITS AT A GLANCE

This chart highlights the major dental benefits. The dental plan is available for you, your spouse/domestic partner and dependents until age 26. Visit www.deltadentalwi.com/state-of-wi for complete benefit information.

Benefit	In-Network Coverage	Examples and Limitations of Covered Services
Deductible	$0	
Annual Benefit Maximum	$1,000 per participant	
Diagnostic/Preventive/ Basic Services	100%	Exams, cleanings, X-rays, fluoride, sealants, fillings
Orthodontics	50%	Lifetime maximum of $1,500 per participant; children under 19 years of age only

WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

HAVE QUESTIONS?
etf.wi.gov/IYC2017

1-877-533-5020 (toll free)
608-266-3285 (local Madison)

PO Box 7931
Madison, WI 53707-7931

@WI_ETF

Open Enrollment: October 17 - November 11, 2016

Mailed application must be postmarked by November 10, 2016.

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) & (d)(1)
The Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

If you believe that ETF 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: Compliance Officer, Department of Employee Trust Funds, 801 West Badger Road, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 1-800-947-3529; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer 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, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 1-800-833-7813).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020（TTY：1-800-947-3529）

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم
1-877-533-5020 (خدمة الصم والبكم: 1-800-947-3529)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529)번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 1-800-947-3529).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 1-800-947-3529).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 1-800-947-3529).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwońpd numer 1-877-533-5020 (TTY: 1-800-947-3529).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë.
Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 1-800-947-3529).

Exhibit C

TERMS AND CONDITIONS FOR COMPREHENSIVE

MEDICAL PLAN PARTICIPATION IN THE STATE OF WISCONSIN

GROUP HEALTH BENEFIT PROGRAM AND UNIFORM BENEFITS

FOR THE 2016 BENEFIT YEAR

Department of Employee Trust Funds

GROUP INSURANCE BOARD

P.O. Box 7931
Madison, Wisconsin 53707

October 2015

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4. UNIFORM BENEFITS

As of the 1994 coverage year, all Health Plans offering coverage to State employees must provide the Uniform Benefits described in this Attachment A. The Health Plan may not alter the language, benefits or exclusions and limitations of the Uniform Benefits plan. Health Plans are required to provide State and participating local government employees with a description of any Prior Authorization or Referral requirements of the Health Plan. Any such requirements must be submitted to the DEPARTMENT, along with all promotional material, for approval and for inclusion in the "It's Your Choice" guides by the dates designated in the Time Table in Section J of the Guidelines.

The Uniform Benefits set forth in this section will be described to all Subscribers via the "It's Your Choice" brochure. The Health Plan does not need to recreate the description of benefits nor distribute it to its members.

TABLE OF CONTENTS

I. SCHEDULE OF BENEFITS

All benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of Your coverage and certain rules, if any, You must follow to obtain covered services. In some situations (for example, Emergency services received from a Non- Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Health Plan will result in all benefit maximums restarting at $0 with the exception of the prescription annual Out-Of-Pocket Limit.

The Group Insurance Board continues to utilize a PBM to provide prescription drug benefits formerly provided directly by the Health Plans and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are insured under the State of Wisconsin Group Health Insurance Program.

NOTE: - For Participants enrolled in a Preferred Provider Plan (WEA Trust), this Schedule of Benefits applies to services received from in-network Plan Providers. Your Health Plan will provide You with a supplemental Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers. Out-of-network Deductible amounts do not accumulate to the in-network Out-Of-Pocket Limit.

Except as specifically stated for Emergency and Urgent Care (see Sections III., A., 1. and 2.), You do not have coverage for services from Non-Plan Providers unless you get a Prior Authorization from your Health Plan. Prior Authorization requirements are described in the Health Plan Descriptions online at etf.wi.gov.

Uniform Benefits: Schedule of Benefits

The covered benefits that are administered by the Health Plan are subject to the following:

- Policy Deductible, Coinsurance and medical Copayments: described below

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

Benefit: State of Wisconsin	**Eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor**[3]	**Medicare prime Participants**	**High Deductible Health Plan for eligible Participants** [3]
Primary Care Office Visit Copayment applies to: • Family Practice • General Practice • Internal Medicine • Gynecology/Obstetrics • Midwives • Nurse Practitioners • Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy • Speech Therapy	$15, Deductible need not be met first Copayment applies towards meeting the annual OOPL, but not the Deductible	No medical copayments	After Deductible: $15 Primary Care Office Visit Copayment applies towards meeting the annual OOPL
Specialist Copayment Applies to: • Specialists • Urgent Care	$25 per visit, Deductible need not be met first Copayments count towards meeting the OOPL, but not the Deductible	No medical copayments	After Deductible: $25 per visit Copayment applies towards meeting the annual OOPL
Illness/injury related services beyond the office visit copayment (if applicable)	After Deductible: 90% (10% member cost to OOPL)	100%	After Deductible: 90% (10% member cost to OOPL)
Emergency Room Copayment (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	$75 copayment to OOPL. After Copayment, Deductible and 90% Coinsurance (10% member cost to OOPL)	$60	After Deductible, $75 copayment to OOPL. After Deductible and copay 90% (10% member cost to OOPL)
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	After Deductible: 80% (20% member cost to OOPL) [2]	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20% member cost to OOPL) [2]	After Deductible: 80% (20% member cost to OOPL) [2]

Uniform Benefits: Schedule of Benefits

Benefit: State of Wisconsin	**Eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor**[3]	**Medicare prime Participants**	**High Deductible Health Plan for eligible Participants** [3]
Cochlear Implants for Participants age 18 and older	After Deductible: 90% hospital charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	After Deductible: 90% hospital charges (10% member cost to OOPL). 80% device, surgery for implantation, follow-up sessions to train on use (20% member cost to OOPL).
Cochlear Implants Participants under age 18	After Deductible: As required by Wis. Stat. §632.895 (16), 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)	100% hospital, device, surgery for implantation and follow-up sessions to train on use.	After Deductible: As required by Wis. Stat. §632.895 (16), 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)
Hearing Aids for Participants age 18 and older. One aid per ear no more than once every 3 years.	After Deductible: 80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	After Deductible: 80% (20% member cost to OOPL) Maximum health plan payment of $1,000 per hearing aid.
Hearing Aids for Participants under age 18	After Deductible: As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL)	As required by Wis. Stat. §632.895 (16), 100%.	After Deductible: As required by Wis. Stat. §632.895 (16), 90%. (10% member cost to OOPL)
Temporo-mandibular Joint Disorders:	After Deductible: 80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 100%. Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.	After Deductible: 80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 90% (10% member cost to OOPL). Maximum health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.
Dental Implants:	After Deductible: 90% (10% member cost to OOPL) following accident or injury up to a maximum health plan payment of $1,000 per tooth.	100% following accident or injury up to a maximum health plan payment of $1,000 per tooth.	After Deductible: 90% (10% member cost to OOPL) following accident or injury up to a maximum health plan payment of $1,000 per tooth.

Benefit: State of Wisconsin	**Eligible Participants who are not eligible for nor enrolled in Medicare as the primary payor**[3]	**Medicare prime Participants**	**High Deductible Health Plan for eligible Participants** [3]
Prescription Drugs:	See below.	See below.	After Deductible: subject to medical Deductible above. After Deductible, subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

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

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

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

[3] State of Wisconsin Medicare eligible annuitants and their Medicare eligible dependents are limited to participation under the Medicare Prime Uniform Benefits Schedule of Benefits.

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)**	**WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor**[3]	**WPE eligible Participants in PO 4 including Medicare eligible and enrolled**	**High Deductible Health Plan WPE eligible (PO7) Participants** [3]
Annual Medical Deductible applies to Out-of-Pocket-Limit (OOPL).	None	$250 Individual/$500 Family When an individual within a family plan meets the $250 Deductible, coinsurance will apply to covered medical services. Medical Deductible does not apply to office visit copayments or prescription drugs.	$500 Individual/ $1,000 Family When an individual within a family plan meets the $500 Deductible, coinsurance will apply to covered medical services. Medical Deductible does not apply to prescription drugs.	The Deductible must be met before coverage begins. The Deductibles are: $1,500 per individual plan $3,000 per family plan. Deductible includes prescription drugs.

Uniform Benefits: Schedule of Benefits

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)**	**WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor**[3]	**WPE eligible Participants in PO 4 including Medicare eligible and enrolled**	**High Deductible Health Plan WPE eligible (PO7) Participants** [3]
Annual Medical Coinsurance	100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to Out-of-Pocket-Limit (OOPL).	After Deductible: 90%/10% applies to medical services except for office visits, and as described below. Coinsurance applies to Out-of-Pocket-Limit (OOPL) except as described below.	100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL.	After Deductible: 90%/10% applies to medical services except for office visits, and as described below. Coinsurance applies to Out-of-Pocket-Limit (OOPL) except as described below.
Annual Medical Out-of-Pocket Limit (OOPL)	None except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL. [1]	$1,250 Participant/$2,500 aggregate family limit except as described below.[1]	After $500 per individual $1,000 aggregate per family Deductible, none except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, 80% to OOPL. [1]	After Deductible: $2,500 per individual plan $5,000 per family plan except as described below.
Routine, preventive services as required by federal law	100%	100%	100%	100%
Primary Care Office Visit Copayment applies to: • Family Practice • General Practice • Internal Medicine • Gynecology/Obstetrics • Midwives • Nurse Practitioners	No medical copayments	$15, Deductible need not be met first Copayment applies towards meeting the annual OOPL, but not the Deductible	No medical copayments	After Deductible: $15 Primary Care Office Visit Copayment applies towards meeting the annual OOPL

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)**	**WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor**[3]	**WPE eligible Participants in PO 4 including Medicare eligible and enrolled**	**High Deductible Health Plan WPE eligible (PO7) Participants** [3]
• Physician Assistants • Chiropractic • Mental Health • Physical Therapy • Occupational Therapy Speech Therapy				
Specialist Copayment Applies to: • Specialists Urgent Care	No medical copayments	$25 per visit, Deductible need not be met first Copayments count towards meeting the OOPL, but not the Deductible	No medical copayments	After Deductible: $25 per visit Copayment applies towards meeting the annual OOPL
Illness/injury related services beyond the office visit copayment (if applicable)	100%	After Deductible: 90% (10% member cost to OOPL)	100%	After Deductible: 90% (10% member cost to OOPL)
Emergency Room Copay (Waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer.)	$60	$75 copayment to OOPL. After Copayment, Deductible and 90%Coinsurance (10% member cost to OOPL)	$60	After Deductible, $75 to OOPL. After Deductible and copay 90% (10% member cost to OOPL)
Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20% member cost to OOPL)[2]	After Deductible: 80% (20% member cost to OOPL) [2]	80% to an annual OOPL of $500 per Participant; no aggregate family limit (20%member cost to OOPL) [2]	After Deductible: 80% (20% member cost to OOPL) [2]
Cochlear Implants for Participants age 18 and older	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use	After Deductible: 90% hospital charges (10% member cost to OOPL). 80% device, surgery for	100% hospital charges. 80% device, surgery for implantation, follow-up sessions to train on use	After Deductible: 90% hospital charges (10% member cost to OOPL). 80% device, surgery for

Uniform Benefits: Schedule of Benefits

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)**	**WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor**[3]	**WPE eligible Participants in PO 4 including Medicare eligible and enrolled**	**High Deductible Health Plan WPE eligible (PO7) Participants** [3]
	(20% member cost does not apply to OOPL)	implantation, follow-up sessions to train on use (20% member cost does not apply to OOPL).	(20% member cost does not apply to OOPL).	implantation, follow-up sessions to train on use (20% member cost to OOPL).
Cochlear Implants Participants under age 18	100% hospital charges hospital, device, surgery for implantation and follow-up sessions to train on use.	After Deductible: As required by Wis. Stat. §632.895 (16), 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)	100% hospital, device, surgery for implantation and follow-up sessions to train on use.	After Deductible: As required by Wis. Stat. §632.895 (16), 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% member cost to OOPL)
Hearing Aids for Participants age 18 and older. One aid per ear no more than once every 3 years.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	After Deductible: 80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	80% (20% member cost does not apply to OOPL) Maximum health plan payment of $1,000 per hearing aid.	After Deductible: 80% (20% member cost to OOPL) Maximum health plan payment of $1,000 per hearing aid.
Hearing Aids for Participants under age 18	As required by Wis. Stat. § 632.895 (16), 100%.	After Deductible: As required by Wis. Stat. § 632.895 (16), 90%. (10% member cost to OOPL)	As required by Wis. Stat. § 632.895 (16), 100%.	After Deductible: As required by Wis. Stat. § 632.895 (16), 90%. (10% member cost to OOPL)
Temporo-mandibular Joint Disorders:	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 100%. Maximum health plan payment of $1,250 for diagnostic	After Deductible: 80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 90% (10% member cost to OOPL). Maximum	80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 100%. Maximum health plan payment of $1,250 for diagnostic	After Deductible: 80% (20% member cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services 90% (10% member cost to OOPL). Maximum

Benefit: Participating Wisconsin Public Employer's (WPE)	**WPE eligible Participants in (Program Option {PO} 2 and Medicare eligible and enrolled in PO 6 and PO 7)**	**WPE eligible Participants in PO 6 who are not eligible for nor enrolled in Medicare as the primary payor**[3]	**WPE eligible Participants in PO 4 including Medicare eligible and enrolled**	**High Deductible Health Plan WPE eligible (PO7) Participants** [3]
	procedures and nonsurgical treatment per Participant per calendar year.	health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.	procedures and nonsurgical treatment per Participant per calendar year.	health plan payment of $1,250 for diagnostic procedures and nonsurgical treatment per Participant per calendar year.
Dental Implants:	100% following accident or injury up to a maximum health plan payment of $1,000 per tooth.	After Deductible: 90% (10% member cost to OOPL) following accident or injury up to a maximum health plan payment of $1,000 per tooth.	100% following accident or injury up to a maximum of $1,000 per tooth.	After Deductible: 90% (10% member cost to OOPL) following accident or injury up to a maximum health plan payment of $1,000 per tooth.
Prescription Drugs:	See below.	See below.	See below.	After Deductible: subject to copays below, to OOPL. See Note, below, for exceptions on preventive prescription drugs.

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

[1] Level 3 prescription drug coinsurance will continue to be paid by You past the OOPL, to the federal MOOP, see more information below.
[2] Federally required preventive services are covered at 100%.
[3] Wisconsin Public Employer Medicare eligible annuitants and their Medicare eligible dependents are limited to participation under the PO2 Uniform Benefits Schedule of Benefits.

- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: Prior Authorization may be required.
- Outpatient Physical, Speech and Occupational Therapy Maximum (includes Habilitation Services or Rehabilitation Services): Covered up to 50 visits per Participant for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be available when Prior Authorized by

the Health Plan, up to a maximum of 50 additional visits per therapy per Participant per calendar year.

- Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan; and Hospital charges. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for Participants under 18 years of age are payable as described in the preceding grid.

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

- Home Care Benefits Maximum: 50 visits per Participant per calendar year. 50 additional Medically Necessary visits per Participant per calendar year may be available when authorized by the Health Plan.

- Hospice Care Benefits: Covered when the Participant's life expectancy is six months or less, as authorized by the Health Plan.

- Transplants: Limited to transplants listed in Benefits and Services section.

- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.

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

- Vision Services: One routine exam per Participant per calendar year. Non-routine eye exams are covered as Medically Necessary. (Contact lens fittings are not part of the routine exam and are not covered.)

- Oral Surgery: Limited to procedures listed in Benefits and Services section.

- Temporomandibular Disorders 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.

- 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:

- **Prescription Drugs and Insulin (Except Specialty Medications):**

NOTE:

- Drugs that are not included on the Formulary are considered non-Preferred drugs and are not covered by the benefits of this program.
- Preventive Prescription Drugs:
  - Certain preventive prescription drugs on the PBM Formulary are covered at 100% as required by federal law.
  - 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.
  - 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. Level 1 Copayments accumulate toward the Level 1/Level 2 annual Out-of Pocket Limit (OOPL) until the Level 1/Level 2 OOPL is met after which, You pay no more out-of-pocket expenses for Level 1 Drugs for that benefit year.

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 2 Coinsurance accumulate toward the Level 1/Level 2 annual OOPL until the Level 1/Level 2 OOPL is met after which You pay no more out-of-pocket expenses for Level 2 Drugs for that benefit year.

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 3 Coinsurance does ***not*** accumulate toward an annual OOPL. You must continue to pay Level 3 Coinsurance even after other annual OOPLs have been met, up to the Federal MOOP.

Level 1/Level 2 Annual Out-of-Pocket Limit (OOPL)
(The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin):
$600 per individual or $1,200 per family for all Participants, except:
$1,000 per individual or $2,000 per family for State and Wisconsin Public Employer Participants enrolled in the Standard Plan.

- **Specialty Medications**

Copayments:
Level 4 Copayment and Coinsurance:

Preferred Specialty Medications Obtained From a Preferred Specialty Pharmacy: $50 Copayment
The Level 4 Copayment applies when Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy. Level 4 copayments for Preferred Specialty Medications accumulate toward the Level 4 annual OOPL until the Level 4 annual OOPL is met after

which You pay no more out-of-pocket expenses for Preferred Specialty Medications for that benefit year.

Preferred Specialty and Non-Preferred Specialty Medications Obtained From a Participating Pharmacy other than a Preferred Specialty Pharmacy
AND
Non-Preferred Specialty Medications Obtained From a Preferred Specialty Pharmacy:
40% Coinsurance ($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 Coinsurance for only Preferred Specialty Medications accumulates toward the Level 4 annual OOPL until the Level 4 annual OOPL is met after which You pay no more out-of-pocket expenses for Preferred Specialty Medications for that benefit year.

Level 4 Coinsurance for Non-Preferred Specialty Medications do ***not*** accumulate toward an annual OOPL. You must continue to pay Level 4 Coinsurance even after other annual OOPLs have been met, up to the Federal MOOP

Level 4 Annual Out-of-Pocket **Limit (OOPL)**
(The amount You pay for Your Level 4 Preferred Specialty Medications.)
$1,200 per individual or $2,400 per family for all Participants.

- **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.

- **Disposable Diabetic Supplies and Glucometers Coinsurance:** 20% member Coinsurance applies to the prescription drug Level 1/Level 2 annual OOPL.

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

II. DEFINITIONS

The terms below have special meanings in this plan. Defined terms are capitalized when used in the text of this plan.

- **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:
  - Understanding your health care treatment options
  - Clarifying your health care goals
  - Weighing your options about what kind of care and treatment you would want or not want
  - Making decisions about whether you want to appoint a health care agent and/or complete an advance directive
  - 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.

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

- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.

- **CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, 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 a Plan Provider, has reached the

maximum level of recovery. Custodial Care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the Plan Provider, that the medical or surgical treatment will enable that person to live outside an institution. Custodial Care also includes rest cures, respite care, and home care provided by family members.

- **DEDUCTIBLE:** Deductible: The amount You owe for health care services Your Health Plan covers before Your Health Plan begins to pay. For example, if Your Deductible is $1,500, Your 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 Department of Employee Trust Funds.

- **DEPENDENT:** Means, as provided herein, the Subscriber's:
  - Spouse.
  - Domestic Partner, if elected.
  - Child.
  - Legal ward who becomes a legal ward of the Subscriber, Subscriber's spouse or insured Domestic Partner prior to age 19.
  - Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
  - Stepchild.
  - Child of the Domestic Partner insured on the policy.
  - Grandchild if the parent is a Dependent child.

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

  2. A spouse and a stepchild cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment. A Domestic Partner and his or her children cease to be Dependents at the end of the month in which the domestic partnership is no longer in effect.

  3. All other children cease to be Dependents at the end of the month in which they turn 26 years of age, except that:

     a. An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age, as long as the child remains so disabled and he or she is dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. The Health Plan will monitor eligibility annually, notifying the employer and Department when terminating coverage prospectively upon determining the Dependent is no longer so disabled and/or meets the support requirement. The Health Plan will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

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

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

5. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.

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

- **DOMESTIC PARTNER:** Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:
  - Each individual is at least 18 years old and otherwise competent to enter into a contract.
  - Neither individual is married to, or in a domestic partnership with, another individual.
  - The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
  - The two individuals consider themselves to be members of each other's immediate family.
  - The two individuals agree to be responsible for each other's basic living expenses.
  - The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:
    - Only one of the individuals has legal ownership of the residence.
    - One or both of the individuals have one or more additional residences not shared with the other individual.
    - One of the individuals leaves the common residence with the intent to return.

- **EFFECTIVE DATE:** The date, as certified by the Department and shown on the records of the Health Plan and/or PBM, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.

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

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

1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.

2. Serious impairment to the Participant's bodily functions.

3. Serious dysfunction of one or more of the Participant's body organs or parts.

Examples of Emergencies are listed in Section III., A., 1., e. Emergency services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.

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

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

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

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

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

- **HABILITATION SERVICES:** Means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t

walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during the calendar year.

- **HIGH DEDUCTIBLE HEALTH PLAN (HDHP):** A health plan that, under federal law, has a minimum annual Deductible and a maximum annual Out-of-Pocket Limit (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 plan 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 Health Plan.

- **HOSPITAL:** Means an institution that:

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

  2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare Provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.

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

- **HOSPITAL CONFINEMENT** or **CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility.

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

- **IMMEDIATE FAMILY:** Means the Dependents, parents, brothers and sisters of the Participant and their spouses or Domestic Partners.

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

- **LEVEL "M" DRUG**: Means an injectable, prescription medication covered by Medicare Parts B and D when the Medicare Prescription Drug Plan is the primary payer. Level M Drugs are required to be on the Medicare Prescription Drug Plan's Medicare Part D Formulary but are not included on the commercial coverage Formulary. Claims associated with Level M Drugs, along with the costs to administer the injection, are adjudicated by the PBM, not the Health Plan.

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

- **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT:** Means items which are, as determined by the Health Plan:

  1. Used primarily to treat an Illness or Injury; and

  2. Generally not useful to a person in the absence of an Illness or Injury; and

  3. The most appropriate item that can be safely provided to a Participant and accomplish the desired end result in the most economical manner; and

  4. Prescribed by a Provider.

- **MEDICALLY NECESSARY:** A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM:

  1. consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; and

  2. appropriate under the standards of acceptable medical practice to treat that Illness or Injury; and

  3. not solely for the convenience of the Participant, physician, Hospital or other health care Provider; and

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

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

- **MEDICARE PRESCRIPTION DRUG PLAN:** Means the prescription drug coverage provided by the PBM to Covered 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 Plan Benefits are available under this Health Plan.

- **NATURAL TOOTH:** Means a tooth that would not have required restoration in the absence of a Participant's trauma or Injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.

- **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM's directory of Participating Pharmacies.

- **NON-PLAN PROVIDER:** Means a Provider who does not have a signed participating Provider agreement and is not listed on the most current edition of the Health Plan's professional directory of Plan Providers. Care from a Non-Plan Provider requires Prior-Authorization from the Health Plan unless it is an Emergency or Urgent Care.

- **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 Plan Service Area.

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

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

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

- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.

- **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.

- **PLAN PROVIDER:** A Provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The Provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Health Plan agrees to give You lists of affiliated Providers. Some Providers require Prior Authorization by the Health Plan in advance of the services being provided.

- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.

- **POSTOPERATIVE CARE:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.

- **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:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other Provider health services and refers the Participant to other Providers.

  You should name Your Primary Care Provider or clinic on Your enrollment application or in a later written notice of change. Each family member may have a different primary physician.

- **PRIOR AUTHORIZATION:** Means obtaining approval from Your Health Plan before obtaining the services. Unless otherwise indicated by Your Health Plan, Prior Authorization is required for care from any Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in the Health Plan Descriptions section of the “It’s Your Choice: Decision Guide.” Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.

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

- **REFERRAL:** When a Participant's Primary Care Provider sends him/her to another Provider for covered services. In many cases, the Referral must be in writing and on the Health Plan Prior Authorization form and approved by the Health Plan in advance of a Participant's treatment or service. Referral requirements are determined by each Health Plan and are described in the Health Plan Descriptions section of the “It’s Your Choice: Decision Guide.” The authorization from the Health Plan will state: a) the type or extent of treatment authorized; and b) the number of Prior Authorized visits and the period of time during which the authorization is valid. In most cases, it is the Participant’s responsibility to ensure a Referral, when required, is approved by the Health Plan before services are rendered.

- **REHABILITATION SERVICES:** Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

- **SCHEDULE OF BENEFITS:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the Health Plan You elected.

- **SELF-ADMINISTERED INJECTABLE:** Means an injectable that is administered subcutaneously and can be safely self-administered by the Participant and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.

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

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

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

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

- **STATE:** Means the State of Wisconsin as the policyholder.

- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.

- **URGENT CARE:** Means care for an accident or Illness which is needed sooner than a routine doctor's visit. If the accident or Injury occurs when the Participant is out of the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **USUAL AND CUSTOMARY CHARGE:** An amount for a treatment, service or supply provided by a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided

in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related charges) prior to receiving services. Health Plan approved Referrals or Prior Authorizations to Non-Plan Providers are not subject to Usual and Customary Charges. Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges, however, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital/dental services.

- **YOU/YOUR:** The Subscriber and his or her covered Dependents.

III. BENEFITS AND SERVICES

The benefits and services which the Health Plan and PBM agree to provide to Participants, or make arrangements for, are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the Participant's Primary Care Provider (except in the case of plan chiropractic services, Emergency or Urgent Care), and are received after the Participant's Effective Date.

Hospital services must be provided by a plan Hospital. In the case of non-Emergency care, the Health Plan reserves the right to determine in a reasonable manner the Provider to be used. In cases of Emergency or Urgent Care services, Plan Providers and Hospitals must be used whenever possible and reasonable (see items A., 1. and 2. below).

The Health Plan reserves the right to modify the list of Plan Providers at any time, but will honor the selection of any Provider listed in the current provider directory for the duration of that calendar year unless that Provider left the Health Plan due to normal attrition (limited to, retirement, death or a move from the Plan Service Area or as a result of a formal disciplinary action for quality of care).

Except as specifically stated for Emergency and Urgent Care, You must receive the Health Plan's written Prior Authorization for covered services from a Non-Plan Provider or You will be financially responsible for the services. The Health Plan may also require Prior Authorization for other services or they will not be covered.

Subject to the terms and conditions outlined herein and the attached Schedule of Benefits, a Participant, in consideration of the employer's payment of the applicable Health Plan and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any Copayment, Coinsurance and other limitations shown in the Schedule of Benefits; and (b) all other terms and conditions outlined in this plan. All services must be Medically Necessary, as determined by the Health Plan and/or PBM.

A. Medical/Surgical Services

1. Emergency Care

a. Medical care for an Emergency, as defined in Section II. Refer to the Schedule of Benefits for information on the emergency room Copayment.

b. You should use Plan Hospital emergency rooms whenever possible. If You are not able to reach Your Plan Provider, go to the nearest appropriate medical facility. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Emergency care. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan. In addition to cost sharing described in the Schedule of Benefits, Emergency care from Non-Plan Providers may be subject to Usual and Customary Charges.

c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Care Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.

e. Some examples of Emergencies are:
   - o Acute allergic reactions
   - o Acute asthmatic attacks
   - o Convulsions
   - o Epileptic seizures
   - o Acute hemorrhage
   - o Acute appendicitis
   - o Coma
   - o Heart attack
   - o Attempted suicide
   - o Suffocation
   - o Stroke
   - o Drug overdoses
   - o Loss of consciousness
   - o Any condition for which You are admitted to the Hospital as an inpatient from the emergency room

2. Urgent Care

a. Medical care received in an Urgent Care situation as defined in Section II. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.

b. You must receive Urgent Care from a Plan Provider if You are in the Plan Service Area, unless it is not reasonably possible. If You are out of the Plan Service Area, go to the nearest appropriate medical facility unless You can safely return to the Plan Service Area to receive care from a Plan Provider. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Urgent Care. Urgent Care from Non-Plan Providers may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan.

c. Some examples of Urgent Care cases are:
   - o Most Broken Bones
   - o Minor Cuts
   - o Sprains
   - o Most Drug Reactions
   - o Non-Severe Bleeding
   - o Minor Burns

3. Surgical Services

Surgical procedures, wherever performed, when needed to care for an Illness or Injury. These include: (a) Preoperative and Postoperative Care; and (b) needed services of assistants and consultants. This does not include oral surgery procedures, which are covered as described under 16. of this section.

Prior Authorization is required for Referrals to orthopedists and neurosurgeons associated directly or indirectly with the Health Plan for any Participant who has not completed an optimal

regimen of conservative care for Low Back Pain (LBP). Prior Authorization is not required for a Participant who presents clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty Referral.

Participants seeking surgical treatment of LBP must participate in a credible Shared Decision Making (SDM) program provided by the Health Plan or its contracted providers consistent with the Prior Authorization requirement.

4. Reproductive Services and Contraceptives

The following services do not require a Referral to a Plan Provider who specializes in obstetrics and gynecology, however, the Health Plan may require that the Participant obtain Prior Authorization for some services or they may not be covered.

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

b. Elective sterilization.

c. Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:
   - Oral contraceptives, or cost-effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
   - IUDs and diaphragms, as described under the Durable Medical Equipment provision.
   - Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

If the Participant is in her second or third trimester of pregnancy when the Provider's participation in the Health Plan terminates, the Participant will continue to have access to the Provider until completion of postpartum care for the woman and infant. A Prior Authorization is not required for the delivery, but the Health Plan may request that it be notified of the inpatient stay prior to the delivery or shortly thereafter.

5. Medical Services

Medically Necessary professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an approved Provider.

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

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

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

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

e. Medically Necessary travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the Participant by the Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)

f. Injectable and infusible medications, except for Self-Administered Injectable medications.

g. Nutritional Counseling provided by a participating registered dietician or Plan Provider.

h. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.

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

6. Anesthesia Services

Covered when provided in connection with other medical and surgical services covered under this plan. It will also include anesthesia services for dental care as provided under item B., 1., c. of this section.

7. Radiation Therapy and Chemotherapy

Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an approved Provider.

8. Detoxification Services

Covers Medically Necessary detoxification services provided by an approved Provider. Methadone Treatment shall be covered only when Medically Necessary and provided by an approved provider.

9. Ambulance Service

Covers licensed professional ambulance service (or comparable Emergency transportation if authorized by the Health Plan) when Medically Necessary to transport to the nearest Hospital where appropriate medical care is available when the conveyance is an Emergency or Urgent in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger Your health. Ambulance services include Medically Necessary transportation and all associated supplies and services provided therein. If the Participant is not in the Plan's Service Area, the Health Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained.

10. Diagnostic Services

Medically Necessary testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations. Prior Authorization is required for Referrals to orthopedists and neurosurgeons associated directly or indirectly with the plan for Participants with a history of low back pain and who have not completed an optimal regimen of conservative care. Such Prior Authorizations are not required for Participants who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty Referral.

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

11. Outpatient Rehabilitation, Physical, Speech and Occupation Therapy

Medically Necessary Habilitation or Rehabilitation services and treatment as a result of Illness or Injury, provided by a Plan Provider. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the Schedule of Benefits, although up to 50 additional visits per therapy per calendar year may be Prior Authorized by the Health Plan if the therapy continues to be Medically Necessary and is not otherwise excluded.

12. Home Care Benefits

Care and treatment of a Participant under a plan of care. The Plan Provider must establish this plan; approve it in writing; and review it at least every two months unless the physician determines that less frequent reviews are sufficient.

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

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

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

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

d. Medical Supplies, drugs and medicines prescribed by a Health Plan physician; and lab services by or for a Hospital. They are covered to the same extent as if the Participant was Confined In A Hospital.

e. Nutritional Counseling. A registered dietician must give or supervise these services.

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

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

1) Hospital Confinement or Confinement in a Skilled Nursing Facility would be needed if home care were not provided.

2) The Participant's Immediate Family, or others living with the Participant, cannot provide the needed care and treatment without undue hardship.

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

A Participant may have been Confined In A Hospital just before home care started. If so, the home care plan must be approved, at its start, by the physician who was the primary Provider of care during the Hospital Confinement.

Home care benefits are limited to the maximum number of visits specified in the Schedule of Benefits, although up to 50 additional home care visits per calendar year may be Prior Authorized by the Health Plan if the visits continue to be Medically Necessary and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating Your needs or developing a plan counts as one visit. Each period of four straight hours in a 24-hour period of home health aide services counts as one home care visit.

13. Hospice Care

Covers Hospice Care if the Primary Care Provider certifies that the Participant's life expectancy is six months or less, the care is palliative in nature, and is authorized by the Health Plan. Hospice Care, 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 six-month period if authorized by the Health Plan.

Covers Advance Care Planning after the Participant receives a terminal diagnosis regardless of life expectancy.

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

Hospice Care is available to a Participant who is Confined. Inpatient charges are payable for up to a total lifetime maximum of 30 days of confinement in a Health Plan-approved or Medicare-certified Hospice Care facility.

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

14. Phase II Cardiac Rehabilitation

Services must be approved by the Health Plan and provided in an outpatient department of a Hospital, in a medical center or clinic program. This benefit may be appropriate only for Participants with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) heart valve surgery; (e) onset of decubital angina; (f) onset of unstable angina; (g) percutaneous transluminal angioplasty; or (h) heart transplant. Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under this contract.

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

Total extraction and/or total replacement (limited to, bridge, denture or implant) of Natural Teeth by an approved Plan Provider when necessitated by an Injury. The treatment must commence within 18 months of the accident. As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the Health Plan before the service is performed. Coverage of one retainer or mouth guard shall be provided when Medically Necessary as part of prep work provided prior to accidental injury tooth repair.

Injuries caused by chewing or biting are not considered to be accidental Injuries for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.

16. Oral Surgery

Participants should contact the Health Plan prior to any oral surgery to determine if Prior Authorization by the Health Plan is required. When performed by Plan Providers, approved surgical procedures are as follows:

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

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

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

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

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

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

g. Intraoral and extraoral incision and drainage of cellulitis.

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

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

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

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

Retrograde fillings are covered when Medically Necessary following covered oral surgery procedures.

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

17. Treatment of Temporomandibular Disorders

As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and Prior Authorized Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

a. A Congenital, developmental or acquired deformity, disease or Injury caused the condition.

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

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

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

18. Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be Prior Authorized by the Health Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill.

Limited to one transplant per organ (which applies to items b., e., f., and g. as listed below) per Participant per Health Plan during the lifetime of the policy, except as required for treatment of kidney disease.

a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
   - Aplastic anemia
   - Acute leukemia
   - Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
   - Wiskott-Aldrich syndrome
   - Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
   - Hodgkins and non-Hodgkins lymphoma
   - Combined immunodeficiency
   - Chronic myelogenous leukemia
   - Pediatric tumors based upon individual consideration
   - Neuroblastoma
   - Myelodysplastic syndrome
   - Homozygous Beta-Thalassemia
   - Mucopolysaccharidoses (e.g. Gaucher’s disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
   - Multiple Myeloma, Stage II or Stage III
   - Germ Cell Tumors (e.g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound

b. Parathyroid transplantation

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

d. Corneal transplantation (keratoplasty) limited to:
   - o Corneal opacity
   - o 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
   - o Corneal ulcer
   - o Repair of severe lacerations

e. Heart transplants will be limited to the treatment of:
   - o Congestive Cardiomyopathy
   - o End-Stage Ischemic Heart Disease
   - o Hypertrophic Cardiomyopathy
   - o Terminal Valvular Disease
   - o Congenital Heart Disease, based upon individual consideration
   - o Cardiac Tumors, based upon individual consideration
   - o Myocarditis
   - o Coronary Embolization
   - o Post-traumatic Aneurysm

f. Liver transplants will be limited to the treatment of:
   - o Extrahepatic Biliary Atresia
   - o Inborn Error of Metabolism
     - Alpha -1- Antitrypsin Deficiency
     - Wilson's Disease
     - Glycogen Storage Disease
     - Tyrosinemia
   - o Hemochromatosis
   - o Primary Biliary Cirrhosis
   - o Hepatic Vein Thrombosis
   - o Sclerosing Cholangitis
   - o Post-necrotic Cirrhosis, Hbe Ag Negative
   - o Chronic Active Hepatitis, Hbe Ag Negative
   - o Alcoholic Cirrhosis, abstinence for six or more months
   - o Epithelioid Hemangioepithelioma
   - o Poisoning
   - o Polycystic Disease

g. Kidney with pancreas, heart with lung, and lung transplants as determined to be Medically Necessary by the Health Plan.

h. In addition to the above-listed diagnoses for covered transplants, the Health Plan may Prior Authorize a transplant for a non-listed diagnosis if the Health Plan determines that the transplant is a Medically Necessary and a cost effective alternate treatment.

i. Kidney Transplants. See item 19. below.

19. Kidney Disease Treatment

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum-see Transplants Section A., 18), donor-related services, and related physician charges.

20. Chiropractic Services

When performed by a Plan Provider. Benefits are not available for Maintenance Care.

21. Women's Health and Cancer Act of 1998

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

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses (see DME in Section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas;
- Breast implants.

22. Smoking Cessation

Coverage includes pharmacological products that by law require a written prescription and are described under the Prescription Drug benefits in Section D., 1. Coverage also includes one office visit for counseling and to obtain the prescription and four telephonic counseling sessions per calendar year. Additional counseling and/or limited extension of pharmacological products require Prior Authorization by the Health Plan.

B. Institutional Services

Covers inpatient and outpatient Hospital services and Skilled Nursing Facility services that are necessary for the admission, diagnosis and treatment of a patient when provided by a Plan Provider. Each Participant in a health care facility agrees to conform to the rules and regulations of the institution. The Health Plan may require that the hospitalization be Prior Authorized.

1. Inpatient Care

a. Hospitals and Specialty Hospitals: Covered for semi-private room, ward or intensive care unit and Medically Necessary Miscellaneous Hospital Expenses, including prescription drugs administered during the Confinement. A private room is payable only if Medically Necessary for isolation purposes as determined by the Health Plan.

b. Licensed Skilled Nursing Facility: Must be admitted within 24 hours of discharge from a general Hospital for continued treatment of the same condition. Care must be Skilled. Custodial Care is excluded. Benefits limited to the number of days specified in the Schedule of Benefits. Benefits include prescription drugs administered during the Confinement. Confinement in a swing bed in a Hospital is considered the same as a Skilled Nursing Facility Confinement.

c. Hospital and Ambulatory Surgery Center Charges and related Anesthetics for dental care: Covered if services are provided to a Participant who is under five years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2. Outpatient Care

Emergency care: First aid, accident or sudden Illness requiring immediate Hospital services. Subject to the cost sharing described in the Schedule of Benefits. Follow-up care received in an emergency room to treat the same Injury is also subject to the cost sharing provisions.

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

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

Surgical Care: Covered.

C. Other Medical Services

1. Mental Health Services/Alcohol and Drug Abuse

Participants should contact the Health Plan prior to any services, including testing or evaluation, to determine if Prior Authorization or a Referral is required from the Health Plan.

a. Outpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. The outpatient services means non-residential services by Providers as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37.

This benefit also includes services for a full-time student attending school in Wisconsin but out of the Plan Service Area as required by Wis. Stat. § 609.655.

b. Transitional Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. Transitional Care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act.

c. Inpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89 and Wis. Adm. Code § INS 3.37. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by a Non-Plan Provider, if provided as required by an Emergency detention or on an Emergency basis and the Provider notifies the Health Plan within 72 hours after the initial provision of service.

d. Other

Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section D., 1.

2. Durable Diabetic Equipment and Related Supplies

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered **subject to cost sharing as outlined in the Schedule of Benefits**. The Participant's Coinsurance will be applied to the annual Out-Of-Pocket Limit. Durable diabetic equipment includes:

- Automated injection devices.
- Continuing glucose monitoring devices.

- Insulin infusion pumps, limited to one pump in a calendar year and You must use the pump for 30 days before purchase.

All Durable Medical Equipment purchases or monthly rentals must be Prior Authorized as determined by the Health Plan.

(Glucometers are available through the PBM. Refer to Section D. for benefit information.)

3. Medical Supplies And Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, Medical Supplies And Durable Medical Equipment will be covered **subject to cost sharing as outlined in the Schedule of Benefits**.

The following supplies and equipment will be covered only when Prior Authorized as determined by the Health Plan:

- Initial acquisition of artificial limbs and eyes including replacements due to significant physiological changes, such as physical maturation, when Medically Necessary, and refitting of any existing prosthesis is not possible.
- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.
- Rental or, at the option of the Health Plan, purchase of equipment including, but not limited to, wheelchairs and hospital-type beds.
- An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).
- IUDs and diaphragms.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, as described in the Schedule of Benefits.
- One hearing aid, as described in the Schedule of Benefits. The maximum payment applies to all services directly related to the hearing aid, for example, an ear mold.
- Ostomy and catheter supplies.
- Oxygen and respiratory equipment for home use when authorized by the Health Plan.
- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.
- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan will consider whether: i) the equipment/supply is still

useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development). Services will be covered subject to cost sharing as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual Out-Of-Pocket Limit.

4. Out-of-Plan Coverage For Full-Time Students

If a Dependent is a full-time student attending school outside of the HMO Service Area, the following services will be covered:

a. Emergency or Urgent Care. Non-urgent follow-up care out of the Plan Service Area must be Prior Authorized or it will not be covered; and

b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area, as required by Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized by the Health Plan. If outpatient services are recommended, coverage will be provided for five visits outside of the Plan's Service Area when Prior Authorized by the Health Plan. Additional visits may be approved by the Health Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to the limitations shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

5. Coverage of Newborn Infants with Congenital Defects and Birth Abnormalities

As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a Dependent is continuously covered under any plan under this health insurance program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6. Coverage of Treatment for Autism Spectrum Disorders

Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following Plan Providers: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those four types of providers, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. 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 benefits at a PBM Participating Pharmacy except when not reasonably possible because of Emergency or Urgent Care. In these circumstances, You may need to make a claim as described in the paragraph below.

If You do not show Your PBM identification card at the pharmacy at the time You are obtaining benefits, You may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, You may be responsible for more than the Copayment amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the Department. Contact the PBM if You have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by the Health Plan.

1. Prescription Drugs

Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed Illness or Injury; and are purchased from a PBM Network Pharmacy after a Copayment or Coinsurance amount, as described in the Schedule of Benefits. A Copayment will be applied to each prescription dispensed. The PBM may lower the Copayment amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual Out-Of-Pocket Limit applies to Participants' Copayments for Level 1 and Level 2 Preferred prescription drugs as described on the Schedule of Benefits. When any Participant meets the annual Out-Of-Pocket Limit, when applicable, as described on the Schedule of Benefits, that Participant's Level 1 and Level 2 Preferred prescription drugs will be paid in full for the rest of the calendar year. Further, if participating family members combined have paid in a year the family annual Out-Of-Pocket Limit as described in the Schedule of Benefits, even if no one Participant has met his or her individual annual Out-Of-Pocket Limit, all family members will have satisfied the annual Out-Of-Pocket Limit for that calendar year. The Participant's cost for Level 3 drugs will not be applied to the annual Out-Of-Pocket Limit. If the cost of a prescription drug is less than the applicable Copayment, the Participant will pay only the actual cost and that amount will be applied to the annual Out-Of-Pocket Limit for Level 1 and Level 2 Preferred prescription drugs.

The Health Plan, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, Confinement, emergency room visit or Urgent Care setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, Confinement, emergency room visit or Urgent Care setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, Self-Administered Injectable).

Medicare eligible Participants will be covered by a Medicare Part D prescription drug plan (PDP) provided by the PBM. Participants who choose to be enrolled in another Medicare Part D PDP other than this PDP will not have benefits duplicated.

Where a Medicare prescription drug plan is the primary payor, the Participant is responsible for the Copayment plus any charges in excess of the PBM allowed amount. The allowed amount is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

In most instances, claims for Medicare Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for Participants with Medicare Part D coverage, will be submitted to the PBM for adjudication even when the HEALTH PLAN or a contracted provider administers the injection. If the HEALTH PLAN or a contracted provider is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

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

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

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

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

e. Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the Formulary. These require a prescription from a physician and must be filled at a Participating Pharmacy. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug Copayment and annual Out-Of-Pocket Limit. Coverage is limited to a maximum of 180 consecutive days of pharmacotherapy per calendar year unless the Participant obtains Prior Authorization for a limited extension.

f. Prior Authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring Prior Authorization is available from the PBM.

g. Cost-effective Generic Equivalents will be dispensed unless the Plan Provider specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the Copayment specified in the Formulary.

h. Mail order is available for many prescription drugs. For certain Level 1 and Level 2 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 member can split the tablet of a higher strength

dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. Participants who use tablet splitting will pay half the normal Copayment amount.

j. 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 Out-Of-Pocket Limit for prescription drugs.

3. Other Devices and Supplies

Other devices and supplies administered by the PBM that are subject to a 20% Coinsurance and applied to the annual Out-Of-Pocket Limit for prescription drugs are as follows:

- Diaphragms
- Syringes/Needles
- Spacers/Peak Flow Meters

IV. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Plan Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by Health Plans and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that subsection 11 applies only to the pharmacy benefit administered by the PBM. Some of the listed exclusions may be Medically Necessary, but still are not covered under this plan, while others may be examples of services which are not Medically Necessary or not medical in nature, as determined by the Health Plan and/or PBM.

1. Surgical Services

a. Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment.

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

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

2. Medical Services

a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, functional capacity examinations or evaluations, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits and Services section.

b. Expenses for medical reports, including preparation and presentation.

c. Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; or (c) treatment of flexible flat feet. This exclusion does not apply when services are performed by a Plan Provider to treat a metabolic or peripheral disease or a skin or tissue infection.

d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include Nutritional Counseling as provided in the Benefits and Services section.

e. Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).

f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be services of a blood donor.

g. Genetic testing and/or genetic counseling services, unless Medically Necessary to diagnose or treat an existing Illness.

3. Ambulance Services

a. Ambulance service, except as outlined in the Benefits and Services section, unless authorized by the Health Plan.

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

4. Therapies

a. Vocational rehabilitation including work hardening programs.

b. Except for services covered under the HABILITATION SERVICES therapy benefit, therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein.

   These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction. (Note: Mandated benefits for autism spectrum disorders under Wis. Stat. §632.895 (12m) limit this exclusion.)

c. Physical fitness or exercise programs.

d. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

e. Massage therapy.

5. Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental Injury

a. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the Benefits and Services section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits and Services section. (Note: Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may limit this exclusion.)

b. All periodontic procedures, except gingivectomy surgery as listed in the Benefits and Services section.

c. All oral surgical procedures not specifically listed in the Benefits and Services section.

6. Transplants

a. Transplants and all related services, except those listed as covered procedures.

b. Services in connection with covered transplants unless Prior Authorized by the Health Plan.

c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

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

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

f. Non-human organ transplants or artificial organs.

7. Reproductive Services

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

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

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

d. Harvesting of eggs and their cryopreservation.

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

f. Surrogate mother services.

g. Maternity services received out of the Plan Service Area one month prior to the estimated due date, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of the Participant's control, for example, family emergency).

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

i. Services of home delivery for childbirth.

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

8. Hospital Inpatient Services

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

b. Hospital stays, which are extended for reasons other than Medical Necessity, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.

c. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.

9. Durable Medical or Diabetic Equipment and Supplies

a. All Durable Medical Equipment purchases or rentals unless Prior Authorized as required by the Health Plan.

b. Repairs and replacement of Durable Medical Equipment/supplies unless authorized by the Health Plan.

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

d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as Prior Authorized by the Health Plan.

e. Equipment, models or devices that have features over and above that which are Medically Necessary for the Participant will be limited to the standard model as determined by the Health Plan. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the Participant’s condition nor is the existing equipment, models or devices in need of repair or replacement.

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

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

h. Replacement or repair of Durable Medical Equipment/supplies damaged or destroyed by the Participant, lost or stolen.

10. Outpatient Prescription Drugs – Administered by the PBM

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

b. Charges for prescription drugs which require Prior Authorization unless approved by the PBM.

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

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

e. Anorexic agents.

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

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

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

i. Charges for injectable medications, except for Self-Administered Injectable medications.

j. Charges for supplies and medicines purchased from a Non-Participating Pharmacy, except when Emergency or Urgent Care is required.

k. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

l. Infertility and fertility medications.

m. Charges for medications obtained through a discount program or over the Internet, unless Prior Authorized by the PBM.

n. Charges to replace expired, spilled, stolen or lost prescription drugs.

11. General

a. Any additional exclusion as described in the Schedule of Benefits.

b. Services to the extent the Participant is eligible for all Medicare benefits, regardless of whether or not the Participant is actually enrolled in Medicare. This exclusion only applies if the Participant enrolled in Medicare coordinated coverage does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage or is not enrolled in a Medicare Part D Plan.

c. Treatment, services and supplies for which the Participant: (a) has no obligation to pay or which would be furnished to a Participant without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

d. Injury or Illness caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.

e. Treatment, services and supplies for any Injury or Illness as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.

f. Treatment, services and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services and supplies for which under the policy the Health Plan and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

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

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

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

j. Maintenance Care.

k. Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).

l. Personal comfort or convenience items or services such as in-Hospital television, telephone, private room, housekeeping, shopping, homemaker services, and meal preparation services as part of home health care.

m. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.

n. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

o. Expenses incurred prior to the coverage Effective Date in the Health Plan and/or PBM, or services received after the Health Plan and/or PBM coverage or eligibility terminates. Except when a Participant's coverage terminates because of Subscriber cancellation or nonpayment of premium, benefits shall continue to the Participant if he or she is Confined as an inpatient on the coverage termination date but only until the attending physician determines that Confinement is no longer Medically Necessary; the contract maximum is reached; the end of 12 months after the date of termination; or Confinement ceases, whichever occurs first. If the termination is a result of a Subscriber changing Health Plans during a prescribed enrollment period as determined by the Board, benefits after the effective date with the succeeding Health Plan will be the responsibility of the succeeding Health Plan unless the facility in which the Participant is Confined is not part of the succeeding Health Plan’s network. In this instance, the liability will remain with the previous insurer.

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

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

r. Charges for any missed appointment.

s. Experimental services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the Health Plan and/or PBM following review of research protocol and

individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be Experimental, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

t. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.

u. Services, including non-physician services, provided by Non-Plan Providers. Exceptions to this exclusion:

   1) On written Referral by Plan Provider with the prior written authorization of the Health Plan.

   2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.

   3) Emergency or Urgent Care services outside the Service Area. Non-urgent follow-up care requires Prior Authorization from the Health Plan.

v. Services of a specialist without a Plan Provider's written Referral, except in an Emergency or by written Prior Authorization of the Health Plan. Any Hospital or medical care or service not provided for in this document unless authorized by the Health Plan.

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.

ab. 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.

ac. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.

ad. Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires Medically Necessary treatment that is performed by a Plan Provider or Prior Authorized by the Health Plan. The treatment of the complication must be a covered benefit of the Health Plan and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.

ae. 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.

af. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services section.

ag. 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.

ah. Sexual counseling services related to infertility and sexual transformation.

ai. 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.

aj. Hypnotherapy.

ak. Marriage counseling.

al. Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 or as required by the federal Mental Health Parity and Addiction Equity Act.

am. 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 Non-Plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Health Plan to determine medical appropriateness and whether services can be provided by Plan Providers.

4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of

available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the Health Plan and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Health Plan, Plan Providers and/or PBM will use their best efforts to provide services and other benefits covered hereunder. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.

6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.

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

8. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

Exhibit D

From: Pray, Tara - ETF
Sent: Thursday, July 21, 2016 8:56 AM
To: McNally; Michael D - ETF
Subject: FW: Follow-up questions

From: Bogardus, Jeff E - ETF
Sent: Thursday, July 14, 2016 12:21 PM
To: Ellinger, Lisa - ETF <Lisa.Ellinger@etf.wi.gov>; Mallow, Eileen K - ETF <Eileen.Mallow@etf.wi.gov>; Carabell, Rachel - ETF <Rachel.Carabell@etf.wi.gov>
Cc: Pray, Tara - ETF <Tara.Pray@etf.wi.gov>; Brockman, Sara - ETF <Sara.Brockman@etf.wi.gov>
Subject: RE: Follow-up questions

Thx for the heads up.

We - and Navitus - have a hold on 9/22 (8am-10am) and 9/30 (1pm-3pm) for the next V.A.L.U.E. meeting. Brock's notes indicate that we are waiting on confirmation from Segal.

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From: Ellinger, Lisa - ETF
Sent: Thursday, July 14, 2016 12:14 PM
To: Mallow, Eileen K - ETF <Eileen.Mallow@etf.wi.gov>; Carabell, Rachel - ETF <Rachel.Carabell@etf.wi.gov>
Cc: Pray, Tara - ETF <Tara.Pray@etf.wi.gov>; Bogardus, Jeff E - ETF <Jeff.Bogardus@etf.wi.gov>
Subject: FW: Follow-up questions

fyi only – wanted to share this board member inquiry. copying Tara and Jeff since it relates to their programs.
LE
Jeff – do we have the next Navitus VALUE meeting on the calendar? September might be a good target. If not, I will have Brock schedule.
LE

From: Ellinger, Lisa - ETF
Sent: Thursday, July 14, 2016 12:12 PM
To: 'Day, Herschel E.' <DAYHE@uwec.edu>
Subject: RE: Follow-up questions

Hi Herschel: Thank you for your patience with our technical difficulties.

1. Yes, we did ask Segal to provide an actuarial estimate and Tara was prepared to share if there were any questions on the cost. Based on the work Segal has conducted in other states, they noted the cost impact is typically less than 0.1%. Given the negligible cost, we did not create a line item for this benefit change in the bid submissions. There are so many unknowns regarding the full scope of this coverage change, which is why our only Uniform Benefit change for 2017 is removal of the exclusion. We are working with our largest insurers to discuss protocols and best practices. We will re-evaluate next year to see if there is evidence to suggest the cost impact is greater than anticipated. If so, this will be accounted for accordingly in the bids.
2. Excellent question (I had the same question ☺). Insulin seems to be a unique maintenance drug in terms of the high costs and lack of low-price alternatives. However, we do have ongoing communication with our ombuds staff to ensure we are aware of recurring member complaints. That relationship helped reveal the insulin issue. Likewise, we meet with Navitus twice annually to review trends. Member impacts from the 2016 benefit structure change will be a priority topic to investigate at our next meeting.

Let me know if you have other questions. Thanks again for stepping into the Secretary role!
Lisa

From: Day, Herschel E. [mailto:DAYHE@uwec.edu]
Sent: Wednesday, July 13, 2016 10:36 AM
To: Ellinger, Lisa - ETF <Lisa.Ellinger@etf.wi.gov>
Subject: Follow-up questions

Lisa,

I hope this Wednesday is treating you well.

My apologies if I missed opportunities to contribute yesterday due to the technical issues with the conference line. It was muted for long periods after I would speak, so I eventually decided that I would only speak if it seemed absolutely essential to the topic at hand. I did have some questions, but I didn't think they were vital, so I decided to just include them below. Please handle them as you see best fit. It is possible they were already addressed in the meeting and I just didn't catch them. I'm sorry if that is the case.

1. I'm fully supportive of the removal of the current exclusion for benefits and services related to gender reassignment or sexual transformation. Typically, though, when benefits are changed, they are accompanied by an actuarial cost estimate. I was wondering if the exclusion of an estimate in the memo meant that the impact was determined to be negligible, or if it signaled that no estimate was completed. Also, given where we are at in the 2017 rate negotiations, will carriers be allowed to reconsider rates for the benefit change? Or, will ETF/Segal simply account for the impact in the negotiations (e.g., give carriers a credit in the negotations for a reasonable additional cost due to the benefit enhancement)? I don't anticipate that the cost of the change will exceed 0.1-0.2%, so this doesn't seem overly material. Having said that, I think the board should be made aware of how the late 2017 benefit change is accounted for, as similar situations could arise in the future (to the extent that some form of fully-insured plan still exists).

2. Regarding the cost-share change for preferred insulin products, are there other chronic conditions (beyond diabetes) that we should be examining for similar issues? Perhaps we haven't seen a significant volume of member complaints for other conditions yet, but I was thinking it would be preferable to be proactive instead of reactive on this front.

That's all. Thanks for your time. Take care and enjoy the rest of your week.

Peace,

Herschel

Exhibit E

State of Wisconsin Group Health Insurance Program

Certificate of Coverage

2017 Benefit Year

It's Your Choice Health Plan

(Program Option 1)

Revised 2/1/17

UNIFORM BENEFITS

As of the 1994 coverage year, all HEALTH PLANS offering coverage to State employees must provide the Uniform Benefits described in this Attachment A. The HEALTH PLAN may not alter the language, benefits or exclusions and limitations of the Uniform Benefits plan. HEALTH PLANS are required to provide State and participating local government employees with a description of any PRIOR AUTHORIZATION or REFERRAL requirements of the HEALTH PLAN. Any such requirements must be submitted to the DEPARTMENT, along with all promotional material, for approval and for inclusion in the "It's Your Choice" guides by the dates designated in the Time Table in Section J of the Guidelines.

The Uniform Benefits set forth in this section will be described to all SUBSCRIBERS via the "It's Your Choice" brochure. The HEALTH PLAN does not need to recreate the description of benefits nor distribute it to its members.

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I. SCHEDULE OF BENEFITS

All benefits are paid according to the terms of the Master Contract between the HEALTH PLAN and PBM and Group Insurance Board. Uniform Benefits and this SCHEDULE OF BENEFITS are wholly incorporated in the Master Contract. The SCHEDULE OF BENEFITS describes certain essential dollar or visit limits of YOUR coverage and certain rules, if any, YOU must follow to obtain covered services. In some situations (for example, EMERGENCY services received from a NON-PLAN PROVIDER), benefits will be determined according to the USUAL AND CUSTOMARY CHARGE. A change to another HEALTH PLAN will result in all benefit maximums restarting at $0 with the exception of the prescription annual OUT-OF-POCKET LIMIT.

The Group Insurance Board continues to utilize a PBM to provide prescription drug benefits formerly provided directly by the HEALTH PLANs and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits for those who are insured under the State of Wisconsin Group Health Insurance Program.

NOTE: - For PARTICIPANTS enrolled in a Preferred PROVIDER Plan (WEA Trust), this SCHEDULE OF BENEFITS applies to services received from in-network PLAN PROVIDERS. YOUR HEALTH PLAN will provide YOU with a supplemental SCHEDULE OF BENEFITS that will show the level of benefits for services provided by NON-PLAN PROVIDERS. Out-of-network DEDUCTIBLE amounts do not accumulate to the in-network OUT-OF-POCKET LIMIT.

Except as specifically stated for EMERGENCY and URGENT CARE (see Sections III., A., 1. and 2.), YOU do not have coverage for services from NON-PLAN PROVIDERS unless YOU get a Prior Authorization from YOUR HEALTH PLAN. Prior Authorization requirements are described in the HEALTH PLAN Descriptions online at etf.wi.gov.

The covered benefits that are administered by the HEALTH PLAN are subject to the following:

Benefits for STATE	**IYC Health Plan Participants that do not have Medicare** *(or have Medicare but it is not the primary payer[3])*	**Participants enrolled in Medicare** *(and Medicare is the primary payer)*	**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 OOPL.
Annual medical COINSURANCE	After DEDUCTIBLE: HEALTH PLAN pays 90% / PARTICIPANT pays 10%. Applies to medical services except for office visit COPAYMENTS, preventive services* or prescription drugs. COINSURANCE applies to OOPL except as described below.	HEALTH PLAN pays 100% except as described below for: durable medical equipment, cochlear implants and hearing aids. Then, HEALTH PLAN pays 80% to OOPL.	After DEDUCTIBLE: HEALTH 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, HEALTH PLAN pays 80% to OOPL.[1]	After DEDUCTIBLE: $2,500 per individual plan / $5,000 per family plan.

Uniform Benefits: Schedule of Benefits

Benefits for STATE	**IYC Health Plan Participants that do not have Medicare** *(or have Medicare but it is not the primary payer[3])*	**Participants enrolled in Medicare** *(and Medicare is the primary payer)*	**Participants enrolled in the** High Deductible Health Plan **(HDHP)**[3]
*Routine, preventive services as required by federal law	HEALTH PLAN pays 100%.	Covered 100%.	HEALTH PLAN pays 100%.
Primary Care Office Visit COPAYMENT applies to: • Family Practice • General Practice • Internal Medicine • Gynecology/ Obstetrics • Midwives (if HEALTH 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/HEALTH 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/HEALTH PLAN pays100%; 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: HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).	Medicare/HEALTH PLAN pays 100%; no medical COPAYMENTS.	PARTICIPANTS pay the full allowed cost until the DEDUCTIBLE is met. After DEDUCTIBLE: HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL).

Benefits for STATE	**IYC Health Plan Participants that do not have Medicare** *(or have Medicare but it is not the primary payer[3])*	**Participants enrolled in Medicare** *(and Medicare is the primary payer)*	**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 OOPL). After COPAYMENT and DEDUCTIBLE: HEALTH PLAN pays 90% COINSURANCE (10% PARTICIPANT cost to OOPL).	PARTICIPANT pays $60 COPAYMENT.	After DEDUCTIBLE: PARTICIPANT pays $75 COPAYMENT (counts towards OOPL). HEALTH 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: HEALTH PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]	Medicare/HEALTH 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: HEALTH PLAN pays 80% (20% PARTICIPANT cost to OOPL).[2]
Cochlear Implants for PARTICIPANTS age 18 and older	After DEDUCTIBLE: HEALTH PLAN pays 90% hospital charges (10% PARTICIPANT cost to OOPL). HEALTH PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	Medicare/HEALTH PLAN pays 100% hospital charges. Medicare/HEALTH PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost does not apply to OOPL).	After DEDUCTIBLE: HEALTH PLAN pays 90% hospital charges (10% PARTICIPANT cost to OOPL). HEALTH PLAN pays 80% device, surgery for implantation, follow-up sessions to train on use (20% PARTICIPANT cost to OOPL).
Cochlear Implants PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), HEALTH PLAN pays 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% PARTICIPANT cost to OOPL).	Medicare/HEALTH 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), HEALTH PLAN pays 90% for hospital charges, device, surgery for implantation and follow-up sessions to train on use. (10% PARTICIPANT cost to OOPL).

Uniform Benefits: Schedule of Benefits

Benefits for STATE	**IYC Health Plan Participants that do not have Medicare** *(or have Medicare but it is not the primary payer[3])*	**Participants enrolled in Medicare** *(and Medicare is the primary payer)*	**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: HEALTH PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum HEALTH PLAN payment of $1,000 per hearing aid.	HEALTH PLAN pays 80% (20% PARTICIPANT cost does not apply to OOPL). Maximum HEALTH PLAN payment of $1,000 per hearing aid.	After DEDUCTIBLE: HEALTH PLAN pays 80% (20% PARTICIPANT cost to OOPL). Maximum HEALTH PLAN payment of $1,000 per hearing aid.
Hearing Aids for PARTICIPANTS under age 18	After DEDUCTIBLE: As required by Wis. Stat. §632.895 (16), 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), HEALTH PLAN pays 90%. (10% PARTICIPANT cost to OOPL).
Temporo-mandibular Joint Disorders:	After DEDUCTIBLE: HEALTH PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum HEALTH PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	Medicare/HEALTH PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services Medicare/HEALTH PLAN pays 100%. Maximum HEALTH PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.	After DEDUCTIBLE: HEALTH PLAN pays 80% (20% PARTICIPANT cost to OOPL) for intraoral splints as Durable Medical Equipment. Other services HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL). Maximum HEALTH PLAN payment of $1,250 for diagnostic procedures and nonsurgical treatment per PARTICIPANT per calendar year.
Dental Implants:	After DEDUCTIBLE: HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum HEALTH PLAN payment of $1,000 per tooth.	Medicare/HEALTH PLAN pays 100% following accident or INJURY up to a maximum HEALTH PLAN payment of $1,000 per tooth.	After DEDUCTIBLE: HEALTH PLAN pays 90% (10% PARTICIPANT cost to OOPL) following accident or INJURY up to a maximum HEALTH PLAN payment of $1,000 per tooth.

Benefits for STATE	**IYC Health Plan Participants that do not have Medicare** *(or have Medicare but it is not the primary payer[3])*	**Participants enrolled in Medicare** *(and Medicare is the primary payer)*	**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.

- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: NONE
- Ambulance: Covered as MEDICALLY NECESSARY for EMERGENCY or urgent transfers.
- Diagnostic Services Limitations: Prior Authorization may be required.
- Outpatient Physical, Speech and Occupational Therapy Maximum (includes HABILITATION SERVICES or REHABILITATION SERVICES): Covered up to 50 visits per Participant for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional MEDICALLY NECESSARY visits may be available when Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per Participant per calendar year.
- Cochlear Implants: Device, surgery for implantation of the device, follow-up sessions to train on use of the device when MEDICALLY NECESSARY and Prior Authorized by the HEALTH PLAN; and Hospital charges. The PARTICIPANT'S out-of-pocket costs are not applied to the annual out-of-pocket maximum. As required by Wis. Stat. §632.895 (16), cochlear implants and related services for PARTICIPANTS under 18 years of age are payable as described in the preceding grid.
- Hearing Aids: One hearing aid per ear no more than once every three years payable as described in the preceding grid, up to a maximum of $1,000 per hearing aid. The PARTICIPANT'S out-of-pocket costs are not applied to the annual out-of-pocket maximum.

Uniform Benefits: Schedule of Benefits

As required by Wis. Stat. §632.895 (16), hearing aids for PARTICIPANTS under 18 years of age are payable as described in the preceding grid and the $1,000 limit does not apply.

- Home Care Benefits Maximum: 50 visits per Participant per calendar year. 50 additional MEDICALLY NECESSARY visits per Participant per calendar year may be available when authorized by the Health Plan.

- HOSPICE CARE Benefits: Covered when the PARTICIPANT'S life expectancy is six months or less, as authorized by the HEALTH PLAN.

- Transplants: Limited to transplants listed in Benefits and Services section.

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

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

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

- Oral Surgery: Limited to procedures listed in Benefits and Services section.

- Temporomandibular Disorders 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.

- 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:

- **Prescription Drugs and Insulin (Except SPECIALTY MEDICATIONS):**

NOTE:

- Drugs that are not included on the FORMULARY are considered NON-PREFERRED DRUGS and are not covered by the benefits of this program.
- Preventive Prescription Drugs:
  - Certain preventive prescription drugs on the PBM FORMULARY are covered at 100% as required by federal law.
  - 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.
  - 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 towards OOPL as follows:

- IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus: $600 per individual or $1,200 per family for all PARTICIPANTS.
- IYC HDHP: 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 OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

Level 3 Annual OOPL

Level 3 out-of-pocket costs accumulate toward OOPLs as follows:

- IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus: no annual OOPL.
- IYC HDHP: 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 OOPL is met, YOU pay no more out-of-pocket costs for covered medical services or prescription drugs.

- **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 SPECIALITY MEDICATIONS. You must continue to pay Level 4 Coinsurance for Non-Preferred SPECIALITY 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 SPECIALITY MEDICATIONS out-of-pocket costs accumulate towards OOPLs as follows:

- IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus: $1,200 per individual or $2,400 per family.
- IYC HDHP: 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.

- **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.

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

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

II. DEFINITIONS

The terms below have special meanings in this plan. Defined terms are capitalized when used in the text of this plan.

- **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:
  - Understanding YOUR health care treatment options
  - Clarifying YOUR health care goals
  - Weighing YOUR options about what kind of care and treatment YOU would want or not want
  - Making decisions about whether YOU want to appoint a health care agent and/or complete an advance directive
  - 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.

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

- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.

- **CONFINEMENT/CONFINED:** Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, 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.

Uniform Benefits: Definitions

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

- **DEDUCTIBLE:** The amount YOU owe for health care services YOUR HEALTH PLAN covers before YOUR HEALTH PLAN begins to pay. For example, if YOUR DEDUCTIBLE is $1,500, YOUR 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 Department of Employee Trust Funds.

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

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

  2. A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment. A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

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

     a. An unmarried DEPENDENT child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is DEPENDENT on the SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER deceases, the disabled adult must still meet the remaining disabled criteria and be incapable of self-support. The HEALTH PLAN will

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

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

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

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

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

- **DOMESTIC PARTNER:** Means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:
  - Each individual is at least 18 years old and otherwise competent to enter into a contract.
  - Neither individual is married to, or in a domestic partnership with, another individual.
  - The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
  - The two individuals consider themselves to be members of each other's IMMEDIATE FAMILY.
  - The two individuals agree to be responsible for each other's basic living expenses.
  - The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:
    - Only one of the individuals has legal ownership of the residence.
    - One or both of the individuals have one or more additional residences not shared with the other individual.
    - One of the individuals leaves the common residence with the intent to return.

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

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

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

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

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

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

  Examples of Emergencies are listed in Section III., A., 1., d. EMERGENCY services from a NON-PLAN PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the HEALTH PLAN must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the USUAL AND CUSTOMARY CHARGES for medical/hospital services.

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.

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

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

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

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

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

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

- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the SUBSCRIBER to provide the uniform benefits during the calendar year.

- **HIGH DEDUCTIBLE HEALTH PLAN (HDHP):** A HEALTH PLAN that, under federal law, has a minimum annual DEDUCTIBLE and a maximum annual OUT-OF-POCKET LIMIT (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 plan 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 HEALTH PLAN.

- **HOSPITAL:** Means an institution that:

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

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

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

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

Uniform Benefits: Definitions

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

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

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

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

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

- **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT:** Means items which are, as determined by the HEALTH PLAN:

  1. Used primarily to treat an ILLNESS or INJURY; and

  2. Generally not useful to a person in the absence of an ILLNESS or INJURY; and

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

  4. Prescribed by a PROVIDER.

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

  1. consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY; and

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

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

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

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

- **MEDICARE PRESCRIPTION DRUG PLAN:** Means the prescription drug coverage provided by the PBM to Covered 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 PLAN BENEFITS are available under this HEALTH PLAN.

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

- **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed written agreement and is not listed on the most current listing of the PBM's directory of Participating Pharmacies.

- **NON-PLAN PROVIDER:** Means a PROVIDER who does not have a signed participating PROVIDER agreement and is not listed on the most current edition of the HEALTH PLAN'S professional directory of PLAN PROVIDERS. Care from a NON-PLAN PROVIDER requires Prior-Authorization from the HEALTH PLAN unless it is an EMERGENCY or URGENT CARE.

- **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 PLAN SERVICE AREA.

- **OUT-OF-POCKET LIMIT (OOPL):** The most YOU pay during a policy period (usually a calendar year) before YOUR HEALTH PLAN begins to pay 100% of the allowed amount. This limit never includes YOUR premium, balance-billed charges or charges for health care YOUR HEALTH 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.

- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the FORMULARY, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the HEALTH PLAN to PARTICIPANTS in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are PLAN BENEFITS.

- **PLAN DEPENDENT:** Means a DEPENDENT who becomes a PARTICIPANT of the HEALTH PLAN and/or PBM.

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

- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the HEALTH PLAN to provide professional services to PARTICIPANTS covered by the HEALTH PLAN.

- **POSTOPERATIVE CARE:** Means the medical observation and care of a PARTICIPANT necessary for recovery from a covered surgical procedure.

- **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:** Means a PLAN PROVIDER who is a physician named as a PARTICIPANT'S primary health care contact. He/She provides entry into the HEALTH PLAN'S health care system. He/She also (a) evaluates the PARTICIPANT'S total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other PROVIDER health services and refers the PARTICIPANT to other PROVIDERS.

  YOU should name YOUR PRIMARY CARE PROVIDER or clinic on YOUR enrollment application or in a later written notice of change. Each family member may have a different primary physician.

- **PRIOR AUTHORIZATION:** Means obtaining approval from YOUR HEALTH PLAN before obtaining the services. Unless otherwise indicated by YOUR HEALTH PLAN, PRIOR AUTHORIZATION is required for care from any NON-PLAN PROVIDERS unless it is an EMERGENCY or URGENT CARE. The PRIOR AUTHORIZATION must be in writing. PRIOR AUTHORIZATIONs are at the discretion of the HEALTH PLAN and are described in the HEALTH PLAN Descriptions section of the It's Your Choice 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 PLAN BENEFITS.

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

the period of time during which the authorization is valid. In most cases, it is the PARTICIPANT'S responsibility to ensure a REFERRAL, when required, is approved by the HEALTH PLAN before services are rendered.

- **REHABILITATION SERVICES:** Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric REHABILITATION SERVICES in a variety of inpatient and/or outpatient settings.

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

- **SELF-ADMINISTERED INJECTABLE:** Means an injectable that is administered subcutaneously and can be safely self-administered by the PARTICIPANT and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.

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

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

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

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

- **STATE:** Means the State of Wisconsin as the policyholder.

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

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

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

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

III. BENEFITS AND SERVICES

The benefits and services which the HEALTH PLAN and PBM agree to provide to PARTICIPANTS, or make arrangements for, are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the PARTICIPANT'S PRIMARY CARE PROVIDER (except in the case of plan chiropractic services, EMERGENCY or URGENT CARE), and are received after the PARTICIPANT'S EFFECTIVE DATE.

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

The HEALTH PLAN reserves the right to modify the list of PLAN PROVIDERS at any time, but will honor the selection of any PROVIDER listed in the current provider directory for the duration of that calendar year unless that PROVIDER left the HEALTH PLAN due to normal attrition (limited to, retirement, death or a move from the PLAN SERVICE AREA or as a result of a formal disciplinary action for quality of care).

Except as specifically stated for EMERGENCY and URGENT CARE, YOU must receive the HEALTH PLAN'S written PRIOR AUTHORIZATION for covered services from a NON-PLAN PROVIDER or YOU will be financially responsible for the services. The HEALTH PLAN may also require PRIOR AUTHORIZATION for other services or they will not be covered.

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

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

A. Medical/Surgical Services

1. EMERGENCY Care

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

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

   It is the Member's (or another individual on behalf of the member) responsibility to notify the HEALTH PLAN of EMERGENCY or URGENT CARE OUT-OF-AREA HOSPITAL

admissions or facility CONFINEMENTS by the next business day after admission or as soon as reasonably possible. OUT-OF-AREA Service means medical care received outside the defined PLAN SERVICE AREA.

c. EMERGENCY services include reasonable accommodations for repair of Durable Medical Equipment as MEDICALLY NECESSARY.

d. Some examples of Emergencies are:
   - o Acute allergic reactions
   - o Acute asthmatic attacks
   - o Convulsions
   - o Epileptic seizures
   - o Acute hemorrhage
   - o Acute appendicitis
   - o Coma
   - o Heart attack
   - o Attempted suicide
   - o Suffocation
   - o Stroke
   - o Drug overdoses
   - o Loss of consciousness
   - o Any condition for which YOU are admitted to the HOSPITAL as an inpatient from the emergency room

2. Urgent Care

a. Medical care received in an URGENT CARE situation as defined in Section II. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the PARTICIPANT returns to the PLAN SERVICE AREA to receive such care from a PLAN PROVIDER.

b. YOU must receive URGENT CARE from a PLAN PROVIDER if YOU are in the PLAN SERVICE AREA, unless it is not reasonably possible. If YOU are out of the PLAN SERVICE AREA, go to the nearest appropriate medical facility unless YOU can safely return to the PLAN SERVICE AREA to receive care from a PLAN PROVIDER. If YOU must go to a NON-PLAN PROVIDER for care, call the HEALTH PLAN by the next business day or as soon as possible and tell the HEALTH PLAN where YOU received URGENT CARE. URGENT CARE from NON-PLAN PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES. Non-urgent follow-up care must be received from a PLAN PROVIDER unless it is Prior Authorized by the HEALTH PLAN or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the HEALTH PLAN.

c. Some examples of URGENT CARE cases are:
   - o Most Broken Bones
   - o Minor Cuts
   - o Sprains
   - o Most Drug Reactions
   - o Non-Severe Bleeding
   - o Minor Burns

3. Surgical Services

Surgical procedures, wherever performed, when needed to care for an ILLNESS or INJURY. These include: (a) Preoperative and POSTOPERATIVE CARE; and (b) needed services of assistants and consultants. This does not include oral surgery procedures, which are covered as described under 16. of this section.

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

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

4. Reproductive Services and Contraceptives

The following services do not require a REFERRAL to a PLAN PROVIDER who specializes in obstetrics and gynecology, however, the HEALTH PLAN may require that the PARTICIPANT obtain PRIOR AUTHORIZATION for some services or they may not be covered.

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

b. Elective sterilization.

c. Contraceptives as required by Wis. Stat. § 632.895 (17), including, but not limited to:
   - Oral contraceptives, or cost-effective FORMULARY equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
   - IUDs and diaphragms, as described under the Durable Medical Equipment provision.
   - Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

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

5. Medical Services

MEDICALLY NECESSARY professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an approved PROVIDER.

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

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

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

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

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

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

g. NUTRITIONAL COUNSELING provided by a participating registered dietician or PLAN PROVIDER.

h. A second opinion from a PLAN PROVIDER or when Prior Authorized by the HEALTH PLAN.

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

j. PARTICIPANT requested biometric screening provided annually at no PARTICIPANT cost. Biometric screenings shall at 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 in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines.

6. Anesthesia Services

Covered when provided in connection with other medical and surgical services covered under this plan. It will also include anesthesia services for dental care as provided under item B., 1., c. of this section.

7. Radiation Therapy and Chemotherapy

Covered when accepted therapeutic methods, such as x-rays, radium, radioactive isotopes and chemotherapy drugs, are administered and billed by an approved PROVIDER.

8. Detoxification Services

Covers MEDICALLY NECESSARY detoxification services provided by an approved PROVIDER. Methadone Treatment shall be covered only when MEDICALLY NECESSARY and provided by an approved PROVIDER.

9. Ambulance Service

Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the HEALTH PLAN) when MEDICALLY NECESSARY to transport to the

nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or Urgent in nature and medical attention is required en-route. This includes licensed professional air ambulance when another mode of ambulance service would endanger YOUR health. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the Plan's Service Area, the HEALTH PLAN or PLAN PROVIDER should be contacted, if possible, before EMERGENCY or Urgent transportation is obtained.

10. Diagnostic Services

MEDICALLY NECESSARY testing and evaluations, including, but not limited to, radiology and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a PLAN PROVIDER, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations. PRIOR AUTHORIZATION is required for REFERRALS to orthopedists and neurosurgeons associated directly or indirectly with the plan for PARTICIPANTS with a history of low back pain and who have not completed an optimal regimen of conservative care. Such PRIOR AUTHORIZATIONS are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty REFERRAL.

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

11. Outpatient Habilitation or Rehabilitation, Physical, Speech and Occupation Therapy

MEDICALLY NECESSARY Habilitation or REHABILITATION SERVICES and treatment. REHABILITATION SERVICES covered as a result of ILLNESS or INJURY. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the SCHEDULE OF BENEFITS, although up to 50 additional visits per therapy per calendar year may be Prior Authorized by the HEALTH PLAN if the therapy continues to be MEDICALLY NECESSARY and is not otherwise excluded.

12. Home Care Benefits

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

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

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

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

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

d. Medical Supplies, drugs and medicines prescribed by a HEALTH PLAN physician; and lab services by or for a HOSPITAL. They are covered to the same extent as if the PARTICIPANT was CONFINED IN A HOSPITAL.

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

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

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

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

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

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

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

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

13. Hospice Care

Covers HOSPICE CARE if the PRIMARY CARE PROVIDER certifies that the PARTICIPANT'S life expectancy is six months or less, the care is palliative in nature, and is authorized by the HEALTH PLAN. HOSPICE CARE, 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 six-month period if authorized by the HEALTH PLAN.

Covers Advance Care Planning after the PARTICIPANT receives a terminal diagnosis regardless of life expectancy.

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

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

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

14. Phase II Cardiac Rehabilitation

Services must be approved by the HEALTH PLAN and provided in an outpatient department of a HOSPITAL, in a medical center or clinic program. This benefit may be appropriate only for PARTICIPANTS with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) heart valve surgery; (e) onset of decubital angina; (f) onset of unstable angina; (g) percutaneous transluminal angioplasty; or (h) heart transplant. Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac REHABILITATION SERVICES are available under this contract.

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

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

16. Oral Surgery

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

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

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

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

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

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

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

g. Intraoral and extraoral incision and drainage of cellulitis.

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

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

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

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

Retrograde fillings are covered when Medically Necessary following covered oral surgery procedures.

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

17. Treatment of Temporomandibular Disorders

As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and Prior Authorized Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

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

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

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

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

18. Transplants

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

Limited to one transplant per organ (which applies to items b., e., f., and g. as listed below) per PARTICIPANT per HEALTH PLAN during the lifetime of the policy, except as required for treatment of kidney disease.

Uniform Benefits: Benefits and Services

a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
   - o Aplastic anemia
   - o Acute leukemia
   - o Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies
   - o Wiskott-Aldrich syndrome
   - o Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
   - o Hodgkins and non-Hodgkins lymphoma
   - o Combined immunodeficiency
   - o Chronic myelogenous leukemia
   - o Pediatric tumors based upon individual consideration
   - o Neuroblastoma
   - o Myelodysplastic syndrome
   - o Homozygous Beta-Thalassemia
   - o Mucopolysaccharidoses (e.g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
   - o Multiple Myeloma, Stage II or Stage III
   - o 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:
   - o Corneal opacity
   - o 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
   - o Corneal ulcer
   - o Repair of severe lacerations

e. Heart transplants will be limited to the treatment of:
   - o Congestive Cardiomyopathy
   - o End-Stage Ischemic Heart Disease
   - o Hypertrophic Cardiomyopathy
   - o Terminal Valvular Disease
   - o CONGENITAL Heart Disease, based upon individual consideration
   - o Cardiac Tumors, based upon individual consideration
   - o Myocarditis
   - o Coronary Embolization
   - o Post-traumatic Aneurysm

f. Liver transplants will be limited to the treatment of:
   - o Extrahepatic Biliary Atresia
   - o Inborn Error of Metabolism
     - Alpha -1- Antitrypsin Deficiency
     - Wilson's Disease
     - Glycogen Storage Disease
     - Tyrosinemia

- o Hemochromatosis
- o Primary Biliary Cirrhosis
- o Hepatic Vein Thrombosis
- o Sclerosing Cholangitis
- o Post-necrotic Cirrhosis, Hbe Ag Negative
- o Chronic Active Hepatitis, Hbe Ag Negative
- o Alcoholic Cirrhosis, abstinence for six or more months
- o Epithelioid Hemangioepithelioma
- o Poisoning
- o Polycystic Disease

g. Kidney with pancreas, heart with lung, and lung transplants as determined to be Medically Necessary by the HEALTH PLAN.

h. In addition to the above-listed diagnoses for covered transplants, the HEALTH PLAN may Prior Authorize a transplant for a non-listed diagnosis if the HEALTH PLAN determines that the transplant is a Medically Necessary and a cost effective alternate treatment.

i. Kidney Transplants. See item 19. below.

19. Kidney Disease Treatment

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum-see Transplants Section A., 18), donor-related services, and related physician charges.

20. Chiropractic Services

When performed by a PLAN PROVIDER. Benefits are not available for MAINTENANCE CARE.

21. Women's Health and Cancer Act of 1998

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

- o Reconstruction of the breast on which a mastectomy was performed;
- o Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- o Prostheses (see DME in Section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas;
- o Breast implants.

22. Smoking Cessation

Coverage includes pharmacological products that by law require a written prescription and are described under the Prescription Drug benefits in Section D., 1. Coverage also includes one office visit for counseling and to obtain the prescription and four telephonic counseling sessions per calendar year. Additional counseling and/or limited extension of pharmacological products require PRIOR AUTHORIZATION by the HEALTH PLAN.

B. Institutional Services

Covers inpatient and outpatient HOSPITAL services and SKILLED NURSING FACILITY services that are necessary for the admission, diagnosis and treatment of a patient when provided by a PLAN PROVIDER. Each PARTICIPANT in a health care facility agrees to conform to the rules and regulations of the institution. The HEALTH PLAN may require that the hospitalization be Prior Authorized.

1. Inpatient Care

a. HOSPITALS and Specialty HOSPITALS: Covered for semi-private room, ward or intensive care unit and Medically Necessary Miscellaneous HOSPITAL Expenses, including prescription drugs administered during the CONFINEMENT. A private room is payable only if Medically Necessary for isolation purposes as determined by the HEALTH PLAN.

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

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

2. Outpatient Care

EMERGENCY care: First aid, accident or sudden ILLNESS requiring immediate HOSPITAL services. Subject to the cost sharing described in the SCHEDULE OF BENEFITS. Follow-up care received in an emergency room to treat the same INJURY is also subject to the cost sharing provisions.

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

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

Surgical Care: Covered.

C. Other Medical Services

1. Mental Health Services/Alcohol and Drug Abuse

PARTICIPANTS should contact the HEALTH PLAN prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the HEALTH PLAN.

a. Outpatient Services

Covers Medically Necessary services provided by a PLAN PROVIDER as described in the SCHEDULE OF BENEFITS. The outpatient services means non-residential services by PROVIDERS as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37.

This benefit also includes services for a full-time student attending school in Wisconsin but out of the PLAN SERVICE AREA as required by Wis. Stat. § 609.655.

b. Transitional Services

Covers Medically Necessary services provided by a PLAN PROVIDER as described in the SCHEDULE OF BENEFITS. Transitional Care is provided in a less restrictive manner than

inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act.

c. Inpatient Services

Covers Medically Necessary services provided by a PLAN PROVIDER as described in the SCHEDULE OF BENEFITS and as required by Wis. Stat. §632.89 and Wis. Adm. Code § INS 3.37. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by a NON-PLAN PROVIDER, if provided as required by an EMERGENCY detention or on an EMERGENCY basis and the PROVIDER notifies the HEALTH PLAN within 72 hours after the initial provision of service.

d. Other

Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section D., 1.

2. Durable Diabetic Equipment and Related Supplies

When prescribed by a PLAN PROVIDER for treatment of diabetes and purchased from a PLAN PROVIDER, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered **subject to cost sharing as outlined in the SCHEDULE OF BENEFITS**. The PARTICIPANT'S COINSURANCE will be applied to the annual OUT-OF-POCKET LIMIT. Durable diabetic equipment includes:

- Automated injection devices.
- Continuing glucose monitoring devices.
- Insulin infusion pumps, limited to one pump in a calendar year and YOU must use the pump for 30 days before purchase.

All Durable Medical Equipment purchases or monthly rentals must be Prior Authorized as determined by the HEALTH PLAN.

(Glucometers are available through the PBM. Refer to Section D. for benefit information.)

3. Medical Supplies And Durable Medical Equipment

When prescribed by a PLAN PROVIDER for treatment of a diagnosed ILLNESS or INJURY and purchased from a PLAN PROVIDER, MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT will be covered **subject to cost sharing as outlined in the Schedule of Benefits**.

The following supplies and equipment will be covered only when Prior Authorized as determined by the HEALTH PLAN:

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

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

- Rental or, at the option of the HEALTH PLAN, purchase of equipment including, but not limited to, wheelchairs and hospital-type beds.

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

- IUDs and diaphragms.

- Elastic support hose, for example, JOBST, which are prescribed by a PLAN PROVIDER. Limited to two pairs per calendar year.

- Cochlear implants, as described in the SCHEDULE OF BENEFITS.

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

- Ostomy and catheter supplies.

- Oxygen and respiratory equipment for home use when authorized by the HEALTH PLAN.

- Other medical equipment and supplies as approved by the HEALTH PLAN. Rental or purchase of equipment/supplies is at the option of the HEALTH PLAN.

- When Prior Authorized as determined by the HEALTH PLAN, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the HEALTH PLAN will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the PARTICIPANT'S condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development). Services will be covered subject to cost sharing as outlined in the SCHEDULE OF BENEFITS. Except for services related to cochlear implants and hearing aids as noted above, the out-of-pocket costs will apply to the annual OUT-OF-POCKET LIMIT.

4. Out-of-Plan Coverage For Full-Time Students

If a DEPENDENT is a full-time student attending school outside of the HMO Service Area, the following services will be covered:

a. EMERGENCY or URGENT CARE. Non-urgent follow-up care out of the PLAN SERVICE AREA must be Prior Authorized or it will not be covered; and

b. Outpatient mental health services and treatment of alcohol or drug abuse if the DEPENDENT is a full-time student attending school in Wisconsin, but outside of the PLAN SERVICE AREA, as required by Wis. Stat. § 609.655. In that case, the DEPENDENT may have a clinical assessment by a NON-PLAN PROVIDER when Prior Authorized by the HEALTH PLAN. If outpatient services are recommended, coverage will be provided for five visits outside of the Plan's Service Area when Prior Authorized by the HEALTH PLAN. Additional visits may be approved by the HEALTH PLAN. If the student is unable to

maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to the limitations shown in the SCHEDULE OF BENEFITS for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the PARTICIPANT.

5. Coverage of Newborn Infants with Congenital Defects and Birth Abnormalities

As required by Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a DEPENDENT is continuously covered under any plan under this health insurance program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

6. Coverage of Treatment for Autism Spectrum Disorders

Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following PLAN PROVIDERS: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those four types of PROVIDERS, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. 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 benefits at a PBM PARTICIPATING PHARMACY except when not reasonably possible because of EMERGENCY or URGENT CARE. In these circumstances, YOU may need to make a claim as described in the paragraph below.

If YOU do not show YOUR PBM identification card at the pharmacy at the time YOU are obtaining benefits, YOU may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, YOU may be responsible for more than the COPAYMENT amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the DEPARTMENT. Contact the PBM if YOU have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by the HEALTH PLAN.

1. Prescription Drugs

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

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

The HEALTH PLAN, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, CONFINEMENT, emergency room visit or URGENT CARE setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, CONFINEMENT, emergency room visit or URGENT CARE setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, SELF-ADMINISTERED INJECTABLE).

MEDICARE eligible PARTICIPANTS will be covered by a MEDICARE Part D prescription drug plan (PDP) provided by the PBM. PARTICIPANTS who choose to be enrolled in another MEDICARE Part D PDP other than this PDP will not have benefits duplicated.

Where a MEDICARE PRESCRIPTION DRUG PLAN is the primary payor, the PARTICIPANT is responsible for the COPAYMENT plus any charges in excess of the PBM allowed amount. The allowed amount is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

In most instances, claims for MEDICARE Part D immunizations, vaccinations and other prescription drugs, including costs to administer injections for PARTICIPANTS with MEDICARE Part D coverage, will be submitted to the PBM for adjudication even when the HEALTH PLAN or a contracted provider administers the injection. If the HEALTH PLAN or a contracted provider is unable to submit such a claim to the PBM, the PARTICIPANT is responsible for submitting the claims to the PBM.

Prescription drugs will be dispensed as follows:

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

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

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

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

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

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

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

h. Mail order is available for many prescription drugs. For certain Level 1 and Level 2 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 member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply, for example, 15 tablets for a 30-day supply. PARTICIPANTS who use tablet splitting will pay half the normal COPAYMENT amount.

j. 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 OUT-OF-POCKET LIMIT for prescription drugs.

3. Other Devices and Supplies

Other devices and supplies administered by the PBM that are subject to a 20% COINSURANCE and applied to the annual OUT-OF-POCKET LIMIT for prescription drugs are as follows:

- Diaphragms
- Syringes/Needles
- Spacers/Peak Flow Meters

IV. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the PLAN BENEFITS); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by HEALTH PLANs and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that subsection 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 plan, while others may be examples of services which are not Medically Necessary or not medical in nature, as determined by the HEALTH PLAN and/or PBM.

1. Surgical Services

a. 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 a PLAN PROVIDER to treat a metabolic or peripheral disease or a skin or tissue infection.

d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include NUTRITIONAL COUNSELING as provided in the Benefits and Services section.

e. Work-related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).

f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be services of a blood donor.

g. Genetic testing and/or genetic counseling services, unless Medically Necessary to diagnose or treat an existing ILLNESS.

3. Ambulance Services

a. Ambulance service, except as outlined in the Benefits and Services section, unless authorized by the HEALTH PLAN.

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

4. Therapies

a. Vocational rehabilitation including work hardening programs.

b. Except for services covered under the HABILITATION SERVICES therapy benefit, and mandated benefits for autism spectrum disorders under Wis. Stat. § 632.895 (12m) therapies.

c. Physical fitness or exercise programs.

d. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.

e. Massage therapy.

5. Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental Injury

a. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the Benefits and Services section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits and Services section. (Note: Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may limit this exclusion.)

b. All periodontic procedures, except gingivectomy surgery as listed in the Benefits and Services section.

c. All oral surgical procedures not specifically listed in the Benefits and Services section.

6. Transplants

a. Transplants and all related services, except those listed as covered procedures.

b. Services in connection with covered transplants unless Prior Authorized by the HEALTH PLAN.

c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.

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

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

f. Non-human organ transplants or artificial organs.

7. Reproductive Services

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

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

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

d. Harvesting of eggs and their cryopreservation.

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

f. Surrogate mother services.

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

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

i. Services of home delivery for childbirth.

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

8. Hospital Inpatient Services

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

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

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

9. Durable Medical or Diabetic Equipment and Supplies

a. All Durable Medical Equipment purchases or rentals unless Prior Authorized as required by the HEALTH PLAN.

b. Repairs and replacement of Durable Medical Equipment/supplies unless authorized by the HEALTH PLAN.

c. MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's

equipment; disposable supplies; alternative communication devices (for example, electronic keyboard for a hearing impairment); and self-help devices intended to support the essentials of daily living, including, but not limited to, shower chairs and reaches, and other equipment designed to position or transfer patients for convenience and/or safety reasons.

d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as Prior Authorized by the HEALTH PLAN.

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

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

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

h. Replacement or repair of Durable Medical Equipment/supplies damaged or destroyed by the PARTICIPANT, lost or stolen.

10. Outpatient Prescription Drugs – Administered by the PBM

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

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

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

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

e. Anorexic agents.

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

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

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

i. Charges for injectable medications, except for SELF-ADMINISTERED INJECTABLE medications.

j. Charges for supplies and medicines purchased from a NON-PARTICIPATING PHARMACY, except when EMERGENCY or URGENT CARE is required.

k. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

l. Infertility and fertility medications.

m. Charges for medications obtained through a discount program or over the Internet, unless Prior Authorized by the PBM.

n. Charges to replace expired, spilled, stolen or lost prescription drugs.

11. General

a. Any additional exclusion as described in the SCHEDULE OF BENEFITS.

b. Services to the extent the PARTICIPANT is eligible for all MEDICARE benefits, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if the PARTICIPANT enrolled in MEDICARE coordinated coverage does not enroll in MEDICARE Part B when it is first available as the primary payor or who subsequently cancels MEDICARE coverage or is not enrolled in a MEDICARE Part D Plan.

c. Treatment, services and supplies for which the PARTICIPANT: (a) has no obligation to pay or which would be furnished to a PARTICIPANT without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.

d. INJURY or ILLNESS caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.

e. Treatment, services and supplies for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any state of the United States, or its Allies, or while serving in the Armed Forces of any country.

f. Treatment, services and supplies furnished by the U.S. Veterans Administration (VA), except for such treatment, services and supplies for which under the policy the HEALTH PLAN and/or PBM is the primary payor and the VA is the secondary payor under applicable federal law. Benefits are not coordinated with the VA unless specific federal law requires such coordination.

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

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

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

j. MAINTENANCE CARE.

k. Care, including treatment, services, and supplies, provided to assist with activities of daily living (ADL).

l. Personal comfort or convenience items or services such as in-Hospital television, telephone, private room, housekeeping, shopping, homemaker services, and meal preparation services as part of home health care.

m. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.

n. Custodial, nursing facility (except skilled), or domiciliary care. This includes community reentry programs.

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

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

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

r. Charges for any missed appointment.

s. EXPERIMENTAL services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the HEALTH PLAN and/or PBM following review of research protocol and individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ

transplants. In general, any service considered to be EXPERIMENTAL, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

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

u. Services, including non-physician services, provided by NON-PLAN PROVIDERS. Exceptions to this exclusion:

   1) On written REFERRAL by PLAN PROVIDER with the prior written authorization of the HEALTH PLAN.

   2) Emergencies in the Service Area when the PRIMARY CARE PROVIDER or another PLAN PROVIDER cannot be reached.

   3) EMERGENCY or URGENT CARE services outside the Service Area. Non-urgent follow-up care requires PRIOR AUTHORIZATION from the HEALTH PLAN.

v. Services of a specialist without a PLAN PROVIDER'S written REFERRAL, except in an EMERGENCY or by written PRIOR AUTHORIZATION of the HEALTH PLAN. Any Hospital or medical care or service not provided for in this document unless authorized by the HEALTH PLAN.

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.

ab. 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.

ac. Services related to an INJURY that was self-inflicted for the purpose of receiving HEALTH PLAN and/or PBM Benefits.

ad. Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires MEDICALLY NECESSARY treatment that is performed by a PLAN PROVIDER or Prior Authorized by the HEALTH PLAN. The treatment of the complication must be a covered benefit of the HEALTH PLAN and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.

ae. 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.

af. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits and Services section.

ag. 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.

ah. Sexual counseling services related to infertility.

ai. 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.

aj. Hypnotherapy.

ak. Marriage/couples/family counseling.

al. 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.

am. 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 NON-PLAN PROVIDERS and HOSPITALS requires prior written approval by the PARTICIPANT'S PRIMARY CARE PROVIDER and the HEALTH PLAN to determine medical appropriateness and whether services can be provided by PLAN PROVIDERS.

4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, PLAN PROVIDERS and HOSPITALS render medical services (and arrange extended care services and home health

service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, PARTICIPANTS may receive covered services from NON-PLAN PROVIDERS and/or Non- Participating Pharmacies.

5. Circumstances Beyond the HEALTH PLAN'S and/or PBM's Control: If, due to circumstances not reasonably within the control of the HEALTH PLAN and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the HEALTH PLAN and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the HEALTH PLAN, PLAN PROVIDERS and/or PBM will use their best efforts to provide services and other benefits covered hereunder. In this case, PARTICIPANTS may receive covered services from NON-PLAN PROVIDERS and/or Non-Participating Pharmacies.

6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a PLAN PROVIDER for determining the need for correction.

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

8. Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.

V. COORDINATION OF BENEFITS AND SERVICES

A. Applicability

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

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

   a. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

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

B. Definitions

In this section, the following words are defined as follows:

1. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is MEDICALLY NECESSARY either in terms of generally accepted medical practice or as specifically defined by the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

   However, notwithstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the secondary plan will also be responsible for paying up to the maximum benefit allowed for its plan. This will not duplicate benefits paid by the primary plan.

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

3. "Plan" means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

   b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under MEDICAID (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other

arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

4. "Primary Plan"/"Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

5. "This Plan" means the part of YOUR group contract that provides benefits for health care and pharmaceutical expenses.

C. Order Of Benefit Determination Rules

1. General

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:

a. the other Plan has rules coordinating its benefits with those of This Plan; and

b. both those rules and This Plan's rules described in subparagraph 2 require that This Plan's benefits be determined before those of the other Plan.

2. Rules

This Plan determines its order of benefits using the first of the following rules which applies:

a. Non-Dependent/Dependent

   The benefits of the Plan which covers the person as an employee or PARTICIPANT are determined before those of the Plan which covers the person as a DEPENDENT of an employee or PARTICIPANT.

b. DEPENDENT Child/Parents Not Separated or Divorced

   Except as stated in subparagraph 2., c. below, when This Plan and another Plan cover the same child as a DEPENDENT of different persons, called "parents":

   1) the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but

   2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in 1. above but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

c. DEPENDENT Child/Separated or Divorced Parents

If two or more Plans cover a person as a DEPENDENT child of divorced or separated parents, benefits for the child are determined in this order:

1) first, the Plan of the parent with custody of the child;

2) then, the Plan of the spouse of the parent with the custody of the child; and

3) finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to C., 2., b.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Active/Inactive Employee

The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule d. is ignored.

e. Continuation Coverage

1) If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

i. First, the benefits of a plan covering the person as an employee, member, or SUBSCRIBER or as a dependent of an employee, member, or SUBSCRIBER.

ii. Second, the benefits under the continuation coverage.

2) If the other plan does not have the rule described in subparagraph 1), and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or SUBSCRIBER longer are determined before those of the Plan which covered that person for the shorter time.

D. Effect On The Benefits Of The Plan

1. When This Section Applies

This Section D. applies when, in accordance with Section C., Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in subparagraph 2. below.

2. Reduction in This Plan's Benefits

The benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

E. Right To Receive And Release Needed Information

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

F. Facility Of Payment

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

G. Right Of Recovery

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

1. the persons it has paid or for whom it has paid;

2. insurance companies; or

3. other organizations.

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

VI. MISCELLANEOUS PROVISIONS

A. Right To Obtain and Provide Information

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

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

1. Health care PROVIDERS as necessary and appropriate for treatment;

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

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

B. Physical Examination

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

C. Case Management/Alternate Treatment

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

a. the recommended treatment offers at least equal medical therapeutic value; and

b. the current treatment program may be changed without jeopardizing the PARTICIPANT'S health; and

c. the charges (including pharmacy) incurred for services provided under the recommended treatment will probably be less.

If the HEALTH PLAN agrees to the attending physician's recommendation or if the PARTICIPANT or his/her authorized representative and the attending physician agree to the HEALTH PLAN'S recommendation, the recommended treatment will be provided as soon as it is

available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback, acupuncture), payment of benefits will be as determined by the HEALTH PLAN. The PBM may establish similar case management services.

D. Disenrollment

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

Change to an alternate HEALTH PLAN via It's Your Choice enrollment is available during a regular It's Your Choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

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

In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate PRIMARY CARE PROVIDER, disenrollment efforts may be initiated by the HEALTH PLAN or the Board. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the GRIEVANCE process and approval of the Board. Coverage may be transferred to the Standard Plan only, with options to enroll in alternate HEALTH PLANS during subsequent It's Your Choice enrollment periods. Reenrollment in the HEALTH PLAN is available during a regular It's Your Choice enrollment period that begins a minimum of 12 months after the disenrollment date.

E. Recovery Of Excess Payments

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

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

F. Limit On Assignability Of Benefits

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

G. Severability

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

H. Subrogation

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

- The third party or any liability or other insurance covering the third party
- The PARTICIPANT'S own uninsured motorist insurance coverage
- Under-insured motorist insurance coverage
- Any medical payments, no-fault or school insurance coverages which are paid or payable.

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

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

In the event the PARTICIPANT can recover any amounts, for an INJURY or ILLNESS for which the insurer provides benefits, by initiating and processing a claim as required by a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the PARTICIPANT shall either assert and process such claim and immediately turn over to the insurer the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the insurer in writing to prosecute such claim on behalf of and in the name of the PARTICIPANT, in which case the insurer shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a PARTICIPANT fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the PARTICIPANT'S right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the PARTICIPANT shall reimburse the insurer for all amounts theretofore or thereafter paid by the insurer which would have otherwise been recoverable under such acts and the insurer shall not be required to provide any future benefits for which recovery could have been made under such acts but for the PARTICIPANT'S failure to meet the obligations of the subrogation provisions of this contract. The PARTICIPANT shall advise the insurer immediately, in writing, if and when the PARTICIPANT files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof Of Claim

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

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

If You receive services from a NON-PLAN PROVIDER outside the PLAN SERVICE AREA, obtain and submit an itemized bill and submit to the HEALTH PLAN, clearly indicating the HEALTH PLAN'S name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of YOUR claim.

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

J. Grievance Process

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

If You exhaust the HEALTH PLAN'S and/or PBM’s GRIEVANCE process and remain dissatisfied with the outcome, You may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. You should also submit copies of all pertinent documentation including the written determinations issued by the HEALTH PLAN and/or PBM. The HEALTH PLAN and/or PBM will advise You of YOUR right to appeal to the DEPARTMENT within 60 days of the date of the final grievance decision letter from the HEALTH PLAN and/or PBM.

However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the Independent Review Organization process under Wis. Stat. § 632.835 and Wis. Adm. Code INS § 18.11. YOU may request an independent review pursuant to Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, YOU must notify the HEALTH PLAN and/or PBM of YOUR request. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11, any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, YOU have no further right to administrative review once the Independent Review Organization decision is rendered.

K. Appeals To The Group Insurance Board

After exhausting the HEALTH PLAN’S or PBM’s GRIEVANCE process and review by the DEPARTMENT, the PARTICIPANT may appeal the DEPARTMENT’S determination to the Group Insurance Board, unless an Independent Review Organization decision that is final and binding

has been rendered in accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the Independent Review Organization process under Wis. Stat. § 632.835 and Wis. Adm. Code INS § 18.11. These appeals are reviewed only to determine whether the HEALTH PLAN and/or PBM breached its contract with the Group Insurance Board.

Exhibit F

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

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

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

September 20, 2016

ALINA BOYDEN
[redacted]

Re: Written complaint

This letter is in response to the written complaint you submitted to Employee Trust Funds (ETF) on August 31, 2016, regarding the denial of services related to gender reassignment.

Per our review it appears that Dean's denial is within its discretion pursuant to the Uniform Benefit provisions of the State health insurance contract for 2016, Exclusions and Limitations:

A.1.a. Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment.

As you noted in the letter accompanying your written complaint, for the contract year 2017 the Group Insurance Board intends to remove this exclusion under Uniform Benefits. Services covered and not covered under Uniform Benefits can vary from year to year. For 2016 however, this remains an excluded benefit.

If you continue to disagree with the decision made by Dean, you may request a written determination from ETF. Written determinations are typically issued within 90 days of receipt of the request, and may be subsequently appealed to the Board. The request must be received by the Department within 60 days of the date of this letter and should specify the benefit provisions that pertain to your denial. Requests for determinations should be sent to:

Eileen Mallow
Office of Strategic Health Policy
Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

I am an ombudsperson for the state insurance programs at ETF. In this capacity, I advocate for plan members and attempt to resolve complaints and disputes on their behalf with the insurance plan. If I am unable to secure a satisfactory resolution, I advise the member of the subsequent avenues of appeal available. I also record such complaints on an automated complaint tracking system. This system produces output reports that help ETF and the State of Wisconsin Group Insurance Board evaluate plan performance.

If there are other matters that I can be of assistance with, please do not hesitate to contact me. Thank you.

Sincerely,

James Kates

Ombudsperson Services/Office of Legal Services
877-533-5020 (ext 17944)
608-261-7944

Alina Boyden
[redacted]

Department of Employee Trust Funds
Ombudsperson Services
PO Box 7931
Madison, WI 53707

Dear Sir or Madam,

My insurer, Dean Health Plan, refuses to cover medically necessary procedures relating to change of gender. The insurance company claims, correctly, that the existing contract explicitly excludes all services and procedures relating to change of gender. However, on July 12th, ETF released news of its intention to remove that exclusion from all future health contracts beginning no later than January 1st 2017. As a result, the insurance company's refusal seems to be a malicious and arbitrary denial, as such services will be covered under the plan in as little as four months' time. Delaying medically necessary services for that length of time serves no purpose but to cause me further injury.

Please find attached a letter from my physician recommending the procedure and the correspondence between myself and Dean Health Plan.

Sincerely,

Alina Boyden

Dean HEALTH PLAN
1277 Deming Way | Madison, Wisconsin 53717

5/20/2016

S160517003
Denied

ALINA BOYDEN
[redacted]

For help to translate or understand this, please call (800) 279-1301. TTY: 711

Regarding: ALINA BOYDEN
00024126201
9/1/1983

Requesting Provider: BRYAN J WEBSTER MD
752 N HIGH POINT RD
MADISON, WI 53717

Servicing Provider: MARCI BOWERS
345 LORTON AVE
SUITE 101
BURLINGAME, CA 94010

Service Type: Specialist Adult Medicine: OTHER Adult Specialist or Care

Denied Date of Service: **From:** 5/17/2016 **To:** 5/17/2017

This letter confirms denial of the requested services outlined within this authorization.

Dean Health Plan has reviewed the request for services with Dr. Marci Bowers for gender reassignment surgery. This request is denied as an exclusion of your plan. Please refer to the section entitled IV. Exclusions and Limitations, 1. Surgical Services which states: "Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment" are an exclusion of your plan. (enclosed) Alternatives to consider include discussing other options with your physician or paying for the services privately.

Benefits are determined in accordance with the eligibility and limitation provisions of the Member Certificate. Approval/Authorization for medical necessity does not guarantee coverage and/or payment for services.

A copy of this authorization denial is being sent to the providers listed above. However, the determination pertains only to a payment decision. The member and the provider make the final decision regarding whether the member will receive services.

If you have questions about benefit determinations for requested services or claims payment, please call our Customer Care Center at (800) 279-1301. If you have a concern, we encourage you to call us first because most problems can be resolved informally.

You may request, free of charge, information about how a determination was made, including: 1) the diagnosis and treatment codes with corresponding meanings, 2) a copy of criterion relied upon, and 3) an explanation of scientific/clinical judgment used.

Sincerely,

Utilization Management Department

Dean HEALTH PLAN

1277 Deming Way | Madison, Wisconsin 53717

June 15, 2016

Alina Boyden
[redacted]

RE: Alina Boyden
Case No: 160609001
Subs. No: 00024126201
Group No: 83445G

Dear Ms. Boyden:

Dean Health Plan (DHP) acknowledges receipt of your letter on June 9, 2016 in which you requested to file a grievance. You expressed concern with the denial of coverage for surgical services related to gender reassignment. This letter is to inform you that these concerns are being forwarded to the DHP Grievance and Appeal Committee for review and that you have the option to attend the meeting.

As a member you are entitled to meet with the committee to discuss your case before a final decision is reached. You may also elect to have someone represent you. The next scheduled meeting of the Grievance and Appeal Committee will be held at the Dean Health Plan office located at 1277 Deming Way, Madison, Wisconsin on Wednesday, July 6, 2016. **If you would like to attend either in person or via teleconference, please contact me by 12:00 noon on Monday, July 5, 2016** to schedule a meeting time. If I am not available when you call please press "0" and ask for someone else in the department to assist you.

Though your personal attendance is not required, this meeting is an opportunity for you to further clarify your concerns and/or present additional information. If you choose not to attend, you may still submit information in advance of the meeting for the Committee's review. The Committee responds in writing within thirty (30) days of the date we received your grievance.

Dean Health Plan complies with the American Disabilities Act in providing services. Our meeting room facilities are fully accessible to individuals with impaired mobility. If you have special accessibility needs or need an interpreter, please contact us as soon as possible. Individuals who are deaf, hearing or speech impaired may contact us through the Wisconsin Telecommunications Relay System (TRS).

If you have any further questions or wish to schedule a time to meet with the Grievance and Appeal Committee, please contact me at 608-827-4126 or 1-800-356-7344, ext. 4126.

Sincerely,

Clinton Kippley
Grievance & Appeals Quality Specialist

Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono	ເພື່ອຊ່ວຍໃນການແປ ຫລືເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະຣຸນາໂທຣະສັບຫາ
Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau	Если вам не всё понятно в этом документе, позвоните по телефону
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	**Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'**

如果需要中文的帮助，请拨打这个号码

For Help to translate or understand this, please call : 1-800-279-1301 (1-608-827-4086, TTY).

Dean HEALTH PLAN

1277 Deming Way | Madison, Wisconsin 53717

July 8, 2016

Alina Boyden
[redacted]

RE: Alina Boyden
Case No: 160609001
Subs. No: 00024126201
Group No: 83445G

Dear Ms. Boyden:

The Dean Health Plan (DHP) Grievance and Appeal Committee would like to thank you for meeting on Wednesday, July 6, 2016, to discuss your grievance. You expressed concern with the denial of coverage for surgical services with Dr. Marci Bowers related to gender reassignment. Please see the following determination.

The following information was taken into consideration during the decision making process:

- Grievance letter.
- Denied authorization.
- Medical records.
- It's Your Choice Booklet (enclosed).
- Discussion at the Grievance and Appeals Committee Meeting.

Based on review of this information, it is the decision of the Grievance and Appeal Committee to uphold the denial of the requested surgical services. Review of the information determined the requested services are an exclusion of your policy.

As stated in your "It's Your Choice Booklet":

Uniform Benefits: Exclusions and Limitations
The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Plan Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by Health Plans and the PBM.

Surgical Services
Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment.

During the committee meeting, you also raised concerns regarding less than satisfactory service and treatment you've received at the Dean Clinics. I encourage you to discuss these concerns with the Patient Advocate team at Dean Clinic ,(608) 294-3807]. If you would like assistance in coordinating a conversation please contact the DHP Grievance and Appeal Program Manager, Michelle Olson, at 608-827-4469.

The following members of the Grievance and Appeal Committee participated in the review of your grievance:

- General Counsel
- Director of Sales
- Director of Quality & Revenue Management
- Board Certified Family Practice/Obstetrics Medical Doctor

If you think a coding error may have occurred, you have the right to obtain the billing and diagnosis code descriptions associated with this request/service. You can request this information by contacting Dean Health Plan Customer Care at 608-828-1301 or 800-279-1301.

At this time you have exhausted all appeal options with Dean Health Plan. Upon request, you have the right to request a copy of documents, and criteria free of charge, relevant to the outcome of your grievance by sending a written request to the address listed below:

Dean Health Plan
Grievance and Appeal Department
1277 Deming Way
Madison, WI 53717

You have the right to request a review of your grievance by the Department of Employee Trust Funds (ETF). The ETF complaint form (ET-2405) is available on ETF's Web site at http:/etf.wi.gov or by contacting ETF at:

Department of Employee Trust Funds
801 West Badger Road
P.O. Box 7931
Madison, WI 53707-7931
(608) 261-7947
Toll Free: 1-877-533-5020, ext. 17947
Email: ombudsperson@etf.state.wi.us
http://etf.wi.gov

Your written request must be received by ETF within 60 calendar days of the date of this letter. Requests must contain all pertinent documentation, including a copy of this letter and a description of the contract provision(s) at issue.

If you would like more information about how filing a request for independent review will affect your rights for a review by ETF, you should contact ETF directly at the number above.

Exhibit G

Hayes, Daniel P - ETF

From: Doss-Anderson, Liz - ETF on behalf of ETF SMB Ombudsperson
Sent: Friday, July 01, 2016 12:21 PM
To: Hayes, Daniel P - ETF
Subject: FW: ETF Appeal, Departmental Review
Attachments: SR Andrews ETF Grievance.odt

From: Shannon Andrews [mailto:[redacted]
Sent: Friday, July 01, 2016 12:20 PM
To: ETF SMB Ombudsperson <ETFSMBOmbudsperson@etf.wi.gov>
Subject: Re: ETF Appeal, Departmental Review

Additionally, please use the following version of my grievance letter (replacing the version of "SR Andrews ETF Grievance") as it now has the correct date attached. Thank you!

On Fri, Jul 1, 2016 at 12:17 PM, Shannon Andrews <[redacted]> wrote:

To whom it may concern:

My name is Shannon R. Andrews. Recently, I filed an appeal for coverage of a surgical procedure I received in October of 2015 with WPS insurance, which I am a member of through ETF. My appeal to WPS was denied, and as such I am continuing the appeal process by filing a grievance with ETF. Attached to this message you will find all the pertinent documents from the first appeal (as "WPS Appeal Documents"), as well as a copy of the letter for my grievance ("SR Andrews ETF Grievance"), along with the signed grievance form ("ETF Shannon").

I am requesting a departmental review for the determination of this appeal.

If there is anything else you need me to send or if this message has not gone to the correct place, please let me know. Thank you for your time.

Sincerely,

Dr. Shannon R. Andrews

WPS HEALTH INSURANCE

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway – P.O. Box 8190
Madison, WI 53708-8190

May 5, 2016

SHANNON ANDREWS
[redacted]

Patient Name:	Shannon Andrews
Patient Date of Birth:	02/25/1982
Subscriber Name:	Shannon Andrews
Subscriber Number:	742671543
Date(s) of Service:	10/27/2015

Dear Shannon Andrews:

This letter is in response to your recent request for a review by the Grievance/Appeals Committee for our denial of surgical services for the above-mentioned date(s) of service.

The Grievance/Appeals Committee voting members were a Medicare Tactical Support Operations Manager, an Actuarial Services Analyst, a Director of Integrated Care Management and a Senior Paralegal.

The Committee considered all of the available information, including your letter received in our office on 04/06/2016, the testimony provided and the language of the plan.

The Committee upheld the denial based on the Exclusions section of your plan, specifically exclusion 19.

Regardless of the medical necessity, this type of surgery is specifically excluded.

According to the General Exclusion section of your Health Plan, your Plan provides no benefits for:

19. HEALTH CARE SERVICES for, or leading to, sex transformation surgery and sex hormones related to such TREATMENT.

The patient/customer has the right, upon request, and free of charge, to access and receive copies of documents, records, criteria and other information, that are relevant to this claim for benefits. Please fax or mail to the below address:

WPS GRIEVANCE AND APPEALS
PO BOX 7062
MADISON WI 53707-7062
Fax (608) 221-6168

You have now exhausted WPS' grievance process and have the right to request a review of your grievance by the Department of Employee Trust Funds (ETF). The ETF complaint form (ET-2405) is available on ETF's Web site at http:/etf.wi.gov or by contacting ETF at:

Department of Employee Trust Funds
801 West Badger Road
P.O. Box 7931
Madison, WI 53707-7931
(608) 261-7947
Toll Free: 1-877-533-5020, extension 17947
Email: ombudsperson@etf.state.wi.us
http://etf.wi.gov

Your written request must be received by ETF within 60 calendar days of the date of this letter. Requests must contain all pertinent documentation, including a copy of this letter and a description of the contract provisions at issue.

If you have any further questions, please contact me at 1-608-226-4940, Monday through Friday from 8:30 AM to 5:00 PM Central Time.

Sincerely,

Kathleen Held

Kathleen Held
Acting Chairperson, Grievance/Appeal Committee

For language line assistance:
Para obtener asistencia en Español, llame al 1-800-221-5313, 1-608-221-1600.

Exhibit H

From: ETF SMB Insurance Submit

To: Pirlot, RJ; LaPlante-Kleinke, Marin; State of WI General Mailbox (stateofwi@anthem.com); Brian Martin (brian.martin@anthem.com); Malinda Mootz (malinda.mootz@anthem.com); Matt Harty (Matthew.Harty@wpsic.com); Carrie Helms (carrie.helms@wpsic.com); Carri Moberg (Carri.moberg@wpsic.com); Katie Beals (kathryn.beals@deancare.com); Bound, Penny; Martha Henderson (martha.henderson@deancare.com); Deb Treinen (debra.treinen@deancare.com); Kim Christophersen (kchristophersen@deltadentalwi.com); Maureen Lewandowski (mlewandowski@deltadentalwi.com); Sunshine Mikulak (smikulak@deltadentalwi.com); Alexander, John - ETF; Doss-Anderson, Liz - ETF; Bogardus, Jeff E - ETF; Bradley, Sarah - ETF; Brockman, Sara - ETF; Carabell, Rachel - ETF; Cooper, James G - ETF; Ellinger, Lisa - ETF; Etes, Sherry A - ETF; Hayes, Daniel P - ETF; Kates, James - ETF; Kirchner, Andrew - ETF; Larson, Arlene - ETF; ETF SMB Insurance Submit; Mallow, Eileen K - ETF; Meier, Jaymee - ETF; Nispel, David - ETF; Pray, Tara - ETF; Richardson, Mary K - ETF; Rossner, Jessica E - ETF; Schomber, Shayna - ETF; Steele, Joan M - ETF; Walk, Renee - ETF; Whitmus, Wade - ETF; Wienkes, Kathy - ETF; Jennifer Rust Anderson; Amy Wolfgram; Elizabeth Dye ; Emily Halter (Ehalter@ghcscw.com); Lenth, Gary; Kris Scholze - Gundersen (Kristine.Scholze@quartzbenefits.com); Ben Brott (Brott.Benjamin@mayo.edu); Jolene Bucher-Jones (BucherJones.Jolene@mayo.edu); Luke Hanson (Hanson.Luke@mayo.edu); Joelle Lambert (joelle.j.lambert@healthpartners.com); Chris Rowen (Rowen.Christopher@mayo.edu); Janette Schull (janette.m.schull@healthpartners.com); Tobias, Elizabeth S; Kori Brudos (brudos.kori@mayo.edu); Fjerstad, Jane; Sara Herrera (herrera.sara@mayo.edu); Nikkia Jost-Coble (Jost-Coble.Nikkia@mayo.edu); Massa, Chris; Shannon McArthur (mcarthur.shannon@mayo.edu); Reinolt, Kathy; Bright, Darin; Rain Buck (rbuck2@humana.com); Christa Klein (cklein@humana.com); Lambert, Sharon; Brittney Teives (bteives@humana.com); Wright, Elizabeth; Medical Associates - ETF Contacts (stateofwisconsin@mahealthcare.com); Putnam, Codi; Amy Dora (adora@mhsjvl.org); Hesse, Mary; Chrisann Lemery (clemery@mhsjvl.org); Josh Mummery (jmummery@mhsjvl.org); Sherrie Sargent (ssargent@mhsjvl.org); DuWayne Severson (dseverson@mhsjvl.org); Dean Wolanyk (dwolanyk@mhsjvl.org); Steven Alexander; Ryan Olson (ryan.olson@navitus.com); Shannon Tischer (Shannon.Tischer@Navitus.com); Stacie Schlafer (stschlaf@networkhealth.com); Lavonne Simon (lsimon@networkhealth.com); Cara Techlin (ctechlin@networkhealth.com); Ron Sebranek (ron.sebranek@pplusic.com); SHP Account Coordinators (shpacctcoord@securityhealth.org); Sharon Davisson (davisson.sharon@securityhealth.org); Gorst, Becky; Security Shared Inbox (shpmembr@securityhealth.org); Kara Johnson (johnson.kara@securityhealth.org); Revling, Jan - HLTHP; Jackie Crist (crist.jacqueline@securityhealth.org); Eileen Flick (eflick@segalco.com); "Sander, Gina T."; Schatten, Kirsten R.; Vieira, Kenneth C.; Mailhiot, Shelly; Kurt Rich (kurt_rich@uhc.com); Kathy Stachura (Kathy_a_stachura@uhc.com); Cari Alexander (cari.alexander@quartzbenefits.com); Dougherty, Phil; Wenzel, Nancy; CIESLEWICZ, GREG - ETF; KSwanson@weatrust.com; Matthew.Harty@wpsic.com; Greg Nelson (greg.nelson@wpsic.com); Vale, Sarah

Subject: ETF OSHP Weekly Notice 2017:05

Date: Tuesday, January 31, 2017 4:10:35 PM

Attachments: GIB_02 08 17_Item 4_UB Services Related to Gender Reassignment.pdf
Addendum to 2017 Uniform Benefits.docx
WPE Res for Jan 17 as of Jan 31 17.docx

ETF Office of Strategic Health Policy (OSHP) Broadcast Email: All Contracted Health Plans

1. **Action Item: 2017 Uniform Benefits and Services Related to Gender Reassignment**
2. **Informational Item: Status of Implementation of Data Warehouse**
3. **Informational Item: Updated List for 2017 Wisconsin Public Employers**
4. **Informational Item: Group Insurance Board Meeting**
5. **Reminders**

1. **Action Item: 2017 Uniform Benefits and Services Related to Gender Reassignment (2 Attachments)**

Description: At the December 30, 2016 Group Insurance Board meeting, the Board approved reinstating the exclusion of health benefits and services based on gender identity after certain contingencies were met. Upon consultation with the Board Chair, it was determined that ETF should issue a 2017 health plan contract amendment to all participating health plans to reinstate the benefit exclusion, effective February 1, 2017.

The Board memo detailing the contingencies is attached.

Due Date: Plans should sign and return the attached contract amendment to ETFSMBInsuranceSubmit@etf.wi.gov by the end of the day on February 3, 2017.

Follow-up questions on this item should be sent to: ETFSMBInsuranceSubmit@etf.wi.gov

2. **Informational Item: Status of Implementation of Data Warehouse**

Description: ETF expects the implementation of the new data warehouse to begin soon. Truven Health Analytics could begin meeting with data submitting entities, including health plans, Delta Dental, Navitus, and Staywell, by mid- to late-March. Additional information will be available in the coming weeks.

Follow-up questions about this item should be sent to: Rachel Carabell at Rachel.Carabell@etf.wi.gov

3. **Informational Item: Updated List for 2017 Wisconsin Public Employers (Attachment)**

Description: On October 18, November 15, December 6, 2016, and January 4, 2017, ETF provided a list of Wisconsin Public Employers (WPE) changes for 2017. There are a few more changes as summarized below and shown in the attachment. Specifically in the sections:

- Joining: *The new Monarch Library System has been created from the combination of two participating libraries (listed next).*
- Withdrawing*: Eastern Shores and Mid-WI Federated libraries have been terminated and their employees have been moved into the new Monarch Library System, listed above.*

These are noted in red on page one and two of the attachment. Changes since October 18 appear in yellow highlight.

Follow-up questions about this item should be sent to: Arlene Larson at Arlene.Larson@etf.wi.gov

4. **Informational Item: Group Insurance Board Meeting**

Description: The GIB will meet on Wednesday, February 8. The meeting will be held from 8:30 a.m. to 3:30 p.m. at the **Sheraton Hotel Madison – Destination South Ballroom**, 706 John Nolen Dr, in Madison. The meeting agenda and materials are available online.

5. **Reminders**

Below are reminders of upcoming deadlines and events. Please refer to the 2016 Key Dates Memo for a complete list of submission deadlines.

February 3, 2017

Signed Addendum Regarding the Reinstatement of Benefit Exclusion Concerning Gender Reassignment submission deadline

February 8, 2017
Group Insurance Board Meeting

February 17, 2017
2016 Participation Data for Well Wisconsin Incentive submission deadline

Exhibit I

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

Correspondence Memorandum

Date: June 22, 2016

To: Group Insurance Board

From: Tara Pray, Alternate Health Plans Manager

Subject: Guidelines Contract and Uniform Benefits Changes for 2017

The Department of Employee Trust Funds (ETF) staff requests that the Group Insurance Board (Board) approve the changes to the Guidelines Contract and Uniform Benefits that are detailed in *Attachment A* and grant ETF staff the authority to make additional technical changes as necessary.

The text in bold in *Attachment A* represents the new changes since the May meeting.

Background
At the May 18, 2016 meeting, the Board approved the recommendations presented and granted staff the authority to make additional technical changes as necessary. The May memo stated that final changes would be brought to the Board for approval at the August 16, 2016 meeting.

In light of recent federal developments, and the scheduling of this extraordinary meeting, we are seeking approval on 2017 changes now to provide ample time for administrative implementation by the health plans and ETF.

Staff will provide the final revised contract document to the Board prior to the November 15, 2016 meeting.

Summary of New HHS Rule and Recommended Changes
On May 13, 2016, the federal Department of Health and Human Services (HHS) issued a final rule pertaining to Section 1557 of the Affordable Care Act (ACA). The rule applies to “covered entities” and prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Included under sex discrimination is discrimination on the basis of gender identity.

There are two areas where we are recommending changes in order to be compliant with the new rule:

1. Removing the current exclusion related to benefits and services related to gender reassignment or sexual transformation. Required effective date is January 1, 2017.
2. Update the current required non-discrimination notification language to be provided on all significant communications published by the health plans. Required effective date is October 16, 2016 (90 days from July 18, 2016).

Prohibited Activities

ACA Section 1557 provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance, or under any program administered by an Executive Agency or a State Exchange.

Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.

Prohibited activities include:

1. Deny, cancel, limit, or refuse to issue health coverage
2. Deny or limit a claim
3. Impose additional cost-sharing or other limitations
4. Deny or limit coverage or impose additional cost-sharing or other limitations for sex-specific health services provided to transgender individuals based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available
5. Categorically excluding coverage for services related to gender transition
6. Otherwise limit services related to gender transition if the limitation would result in discrimination against a transgender individual

Analysis of ETF as a Covered Entity and Rationale for Recommendation

The rationales for the following components that make up the definition of a "covered entity" under section 1557 were provided by Segal:

Covered entities include:	Rationales:
1. Group health plans that accept funding from HHS, such as the Retiree Drug Subsidy	The health insurance companies themselves are covered entities that cannot contract away their own nondiscrimination obligations via an agreement with the Board
2. Insurers that participate in the Exchanges or otherwise receive federal	Same rationale as for #1

funding; and their related third party administration business	
3. Employers whose primary business is related to health care – for both their services and their employees. Example – a hospital that sponsors an employee health plan will be covered not only for the services it offers to its patients but also for the health benefits it provides to its employees.	The State of Wisconsin is probably not a covered entity under the Section 1557 rules with respect to its entire employee benefit program. However, it would be a covered entity for its Medicaid-related employees or Exchange-related employees, or other State departments that accept Federal funds from HHS (community health, public health, etc.). So if Medicaid-related employees (or others where the State accepts Federal funds) are covered under a State self-insured plan, the State will probably need to comply with 1557
4. State or local governments that accept HHS funding for services such as Medicaid or community health programs, but only for those programs	Same rationale as for #3

Other factors

1. Health programs or activities include group health plans:
    a. Employee health benefit programs include group health plans, third party administers, insurers, evidence-based insurance designs, employer-sponsored wellness programs, health clinics or long term care.
    b. Excepted benefits (e.g., dental, vision) are covered under this rule – not exempted.

2. Covered entities may still use reasonable medical management techniques, and are not required to cover any particular treatment or procedure. However, they will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination.

3. Even if an employer is not covered under Section 1557, they will generally be prohibited from discriminating on the basis of sex, gender identity, or sexual orientation under Title VII and EEOC regulations.

[1] Where, by contrast, the alleged discrimination relates to the benefit design of a self-insured plan—for example, where a plan excludes coverage for all health services related to gender transition—and where OCR has jurisdiction over a claim against an employer under Section 1557 because the employer falls under one of the categories in § 92.208, OCR will typically address the complaint against that employer.

As part of its enforcement authority, OCR may refer matters to other Federal agencies with jurisdiction over the entity. Where, for example, OCR lacks jurisdiction over an employer responsible for benefit design, OCR typically will refer or transfer the matter to the EEOC and allow that agency to address the matter. The EEOC has informed OCR that, provided the filing meets the requirements for an EEOC charge, the date a complaint was filed with OCR will be deemed the date it was filed with the EEOC (although any subsequent denial of a renewed coverage request could be separately challenged by a timely complaint). Citation: Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31432 (May 18, 2016)

Recommendation from ETF's legal counsel

ETF's legal counsel recommends that ETF, in its role of administering benefits for the Board, act as if it is a covered entity subject to the final HHS regulations. This is the safest course of action in connection with both the self-insured and fully-insured plans. This will avoid future complaints to the EEOC regarding Uniform Benefits or prescription drug coverage, as the preamble[1] specifically states that HHS will refer all complaints that happen to be outside of their jurisdiction to the EEOC.

Other Key Changes

The other changes were mentioned in concept in the memo and presentation in May. The draft contract language is now detailed in *Attachment A*. These topics include wellness, claims data submission requirements, and disease management, and are all related to the current vendor procurements in these areas.

New Clarification Language

1. Added clarification about when deductible and out-of-pocket limit accumulations transfer.
2. Definition of benefits: clarification that benefits are described in the Uniform Benefits section of the contract.
3. Revised the therapy benefit to make it clear that habilitation services are not restricted to illness or injury.
4. Clarification on no double coverage under the program.
5. Clarify effective date in relation to the receipt of the application.

Staff will be at the Board meeting to answer any questions.

Attachment A: 2017 Guidelines Contract and Uniform Benefits Changes

Exhibit J

From: Kox, Bill
Sent: Friday, September 08, 2006 11:21 AM
To: Bogardus; Jeff
Subject: FW: copy of bargaining demands
Attachments: 2005-2007demands.doc; 2005-2007table.doc

-----Original Message-----

From: Licht, Pam

Sent: Monday, August 21, 2006 10:59 AM

To: Kox, Bill

Cc: Walk, Sharon

Subject:FW: copy of bargaining demands

Here is an electronic copy of the 2005-07 bargaining demands.

-----Original Message-----

From: Berger, Mary

Sent: Monday, August 21, 2006 9:06 AM

To: Licht, Pam

Subject:RE: copy of bargaining demands

I have no idea if this is the final copy that was submitted. But here is what I have.

-----Original Message-----

From: Licht, Pam

Sent: Monday, August 21, 2006 8:51 AM

To: Berger, Mary

Subject:copy of bargaining demands

Can you email me a copy of the 2005-07 Bargaining Demands ETF submitted?

~~~~~~

Pamela A. Licht

Section Chief, Staff Services

Quality Assurance Services Bureau

WI Dept. of Employee Trust Funds

801 W. Badger Rd., P.O. Box 7931

Madison, WI 53707-7931

W: (608) 266-0301 Fax: (608) 267-0633

~~~~~~

WISCONSIN RETIREMENT SYSTEM

1. Permanent rule of 85 with age 55 as the floor.

Proposal submitted by:
Wisconsin Education Association Council

ETF Response

Most retirement benefits are priced and funded as a percentage of the covered employees' payroll. In 2004, the contribution rate for general category state employees is 9.8%. This figure includes a 5% statutory employee contribution, a 0.6% Benefit Adjustment Contribution payable by employees, a 4.2% employer contribution for current service. These rates do not include the employer contribution for the accumulated sick leave program that is an additional 3.0% of covered employee's payroll.

The general employee retirement contribution rate for 2005 will increase to 10.2% of covered employee's payroll and the accumulated sick leave conversion program contribution rates will decrease to 1.4% of covered employee's payroll. Consequently, the total decrease in contribution rates beginning January 1, 2005 for the retirement and accumulated sick leave programs is 1.2%.

Estimated Annual Cost:

The cost of adopting this proposal could be funded either through increases to the employee and employer contribution rates or through employer payment of the actuarial discount applied to employees who retire prior to normal retirement age. The costs are estimated as follows:

a. Contribution rate increase for all employees- In April 1993 the consulting actuary to the Wisconsin Retirement System (WRS) estimated that a permanent rule of 85 would cost an additional **0.7%** of payroll. This is only an approximate cost. A new actuarial study would be necessary to develop more precise numbers.

b. Employer payment of actuarial discount-The employer can pay the present value of the actuarial reduction for each affected employee when he or she retires. This is currently permitted under Wis. Stats. 40.23 (2m) (g). Such payments are not earnings for purposes of computing the employee's final average earnings. They are also not restricted by the federal Section 415 (c) limits. For a 55-year-old employee with 30 years of service and a final average salary of $30,000, the required payment is $19,896. For a 60-year-old employee with 25 years of service and a final average salary of $30,000, the payment is $6,279. **The total cost for all bargaining unit employees cannot be estimated since it is not known how many employees in the bargaining unit will retire each year with an actuarial discount and the lump sum cost for each employee.**

Currently state law provides for a modified rule of 87 for general employees under the Wisconsin Retirement System (WRS). Beginning at age 57, general employees with 30 years of service may retire with full benefits (no actuarial reduction). Between age 55 and 57, employees are subject to a 0.4% reduction for each month from retirement to the 57th birthday (a total of 9.6% at age 55). General employees

with less than 30 years have a further actuarial reduction until age 65; however at age 57 and later this reduction is offset based on the employee's years of service and the reduction is often minimal.

This proposal would increase retirement benefits for certain general employees in the bargaining unit whose combined age and creditable service equal 85 or more. The increase would range from 9.6% at age 55 with 30 years of service to 1.4% at age 64 with 21 years of service.

At the end of 2003, the general employee average age was 44.4 with 11.2 years of service. If this hypothetical employee works full-time for the rest of his or her career, the rule of 85 will apply when the employee reaches age 59.2 and has 25.8 years of service. Under current law, the actuarial reduction for an employee with this combination of age and service is 3.8%. **Consequently, the average benefit increase for which employees could qualify under a rule of 85 is 3.8%.**

However, individual career patterns vary widely from the average. In 2003, the average retirement age for employees in the WRS was 60.8 with average service at retirement of less than 25 years. **This average suggests that a rule of 85 without any other improvements in the actuarial reduction *would be of little benefit to many employees.***

2. **All employees in the Department of Corrections, Division of Care and Treatment Facilities (DHSS) and Division of Youth Services (DOC) who are responsible for supervision of inmates, forensic patients, or delinquent youth, or, who four hours per day or more have direct contact with inmates, will be placed in protective occupation retirement status.**

Proposal submitted by:
Wisconsin Education Association Council

ETF Response:

The tables below show the total cost differential between the protective occupation category and the general employee category for 2005. These rates include retirement, sick leave and s.40.65 duty disability. The Department is unable to identify either the number of employees affected by this proposal or the total amount of covered payroll. If OSER is able to identify those employees, the cost of this demand should be relatively easy to determine. The affected employees are in two agencies for which the contribution rates for general and protective category employees are shown below. The increase in contribution rates can be multiplied by the total covered salary of the affected employees in the bargaining unit to arrive at an annual cost.

Estimated Annual Cost:

	2005		
	General Category	Protective Category	Net Increase
DHFS	11.6%	16.7%	+5.1%
Corrections	11.6%	16.2%	+ 4.6%

*See background comments below concerning restrictions on collective bargaining of protective occupation category employment.

Background Comments:

Protective occupation status is not discretionary. Employers are required to report qualifying employees as protectives (with DER concurrence for state employees), and employees who disagree with the employer's determination have a right to appeal under Wis. Stats. 40.06 (1) (e).

"Protective occupation participant" is defined in Wis. Stats. 40.02 (48). In addition to certain job titles which are automatically deemed protective, any employee must be so classified if his or her principal duties "involve active law enforcement or active fire suppression or prevention, provided the duties require frequent exposure to a high degree of danger or peril and also require a high degree of physical conditioning."

On June 26, 1996 the Wisconsin Employment Relations Commission (WERC) ruled that LaCrosse County does not have a duty to bargain with the Wisconsin Professional Police Association (WPPA) regarding protective employee status for jailers employed by the County. The key language of the ruling is as follows:

> Collective bargaining over "protective status" irreconcilably conflicts with the statutory entitlement to "protective occupation" benefits because collective bargaining could produce scenarios in which ineligible employees receive benefits or eligible employees lose benefits. Collective bargaining over "protective occupation" status issues also irreconcilably conflicts with the statutory entitlement to benefits because it places the Commission in the role of evaluating the statutory eligibility criteria under Sec. 40.02 (48), Stats. where the Legislature has reserved those roles to the County initially and ETF and ETFB, ultimately. . . .
>
> [T]he statutory process set forth in Chapter 40 is the exclusive means by which protective occupation participant issues are to be resolved. If these issues were subject to the collective bargaining process, it is obvious that employees who do not meet the statutory standards could acquire the legislatively established benefits and also that employees who do meet the standards in question could lose those benefits. We do not think that potential is within the range of options and alternatives contemplated by the Legislature when it created the Public Employee Trust Fund.

This ruling is in accord with ETF's view that protective occupation status cannot be collectively bargained.

3. BRINGING GRADUATE ASSISTANTS UNDER WISCONSIN RETIREMENT SYSTEM

Proposal submitted by:
Teaching Assistants Association
Milwaukee Graduate Assistants Association

ETF Response:

The cost of bringing graduate students under the Wisconsin Retirement System (WRS) is 11.6 percent of the graduate student payroll, based on 2005 WRS contribution rates. The contribution rate is made up of:

Employee Required Contribution:	5.0%
Employer Required Contribution:	4.4%
Benefit Adjustment Contribution:	.8%
Sick Leave Contribution:	1.4%
Total Contribution:	11.6%

The following is the total annual cost of bringing Graduate Assistants under the WRS based on annual payroll estimates from UW Payroll and assume employer pickup of entire 11.6% contribution:

Graduate Assistant Classification	Estimated Annual Payroll	Estimated Annual Cost
Research Assistants (from UW Madison and UW Milwaukee)	$ 42,353,309	$ 4,912,984
Teaching Assistants and Project/Program Assistants (from UW Madison, UW Milwaukee & UW Extension)	$ 39,811,520	$ 4,618,136
Other Graduate Assistants (all other campuses)	$ 3,555,651	$ 412,456

Estimated Annual Cost:

$9,943,576

INCOME CONTINUATION INSURANCE

1. Decouple Income Continuation Insurance from sick leave.

Proposal submitted by:
Wisconsin State Employees Union
State Employees Council

ETF Response:

For purposes of this estimate, we assume this demand refers to the proposed Income Continuation Insurance (ICI) plan redesign that was approved by the Group Insurance Board (Board) at its April 1998 meeting.

At that time, the Board approved a proposal that would change the requirement of the ICI plan that all accumulated sick leave be exhausted prior to the availability of ICI benefits. In addition, employees could choose an elimination period of 30, 90, 125, or 180 days prior to the begin date for benefits. The state would pay the cost of the premium for the 180-day elimination period, with employees picking up the premium cost if they wanted to "buy down" to a lower elimination period.

Costs to the state would increase because all covered employees would be eligible for a contribution towards their ICI coverage whereas currently, employees in Categories 1 and 2 receive no employer contribution. Off setting this would be a reduction in the employers share of premiums for Categories 3, 4, and 5. Further savings would accrue to the State because people would not be forced to use all sick leave prior to the date their ICI benefits begin. Finally, the State may experience a small increase in the cost of the Accumulated Sick Leave Conversion Credit (ASLCC) program as more converted sick leave would be available at the time these employees retire. This last effect would likely be gradual, so any increase in the cost to the State to fund higher sick leave balances would be several years into the future.

At the time this proposal was evaluated, the department required an actuarial analysis of the changes by both of its actuarial consulting firms. The following estimate is based on the results of those reviews and has not been updated due to the costs involved. Nonetheless, due to the fact that there has been no change to the premium levels for the ICI program, and the relatively low increase in salary levels from that time, these estimates should be fairly representative. If this demand is seriously considered, it may be wise to request that the actuarial analyses be updated.

Annual increase in the total State share of premium:	$1,373,736
Savings from current sick leave not required to be exhausted: (estimated at 19,300 days saved per year)	$3,647,700
Additional cost to fund increased ASLCC balances: (estimated at 0.1% of payroll)	$2,150,000
Net savings to State:	$ 123,964

This change would require amendment to sections 40.02(25m), 40.05(5), 40.61, and 40.62 of the Statutes.

Estimated Annual Cost:

A savings of $123,964 per year.

2. Employer contribution for Income Continuation Insurance premiums.

Proposal submitted by:
State Engineering Association

Estimated Annual Cost:

Unable to determine.

3. Provide Access to Graduate Employees to Other Voluntary Insurance Benefit Programs – Disability

Proposal submitted by:
Teaching Assistants Association

ETF Response:

There are approximately 7300 graduate teaching assistants who may wish to apply for ICI coverage. Because graduate assistants cannot currently accumulate sick leave, all of the graduate teaching assistants that would apply for coverage would be placed in Category 1, where the employee pays the entire premium. Therefore, there would be no immediate cost to State.

This would require a statutory change to include graduate-teaching assistants as participating employees under 40.02 (25), and 40.22 for voluntary participation in the Income Continuation Insurance plan.

Estimated Annual Cost

None

TIAA-CREF PROGRAM

1. Matching Employer Contributions to TIAA-CREF Program

Proposal Submitted By:
Teaching Assistants Association

ETF Response:

The TIAA-CREF Program is a Section 403 (b) tax-sheltered annuity program that is administered by educational institutions such as the University or other state agencies with those functions. This program is not administered by ETF.

There currently is no employer match by the UW under the s. 403 (b) program.

Estimated Annual Cost:

Unable to determine.

HEALTH INSURANCE

1. Provide health insurance coverage to domestic partners and their dependents.

Proposal submitted by:

Milwaukee Graduate Assistants Association
Teaching Assistants Association
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Service Employees International Union
Wisconsin Education Association Council
Wisconsin State Attorneys Association

ETF Response:

The demand does not include a definition of domestic partners or alternative families and a wide variety of relationships could be included.

It is recommended that if the State considers this change, it limits eligibility by basing available coverage on the following commonly used definition: both parties are age 18 or over; the partners have shared a residence for six months and intend to remain together indefinitely; neither partner is married or in another domestic partnership; the partners are financially and emotionally interdependent, and are not related by blood.

Note that depending on the specific definition of domestic partner to be used, estimates may vary, but in general there does not appear to be material adverse risk associated with this coverage. Rather, it is more a question of trying to determine how many additional individuals will be added to the policy.

According to the estimate by the Group Insurance Board's actuary, membership would increase an additional one to two percent depending on whether or not opposite-sex partners are included. Using 2004 total estimated annual state costs of $642,104,000, this coverage would result in an annual cost of one percent of premium ($6.42 million) for coverage limited to same-sex partners and two percent of premium ($12.84 million) if opposite-sex partners are included.

We assume that costs for this proposal will change in proportion to the overall changes in health insurance costs for the program. However if the risk profile or the overall numbers of domestic partners changes in the future, then costs will be proportionally less than or greater than average.

Upon termination of the relationship or the employment, federal COBRA regulations would require dependent children to remain eligible for coverage for an additional 36 months. Dependent adults, other than divorced spouses, are not eligible for extended coverage under current COBRA regulations. In addition, according to the latest information we have, federal tax law will treat the portion of employer paid premium for family coverage as taxable income if there is no federally recognized dependent. Since domestic partners are not federally recognized as dependents, employees who take family coverage solely for the purpose of covering a domestic partner will incur additional tax liabilities.

If coverage for domestic partners is granted, the Department would recommend modifying the definition of "dependent" in s. 40.02(20).

Wis. Stat.§ 40.02 (25) (b) 3. currently provides eligible employee status to surviving spouses of employees or retired employees. If it is the intent of this proposal to grant spousal status to surviving domestic partners, this provision should be modified to include domestic partners. However, if domestic partners are only to be provided dependent status then the change to Wis Stat. § 40.02 (20) should be sufficient.

The practical effect of granting eligible employee status is to allow a surviving domestic partner access to family coverage if they later wish to establish another domestic-partner relationship or get married.

Domestic partner coverage presents administrative and risk issues that will raise cost issues for the State. Consequently, significant care should be taken when considering this proposal. ETF does not recommend granting status equivalent to that of a spouse that would provide benefits even after dissolution of a domestic partnership.

Estimated Annual Cost

$6.42 million – 12.84 million

2. Establish a freestanding (statewide) comprehensive dental plan.

Proposal submitted by:

Milwaukee Graduate Assistants Association
State Engineering Association
Teaching Assistants Association
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Employees Union
Wisconsin State Public Defenders Association
Service Employees International Union
Wisconsin Education Association Council
Wisconsin State Attorneys Association

ETF Response:

This response is based on the fee for service plan design, originally proposed to be effective January 2005. It provides 100% coverage for routine examinations, cleanings, x-rays, fluoride treatment and space maintainers. Basic restorative services, periodontia, endodontics and oral surgery are covered at 80%. Major restorative services, prosthodontics, for all covered individuals and orthodontics for dependent children under 19 years of age are covered at 50%. The annual deductibles are $25 for and individual and $75 for a family.

Updated premium estimates were made by using the trend recommended by the Board's actuary. As noted in a previous workgroup report, the actuary recommends a detailed analysis of any plan considered for implementation. A change in benefit

structure, or employer share of premium can impact the premium amount, and the participation level, both would affect the total cost to the state.

The net cost of dental is estimated at seven and a half million dollars annually based on the benefit level summarized above, increasing the premium since that time, and assuming:

- Single premiums will average $34.00 per contract per month;
- Family premiums will average $101.00 per month;
- The state will pay 60% of the premium;
- HMOs currently offering dental benefits eliminate that benefit; and
- 73% of active employees choose to participate in the new dental plan.

Estimate Calculations:

33,546 family contracts (73% of 69,000 * 66%)
x $60.60 per month (60% of $101)
x 12 months per year
$24,394, 651 annual family premium

16,773 single contracts (73% of 69,000 * 33%)
x $20.40 per month (60% of $34)
x 12 months per year
$4,106,030 annual single premium

$24,394,651 annual family premium
$ 4,106,030 annual single premium
$28,500,681 total annual premium

The estimated 2005 dental premium rates that are included in the health plans premiums is $21,000,000. Subtracting this amount from the total annual premium above, 28,500,000, results in a net estimated annual cost of $7,500,000.

Estimated Annual Cost

$7,500,000

3. **Affordable, quality health care coverage for all employees. Including the following:**

- **Institute a formula to base the pro-ration of health insurance employee contribution based on the deciles of comparative pay.**
- **Cap employee contribution based on proportion of annual income.**
- **Create a formula that will bind future premium to future wage adjustments**

Proposal submitted by:
Milwaukee Graduate Assistants Association
Wisconsin State Attorneys Association
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Employees Union

Wisconsin State Public Defenders Association

ETF Response:

The demand for "affordable, quality, health care" is too vague to make a cost estimate. A formula could be created that is based on the pro-ration of health insurance premium according to comparative pay and that could be designed to be cost neutral to the State. This appears to be a compensation or equity issue not a cost issue.

The cost of an employee cap on contribution can not be calculated without a more complete explanation of how that would be structured, and whether or not it is indexed.

Creating a formula that would bind future premium to future wage adjustments presumably would cost the State whatever the increase in future health premium would be. This can not be calculated.

Estimated Annual Cost

Unable to determine

4. Maintain at least one zero premium health plan for TA union members and expand access to zero premium plans outside of State and Country.

Proposal submitted by:
Teaching Assistants Association

ETF Response:

The State premium contribution for employees represented by the TAA currently is determined by using a three-tier system. The total 2005 projected employer cost for all graduate students is $161,774. If at least one zero-premium cost plan was available to all graduate students, the immediate employer cost would be something less than $161,744. This assumes at least some students would prefer, and choose a plan with some cost to the student. The exact cost of this change is can not be determined as it depends on unpredictable behavior. The cost depends on several criteria including the cost difference between the zero-cost and other tier contribution levels, individual considerations on choice of plan and any factor that eventually contributes to the make up the enrollment distribution.

The longer-term consequences should be also considered. The incentives of the three-tier system would be undermined. Bidders knowing that there must be at least one no-cost alternative would have less incentive to bid low, and would be less willing to negotiate to enter a lower tier.

Although the immediate cost can be considered less than $161,744 annually, the cost will increase with the general increase in health premium. Longer range there are implications that costs would increase because bidding and negotiating incentives would be undermined.

Estimated Annual Cost

Unable to determine

5. **Premium sharing formula remains status quo.**

Proposal submitted by:
Wisconsin Education Association Council

ETF Response:

The cost of maintaining the current benefits will depend upon the premiums charged by the participating plans. It is not possible to determine the cost of this demand.

Estimated Annual Cost

Unable to determine.

6. **Change the structure of employer/employee premium sharing system, and have at least one tier-one plan available to employee working for the state.**

Proposal submitted by:
State Engineering Association

The proposal is not specific regarding the change in structure and so the cost can not be estimated. There is a one tier-one plan per county requirement currently in effect. The State Maintenance Plan is offered at a tier-one contribution in counties where there are no alternative qualified tier-one plans.

The state employees that currently reside out-of-state are offered the Standard Plan at a tier-two rate. There are currently 299 single contracts and 614 family contracts held by out-of-state employees. If these employees were offered the coverage at a tier-one rate, it would increase state costs by $653,064 per year.

Estimated Annual Cost

$653,064 per year.

7. **Provide health insurance coverage for represented employees on the first day of employment.**

Proposal submitted by:
State Engineering Association
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Service Employees International Union
Wisconsin Education Association Council
Wisconsin State Attorneys Association

ETF Response:

This proposal would require the state to pay health insurance premiums beginning on the first day of employment. Currently new employes must pay all such premiums or defer enrollment until the end of six months. Insurance coverage now begins on the first of the month following the receipt of the application.

In January 2004, the state's estimated average monthly contribution per insurance contract was $780.58. Contributions for the full six months not currently covered would average $4683.48 per person. The Department cannot currently accommodate partial month premium collections so the estimate is based upon coverage becoming effective on the first of the month after employment begins. If coverage were to be effective mid-month, there would be additional cost and statutory changes would be required.

Using information provided by DOA Central Payroll and extrapolating that information to include the University of Wisconsin, for fiscal year 2004 it is estimated that there would be approximately 2,990 new employees each year. On the basis of average state contribution per contract, the annual cost to the state would be $14,003,605.20.

The long-term costs are a function of the number of new hires and can vary widely from year to year. The analysis for 2005-07 may be depressed because it was derived using actual fiscal year 2004 data. The number of new hires estimated for this analysis was 2,990. A similar analysis completed in 2002 estimated new hires at 5,250, though it should be noted at that time U.W. faculty were not entitled to immediate pick-up.

This change would require statutory changes to Wis. Stat. § 40.05.

Estimated Annual Cost

$4,683.48 x 2,990 new appointments = $14,003,605.20

8. Change the lifetime maximum benefits imposed under the alternate plans to $5 million and increase the maximum benefit under the standard plans to $5 million.

Proposal submitted by:
State Engineering Association

ETF Response:

The lifetime maximum for 2004 is $2 million for all plans, including the Standard and State Maintenance plans. The Group Insurance Board’s actuary estimates that moving the lifetime maximum to $5 million for all plans would cost in the range of $0.15-$0.20 per member per month (pmpm).

Using $0.17 pmpm for a population of 162,559 members the total annual cost would be 162,559 x .17 x 12 = $331,620.

The GIB has expressed its intent to maintain the relative value of Uniform Benefits at its current level, therefore, the addition of this benefit could be held cost neutral through a corresponding reduction of another benefit.

Estimated Annual Cost

$331,620

9. Appoint a State Engineering Association Representative to sit on the Group Insurance Board (GIB).

Proposal submitted by:
State Engineering Association

ETF Response:

Wis. Stats. '15.165 (2), states that the Board shall consist of five standing members (e.g., the Governor, Attorney General, etc., or their designees) plus five persons appointed by the Governor for two year terms. The appointees include an insured participant in the Wisconsin Retirement System who is not a teacher, one who is a teacher, a retiree and an insured employee of a local unit of government. The current statutes could accommodate this demand if the Governor were willing to fill a current Board position with a represented state employee when the current member's appointment expires. Under this scenario there would be no cost impact. If the union is seeking a new, solely dedicated position on the Board, actual cost would be relatively minor, about $500 to $1,500 per year, but could lead to similar demands by other employee and employer groups.

If a new member were to be added, Wis. Stat. § 15.165 (2) would need to be amended.

Estimated Annual Cost

$0 to $1,500 per year

10. 100% Employer paid Health Insurance.

Proposal submitted by:
Service Employees International Union

ETF Response:

The estimated total employee share of all health insurance premiums for calendar year 2004 is $17,000,969.00.

The impact on future premium should be noted. If the employer were paying 100% of the premium, the incentive for a subscriber to choose an efficient health provider would be greatly reduced. Health insurance providers would have less reason to bid low and the State would have less leverage in negotiations. Health insurance premium increases would be harder to control. Further, the annual cost of this benefit will rise at least as fast as health insurance premium in general.

This benefit change would require statutory changes under s. 40.05..

Estimated Annual Cost

$17,000,969.00.

11. 100% Employer paid Health Insurance for Retirees.

Proposal submitted by:
Service Employees International Union

ETF Response:

For 2004, the estimated total annuitant premium is $140 million. Of this, approximately $70 million is paid from sick leave accounts. Of the remaining $70 million, about $59 million is paid by the retiree using annuity deductions, nearly $11 million is made by annuitants by direct payment to the health plan. Less than $1 million is paid by converting the value of life insurance to sick leave credits.

The impact on the sick leave program and future use of sick leave would also need to be considered. Currently, sick leave credits can be used only for the premium in the Group Insurance Board's health insurance program. With employer paid retiree health insurance, the incentive to save sick leave would be limited to the reduction of Income Continuation Insurance premium for high levels of sick leave accrual.

The use of sick leave may go up. This adds additional employer costs because sick leave paid as a benefit to an active employee requires tax contributions by both parties. Sick leave used as credits to pay for premium does not.

Estimated Annual Cost

$70,000,000

12. Provide Long Term Care Health Care Benefits and share the cost of premium for employees.

Proposal submitted by:
State Engineering Association

ETF Response:

We assume for our response that the demand is related to the Long-term Care Insurance program. Long-term care rules allow for employees to cover relatives. It is assumed that only employees would be provided this benefit. Costs are based on a group rate for a base plan providing for a maximum daily benefit of $160, and a 90-day waiting period. We will further assume that the employer share of the premium will be 50%. Using the current age distribution of state employees the annual cost of coverage is estimated to be $ 31.05 million. The premium for this benefit increases significantly with age.

70,000 contracts
x $221.79 50% of average annual premium per contract
$15,524,950

Estimated Annual Cost

$15.52 Million

11. Establish a free standing vision benefit.

Proposal submitted by:
Service Employees International Union
Wisconsin State Employees Union
Milwaukee Graduate Assistants Association
Teaching Assistants Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Wisconsin Education Association Council

ETF Response:

There is a wide variety of benefit levels among free standing vision programs. For this estimate, we assumed a program that provides benefits for in-network and out-of network providers. In-network exams, lenses and frames are paid in full with a $10 copay for exams and $25 copay for materials (lenses and frames). Exams and lenses are allowed every twelve months, new frames are allowed every 24 months. For out-of-network exams and materials there is a benefit schedule. Examinations are paid for up to $40, lenses from $40 to $80 depending if they are single, bifocal, or trifocal. Frames are paid up to $105 and contact lenses up to $210.

Rates are based on a population of 65,000, with full participation. Rates would increase if not all the population were insured. The monthly rate is a composite based on the total number of employees, which provides coverage for all immediate family members. The composite rate is $7.45 per month.

$65,000 * $7.45* 12 = $5,800,000

Estimated Annual Cost

$5.8 Million

12. Alter procedure followed in notifying new employees of window for enrolling in Dual-Choice health insurance, and propose a thirty- (30) day window for enrolling that begins with employee receipt of an individually-addressed notice from the Employer.

Proposal submitted by:
Milwaukee Graduate Assistants Association

ETF Response:

No fiscal impact.

13. Arrange an annual meeting with ETF staff to discuss member concerns and problems encountered in the State Health Plan.

Proposal submitted by:
State Engineering Association

ETF Response:

No fiscal impact

14. Add a union seat on the formulary review committee.

Proposal submitted by:
Milwaukee Graduate Assistants Association

ETF Response:

The "Pharmaceutical and Therapists" (P&T) Committee is operated by a private sector company. The State cannot direct the company to include members of a union on the P & T Committee

Estimated Costs

No Fiscal Impact.

15. Allow spouse access to sick leave conversion credits when employee retires or dies while covered by spouse's health insurance outside of the state group.

Proposal submitted by:
Milwaukee Graduate Assistants Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association

ETF Response:

Statute currently requires an employee be enrolled for family coverage in order to permit the conversion of any remaining sick leave to credits for use by surviving spouse and dependents upon the employee's death. Upon retirement, an annuitant may escrow his or her sick leave credits; these would be available to his or her survivors upon the annuitant's death. The former employee may also use sick leave credits to pay for health insurance premium in retirement, but if covered by a single plan, the sick leave credits will not be available to the spouse or dependents upon the retiree's death.

We can not determine precisely how many people fall into these categories, but intuitively and anecdotally, compliance to the statute is considered high. Because of the value of the credits and access to the state group health plan we believe most couples have opted for family coverage. For those who have not, the state employees have typically enrolled for coverage just prior to retirement in order to preserve lifetime access to any credits and an open enrollment into the health plan.

Calculating the cost of this is further complicated by the implications of behavior resulting from the change. First, in the pure form where no other changes would take place beyond opening access to survivors, the cost of funding the sick leave program would increase. This is simply because there would be more people accessing sick leave. Just how many people under current conditions is not calculable, but it would probably not be high for the reasons stated above.

However, if this benefit change were made, perhaps more state employees would opt out of the program and use coverage provided through a spouse's employer. There would be an immediate saving due to the decrease in employer share of premium, but there may be longer-term considerations due to risk selection. Depending upon the nature of the family's risk profile, the quality of the alternative coverage, and the employer's share of that coverage the state health program may lose better than average risks, or alternatively gain the poorer risks eventually impacting premium and participation in the plan.

Estimated Cost

Unable to estimate.

16. A number of demands regarding the evaluation of the Pharmacy Benefit Manager (PBM) were not calculable or had no fiscal impact including:

- **Evaluate Pharmacy Benefit Manager quality of service**
- **Evaluate alternatives to the current benefits being administered**
- **Conduct a comprehensive audit of the formulary**
- **Evaluate the PBM performance in responding to employee appeals/reviews**
- **The PBM contract will require an internal appeal process with no application fee**
- **Challenge the PBM to address inequities in the cost of prescription drugs, in particular the blatantly sexist classification of various contraceptive options**

Proposal submitted by:
Milwaukee Graduate Assistants Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association

ETF Response:

Continual evaluation of all administrators of self-insured benefit programs is a standard practice. This includes complaint resolution as well as fiscal impact and benefit design. The PBM, which has the appropriate medical expertise, continually reviews the formulary with reference to new studies and information. In addition, an independent audit of the PMB is required by contract.

There is no application fee for requesting an internal PBM review, apparently this is being confused with the fee required for an independent review organization. The demand to address the inequities of the cost of prescription drugs is too vague to evaluate the cost. It is also unclear what the blatant sexist classification of various contraceptive options reference means.

Estimated Annual Cost

No fiscal impact.

17. Expand mental health coverage and expand preventative health coverage, e.g. health club membership, weight control programs, smoking cessation.

Proposal Submitted by:
Wisconsin State Attorneys Association
Teaching Assistants Association

ETF Response:

The proposal is not specific regarding the level of benefit change and so the cost can not be estimated. Further, various preventative benefits are included in the benefits offered by participating health plans, including coverage for smoking cessation.

Estimated Annual Cost

Unable to determine

18. Provide coverage for transgender, and transsexual individuals to get surgery and follow-up hormone therapy.

Proposal Submitted by:
Teaching Assistants Association

ETF Response:

The Board's actuary estimates that in a population of the size of the state program there would be two procedures annually, each costing about $55,400, including all follow-up therapy. The annual cost could be expected to rise at the rate of general increases in health care costs.

Estimated Annual Cost

$110,800

19. **Disclosure of any payments by pharmaceutical manufacturer to PBM or PBM employees.**

Proposal Submitted by:
Wisconsin State Attorneys Association

ETF Response:

ETF has a contractual right to full disclosure of any financial arrangement between the PBM and Pharmaceutical manufacturers.

Estimated Annual Cost

No fiscal impact

20. **Require disclosure of compensation paid to executives of all health care providers and PBM, and publish financial statements of all health care providers and PBM in open enrollment materials distributed to employees annually.**

Proposal Submitted by:
Wisconsin State Attorneys Association

ETF Response:

The Office of the Commissioner of Insurance annually collects compensation information on the top executives of all Wisconsin insurers. That information is therefore already available to people who may want it. It is not practical for ETF to duplicate this information in the enrollment materials.

Estimated Annual Cost

No fiscal impact

21. Set separate out-of-pocket maximums for each drug level, including level 3.

Proposal Submitted by:
Wisconsin State Attorneys Association
State Engineering Association

ETF Response:

Three level formularies are designed to obtain the best prices for prescription drugs yet still allow subscribers access to most covered prescription drugs. Setting out-of-pocket maximums for each level would undermine this subscriber incentive and would in turn jeopardize the discounts we receive from the manufacturers of the drugs on our formulary. Subscriber incentives to use these formulary drugs would be eliminated once people met the out-of-pocket maximum, but drug manufacturers insist on the incentives in order to get the best prices.

Placing a value on the cost of this change in not easily calculable. It is estimated that the value of these discounts exceed $20 million per year, and if this change negated the rebate arrangements, that is the amount that the change could cost.

Estimated Annual Cost

Potentially in excess of $20 million.

22. Provide access to non-utilized sick leave from employees who have left state service for additional employee release time.

Proposal Submitted by:
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Milwaukee Graduate Assistants Association

ETF Response:

To estimate the cost of this benefit, we will assume that all of the sick leave not used by former employees will be used by an active employee some time at least five years after the former employee leaves service. The value of the unused sick leave will be calculated by multiplying the number of unused sick leave hours times the average employee salary.

This will not account for the extra costs that may be incurred when an active employee must be replaced if absent from the job. Further, any additional costs that might be required to fund the sick leave program have not been considered.

Using information provided by DOA Central Payroll and extrapolating that information to include the University of Wisconsin, for fiscal year 1998-1999 it is estimated that there would be approximately 476,000 sick leave hours unused by terminated employees that did not return to state service. Using an average hourly wage of $22.99 per hour the total annual cost of this benefit would be $10,943,240.

As noted above, this estimate takes into account only the direct cost of converting unused sick leave into wages. It is unknown whether or not the hours must be used as release time, how the hours will be distributed and what the eligibility criteria for using it will be. Employees who terminate prior to retirement may be junior and earning a lower wage to those who will eventually use the sick leave hours. In any case, employees who do not need to use the sick leave they earn personally will presumably have more to convert at retirement. This may have additional costs in funding the sick leave program. Further, because of tax consequences, sick leave used as release time is more costly to the state than sick leave converted to credits.

Estimated Annual Cost

$10,943,240.00

23. Independent audit of performance of three-tier plan to evaluate success of plan in controlling health care cost increases. Independently audit and evaluate the effect of PBM in reducing pharmacy costs due to management and volume purchasing vs. cost shifting to employees

Proposal Submitted by:
Wisconsin State Attorneys Association

ETF Response:

An independent audit of this scope is estimated to cost from $40,000 to $50,000. This is based on using an actuarial firm other than the five under contract to the Group Insurance Board. A firm unfamiliar with the intricacies of the state program and setting rates would require considerable research hours to validate previous data rate settings and develop the estimates proposed in the question.

Estimated Annual Cost

$40,000 to 50,000

24. Require PBM purchase drugs from Canada

Proposal Submitted by:
Wisconsin State Attorneys Association

ETF Response:

The PBM cannot be required to purchase drugs from Canada. The PBM does not directly purchase drugs from wholesalers, pharmacies purchase the drugs and the PBM reimburses the pharmacies for the cost of drugs consumed by our covered members.

It should also be noted that when using a comparison of the top 10 most prescribed drugs shows that the costs of Canadian imported drugs would be comparable to the cost under the current PBM. Further, generic drugs in Canada are typically much more expensive then generic drugs in the US.

Estimated Annual Cost

No fiscal impact

25. Eliminate SHIP requirement for international students, and streamline the rebate procedure for erroneous enrollment.

Proposal Submitted by:
Teaching Assistants Association

ETF Response:

SHIP is a federally mandated program and its requirements can not be waived by the state.

Estimated Annual Cost

No fiscal impact

26. Create a "single plus one" family category to be priced less than family coverage.

Proposal submitted by:
Milwaukee Graduate Assistants Association
State Engineering Association
Teaching Assistants Association
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Employees Union
Wisconsin State Public Defenders Association
Service Employees International Union
Wisconsin Education Association Council
Wisconsin State Attorneys Association

ETF Response:

The costs associated with changing to a two-person family option are a result of the distribution of contracts between actively employed and retirees under age 65. The board's actuary has estimated the additional cost to be $3.8 million to $5.2 million annually.

The cost is due to the fact that the under 65 year old retiree group has a high percentage of the two-person family category contracts that are now included in the family category. When those contracts are extracted into a cheaper member+1 category, the family category must rise to make the shift cost neutral. This shift in cost does not affect the total amount of premium that will be collected as a whole, but it does affect the amount of premium that is collected by the active and under-65 retiree group independently. The change causes the amount of premium collected from the active group to rise. The actuary assumed that 95% of the cost of an active employee's premium is the responsibility of the state.

This change will require a statutory change because the current single/family premium structure is established under s. 40.52(1)(a)

Estimated Annual Cost

$3,800,000 to $5,200,000

27. Allow the use of sick leave credits to pay premium for voluntary benefit plans including Long-term Care, dental, and vision.

Proposal Submitted by:

Milwaukee Graduate Assistants Association
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Wisconsin State Attorneys Association

ETF Response:

It is assumed that this benefit would be first accessible at retirement when sick leave is converted to sick leave credits. The program's actuary estimates that this will cost one tenth of one per cent of total payroll. The cost of this is affected both by the fact that sick leave credits will be depleted more quickly, and there will be more members who use all their sick leave credits.

Based on the 2003 total sick leave payroll of $ 3,349,008,795.00 * .001 = $3,349,795.00.

Estimated Annual Cost

$3,349,795.00

Exhibit K

From: Owen, Linda
Sent: Wednesday, October 22, 2008 10:13 AM
To: Bogardus; Jeff
Cc: Gilding; Jean
Subject: RE: demands table
Attachments: 2008 bargaining demands.doc

I got the estimated grad assistant annual payroll from Dick Laufenberg, so was able to complete the DRS portion of the information needed for the bargaining demands. The document with the DRS information is attached.

-----Original Message-----

From: Bogardus, Jeff

Sent: Tuesday, October 21, 2008 11:16 AM

To: Owen, Linda

Subject:demands table

<< File: CC-08-043_2009-2011 Bargaining Demands_Draft1.xls >>

Jeff Bogardus

Manager, Pharmacy Benefit Programs

Division Of Insurance Services

Department of Employee Trust Funds

Phone: (608) 266-3099

FAX: (608) 267-0633

WISCONSIN RETIREMENT SYSTEM

1. Permanent rule of 85 with age 55 as the floor.

Proposal submitted by:
Wisconsin Education Association Council

ETF Response

Most retirement benefits are priced and funded as a percentage of the covered employees' payroll. In 2008, the contribution rate for general category state employees is 10.6%. This figure includes a 5% statutory employee contribution, a 1.0% Benefit Adjustment Contribution payable by employees, a 4.6% employer contribution for current service. These rates do not include the employer contribution for the accumulated sick leave program that is an additional 1.2% of covered employee's payroll.

The general employee retirement contribution rate for 2009 will remain the same at 10.6% of covered employee's payroll and the accumulated sick leave conversion program contribution rates will decrease to .8% of covered employee's payroll. Consequently, the total decrease in contribution rates beginning January 1, 2007 for the retirement and accumulated sick leave programs is .4%.

Estimated Annual Cost:

The cost of adopting this proposal could be funded either through increases to the employee and employer contribution rates or through employer payment of the actuarial discount applied to employees who retire prior to normal retirement age. The costs are estimated as follows:

a. Contribution rate increase for all employees- In April 1993 the consulting actuary to the Wisconsin Retirement System (WRS) estimated that a permanent rule of 85 would cost an additional **0.7%** of payroll. This is only an approximate cost. A new actuarial study would be necessary to develop more precise numbers.

b. Employer payment of actuarial discount-The employer can pay the present value of the actuarial reduction for each affected employee when he or she retires. This is currently permitted under Wis. Stats. 40.23 (2m) (g). Such payments are not earnings for purposes of computing the employee's final average earnings. They are also not restricted by the federal Section 415 (c) limits. For a 55-year-old employee with 30 years of service and a final average salary of $30,000, the required payment is $21,861.95 For a 60-year-old employee with 25 years of service and a final average salary of $30,000, the payment is $6,922.08. **The total cost for all bargaining unit employees cannot be estimated since it is not known how many employees in the bargaining unit will retire each year with an actuarial discount and the lump sum cost for each employee.**

Currently state law provides for a modified rule of 87 for general employees under the Wisconsin Retirement System (WRS). Beginning at age 57, general employees with 30 years of service may retire with full benefits (no actuarial reduction). Between age 55 and 57, employees are subject to a 0.4% reduction for each month from retirement to the 57th birthday (a total of 9.6% at age 55). General employees

with less than 30 years have a further actuarial reduction until age 65; however at age 57 and later this reduction is offset based on the employee's years of service. The more service, the less reduction there is for each month of age, and the reduction is often minimal.

This proposal would increase retirement benefits for certain general employees in the bargaining unit whose combined age and creditable service equal 85 or more. The increase would range from 9.6% at age 55 with 30 years of service to 1.4% at age 64 with 21 years of service.

At the end of 2007, the general employee average age was 45.9 with 11.9 years of service. If this hypothetical employee works full-time for the rest of his or her career, the rule of 85 will apply when the employee reaches age 59.5 and has 25.5 years of service. Under current law, the actuarial reduction for an employee with this combination of age and service is 4.0%. **Consequently, the average benefit increase for which employees could qualify under a rule of 85 is 4.0%.**

However, individual career patterns vary widely from the average. In 2007, the average retirement age for retirees in the WRS was 60.0 with average service at retirement of 23.2 years. **This average suggests that a rule of 85 without any other improvements in the actuarial reduction *would be of little benefit to many employees.***

2. **All employees in the Department of Corrections, Division of Care and Treatment Facilities (DHSS) and Division of Youth Services (DOC) who are responsible for supervision of inmates, forensic patients, or delinquent youth, work within DHSS and DOC facilities and have direct contact with inmates, all Department of Natural Resources park rangers, and all state security officers** Wisconsin State Building Trades **will be placed in protective occupation retirement status.**

   Proposals submitted by:

   Wisconsin Education Association Council, Wisconsin State Employees Union, Wisconsin Professional Employees Council, AFT-Wisconsin State Employees Council, Professional Employees in Research, Statistics & Analysis, Wisconsin Science Professionals, Wisconsin State Public Defenders Association, Wisconsin Physician & Dentist Association, Wisconsin State Building Trades

   ETF Response:

   The tables below show the total cost differential between the protective occupation category and the general employee category for 2009. These rates include retirement, sick leave and s.40.65 duty disability. The Department is unable to identify either the number of employees affected by this proposal or the total amount of covered payroll. If OSER is able to identify those employees, the cost of this demand should be relatively easy to determine. The affected employees are in two agencies for which the contribution rates for general and protective category employees are shown below. The increase in contribution rates can be multiplied by the total covered salary of the affected employees in the bargaining unit to arrive at an annual cost.

Estimated Annual Cost:

	2009 Rates		
	General Category	Protective Category	Net Increase
DHFS	11.2%	17.5%	+6.3%
Corrections	11.2%	15.8%	+ 4.6%

*See background comments below concerning restrictions on collective bargaining of protective occupation category employment.

Background Comments:

Protective occupation status is not discretionary. Employers are required to report qualifying employees as protectives (with DER concurrence for state employees), and employees who disagree with the employer's determination have a right to appeal under Wis. Stats. 40.06 (1) (e).

"Protective occupation participant" is defined in Wis. Stats. 40.02 (48). In addition to certain job titles which are automatically deemed protective, any employee must be so classified if his or her principal duties "involve active law enforcement or active fire suppression or prevention, provided the duties require frequent exposure to a high degree of danger or peril and also require a high degree of physical conditioning."

On June 26, 1996 the Wisconsin Employment Relations Commission (WERC) ruled that LaCrosse County does not have a duty to bargain with the Wisconsin Professional Police Association (WPPA) regarding protective employee status for jailers employed by the County. The key language of the ruling is as follows:

> Collective bargaining over "protective status" irreconcilably conflicts with the statutory entitlement to "protective occupation" benefits because collective bargaining could produce scenarios in which ineligible employees receive benefits or eligible employees lose benefits. Collective bargaining over "protective occupation" status issues also irreconcilably conflicts with the statutory entitlement to benefits because it places the Commission in the role of evaluating the statutory eligibility criteria under Sec. 40.02 (48), Stats. where the Legislature has reserved those roles to the County initially and ETF and ETFB, ultimately. . . .
>
> [T]he statutory process set forth in Chapter 40 is the exclusive means by which protective occupation participant issues are to be resolved. If these issues were subject to the collective bargaining process, it is obvious that employees who do not meet the statutory standards could acquire the legislatively established benefits and also that employees who do meet the standards in question could lose those benefits. We do not think that potential is within the range of options and alternatives contemplated by the Legislature when it created the Public Employee Trust Fund.

This ruling is in accord with ETF's view that protective occupation status cannot be collectively bargained.

3. Bring Graduate Assistants Under the Wisconsin Retirement System (WRS)

Proposal submitted by:
Teaching Assistants Association

ETF Response:

The cost of bringing graduate students under the Wisconsin Retirement System (WRS) is 11.6 percent of the graduate student payroll, based on 2009 WRS contribution rates. The contribution rate is made up of:

Employee Required Contribution:	5.0%
Employer Required Contribution:	4.5%
Benefit Adjustment Contribution:	.9%
Sick Leave Contribution:	.8%
Total Contribution:	11.2%

The following is the total annual cost of bringing Graduate Assistants under the WRS based on annual payroll estimates from UW Payroll and assume employer pickup of entire 11.2% contribution:

Graduate Assistant Classification	Estimated Annual Payroll	Estimated Annual Cost
Teaching Assistants and Project/Program Assistants (UW Madison & UW Extension)	$34,777,299	$3,895,057

Estimated Annual Cost:

$3,895,057

4. Establish a program that through the use of economic and other incentives, would accelerate the early retirement age and encourage senior employees to retire sooner than they otherwise would, thus reducing the State's long-term personnel costs.

Proposal submitted by:
Wisconsin State Attorneys Association

ETF Response:

This proposal is not specific with respect to what type of economic and non-economic incentives are being requested, so no costs can be determined. If the acceleration of the early retirement age would be accomplished through changes to the Wisconsin Retirement System (WRS), an actuarial study of the proposed changes would be necessary to determine the effect on contribution rates.

Estimated Annual Cost: Cannot be determined.

5. **Continue full payment of required employee contributions for retirement by the employer, under Chapter 40, Wi. Stats.**

   Proposal submitted by:
   Wisconsin State Attorneys Association

   ETF Response:

   Since the state already pays all Employee Required and Benefit Adjustment contributions on behalf of these employees, and the cost should basically remain proportional to changes in annual earnings as in the past, there would not be any *additional* costs for this proposal.

Estimated Annual Cost: Costs would be based on future salary and contribution rates so cannot be determined.

INCOME CONTINUATION INSURANCE

1. Decouple Income Continuation Insurance from sick leave.

Proposal submitted by:
Wisconsin State Employees Union
State Employees Council
Milwaukee Graduate Assistants Association

ETF Response:

For purposes of this estimate, we assume this demand refers to the proposed Income Continuation Insurance (ICI) plan redesign that was approved by the Group Insurance Board (Board) at its April 1998 meeting.

At that time, the Board approved a proposal that would change the requirement of the ICI plan that all accumulated sick leave be exhausted prior to the availability of ICI benefits. In addition, employees could choose an elimination period of 30, 90, 125, or 180 days prior to the begin date for benefits. The state would pay the cost of the premium for the 180-day elimination period, with employees picking up the premium cost if they wanted to "buy down" to a lower elimination period.

Costs to the state would increase because all covered employees would be eligible for a contribution towards their ICI coverage whereas currently, employees in Categories 1 and 2 receive no employer contribution. Offsetting this would be a reduction in the employer's share of premiums for Categories 3, 4, and 5. Further savings would accrue to the State because people would not be forced to use all sick leave prior to the date their ICI benefits begin. Finally, the State may experience a small increase in the cost of the Accumulated Sick Leave Conversion Credit (ASLCC) program as more converted sick leave would be available at the time these employees retire. This last effect would likely be gradual, so any increase in the cost to the State to fund higher sick leave balances would be several years into the future.

At the time this proposal was evaluated, the department required an actuarial analysis of the changes by both of its actuarial consulting firms. The following estimate is based on the results of those reviews and has not been updated due to the costs involved. Nonetheless, due to the fact that there has been minimal change to the premium levels for the ICI program, and the relatively low increase in salary levels from that time, these estimates should be fairly representative. If this demand is seriously considered, it would be wise to request that the actuarial analyses be updated.

Annual increase in the total State share of premium:	$1,373,736
Savings from current sick leave not required to be exhausted: (estimated at 19,300 days saved per year)	$3,647,700
Additional cost to fund increased ASLCC balances: (estimated at 0.1% of payroll)	$2,150,000
Net savings to State:	$ 123,964

This change would require amendment to sections 40.02(25m), 40.05(5), 40.61, and 40.62 of the Statutes.

Estimated Annual Cost:

A savings of $123,964 per year.

2. **Employer contribution for Income Continuation Insurance premiums.**

Proposal submitted by:
State Engineering Association

Estimated Annual Cost:

Unable to determine.

3. **Provide Access to Graduate Employees to Other Voluntary Insurance Benefit Programs – Disability**

Proposal submitted by:
Teaching Assistants Association

ETF Response:

There are approximately 8,000 graduate teaching assistants who may wish to apply for ICI coverage. Although graduate assistants can accumulate up to 12 days of sick leave per academic year, they would likely be placed in Category 1 because of limited appointments (where the employee pays the entire premium). Therefore, there would be no immediate cost to the State.

There is a set administrative fee paid to the ICI third party administrator. However, when bids are accepted for this contract, we estimate the number of potential enrollees and subsequent claims. Bids are then based on this estimate (which would be higher if graduate employees were included). We cannot estimate what bids would be.

This would require a statutory change to include graduate-teaching assistants as participating employees under 40.02 (25), and 40.22 for voluntary participation in the Income Continuation Insurance plan.

Estimated Annual Cost

Unable to determine.

LONG TERM DISABILITY INSURANCE

1. Increase benefits for Long-Term Disability

Proposal submitted by:
SEIU District 1199W/UP

ETF Response:

For purposes of this estimate, we assume this demand refers to the Long-Term Disability Insurance (LTDI) program, which is authorized under § ETF 50.

A Wisconsin Retirement System (WRS) participant is eligible for LTDI if he/she began employment on or after October 16, 1992 or was covered under the WRS before that date but had a break in covered employment after that date. In addition, .33 years of creditable service in five of the last seven years (beginning with the year prior to filing of claim) is required. The definition of disability for this program is the inability to engage in substantial gainful activity by reason of a medically determinable physical or mental impairment, which can reasonably be expected to result in death or to be of an indefinite and long-continued nature. Two physicians must certify that the disability is work-related. The individual's employer must also certify that he/she is not expected to resume active service and that they are not contesting the disability. The participant may be on a leave of absence or terminated (at the employer's discretion). The participant can work after he/she has been approved for LTDI, but cannot exceed an annual earnings limit.

The LTDI benefit amount is calculated as follows:

1) 3 high years of earnings/36 months = final average salary

2) final average salary x 40% (if eligible for Social Security Retirement, if not, 50% is used) = LTDI benefit

The taxable portion of any WRS benefits is offset from the LTDI benefit. The LTDI benefit is taxable, as the participant pays no premiums.

Normally, the LTDI is payable until age 65 as long as the individual remains disabled. It may be payable later, which is dependent on the age at which the LTDI benefit became effective.

There is no affect on the required contributions to the participant's WRS retirement account. Supplemental contributions are paid into retirement account by the LTDI program while receiving LTDI.

Estimated Annual Cost:

Unable to determine.

TIAA-CREF PROGRAM

1. Matching Employer Contributions to TIAA-CREF Program

Proposal Submitted By:
Teaching Assistants Association

ETF Response:

The TIAA-CREF Program is a Section 403 (b) tax-sheltered annuity program that is administered by educational institutions such as the University or other state agencies with those functions. This program is not administered by ETF.

There currently is no employer match by the UW under the s. 403 (b) program.

Estimated Annual Cost:

Unable to determine.

HEALTH, LIFE & OPTIONAL INSURANCE PROGRAMS

1. Provide health insurance coverage to domestic partners and their dependents, and include dental and vision coverage.

Proposal submitted by:
Milwaukee Graduate Assistants Association
Teaching Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Professional Employees in Research, Statistics & Analysis
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Wisconsin Professional Employees Council
Wisconsin Physician and Dentist Association

ETF Response:

The demand does not include a definition of domestic partners or alternative families and a wide variety of relationships could be included.

It is recommended that if the State considers this change, it limit eligibility by basing available coverage on the following commonly used definition:

> Both parties are age 18 or over; the partners have shared a residence for six months and intend to remain together indefinitely; neither partner is married or in another domestic partnership; the partners are financially and emotionally interdependent, and are not related by blood.

Note that depending on the specific definition of domestic partner to be used, estimates may vary, but in general there does not appear to be material adverse risk associated with this coverage. Rather, it is more a question of trying to determine how many additional individuals will be added to the policy.

According to the estimate by the Group Insurance Board's actuary, current research shows that an employer can expect to experience an increase in dependent coverage enrollment of approximately 0.5% - 1.0% when same sex domestic partners are offered coverage. If same and opposite domestic partner coverage is offered, employers can expect to experience about a 1.5% - 2.0% increase in enrollment. . More recent client experience has resulted in this slightly lower utilization than the 1% and 2% quoted in previous bargaining years.

There are many potential reasons for lower than expected utilization of domestic partner benefits. One reason may be privacy issues in the case of same-sex couples, as employees may not wish to disclose their relationship to their employer. Also, same-sex couples have a higher instance of dual incomes and therefore partners often have their own health care coverage. Taxation rules and regulations must also be considered.

Using 2006 total estimated annual state costs of $750,937,843, this coverage would result in an annual cost between 0.5% to 1.0% of premium ($3.75 to $7.5 million) for coverage limited to same-sex partners and between 1.0% and 2.0% of premium ($7.5 to 15 million) if opposite-sex partners are included.

We assume that costs for this proposal will change in proportion to the overall changes in health insurance costs for the program. However if the risk profile or the overall numbers of domestic partners changes in the future, then costs will be proportionally less than or greater than average.

Upon termination of the relationship or the employment, federal COBRA regulations would require dependent children to remain eligible for coverage for an additional 36 months. Dependent adults, other than divorced spouses, are not eligible for extended coverage under current COBRA regulations. In addition, according to the latest information we have, federal tax law will treat the portion of employer paid premium for family coverage as taxable income if there is no federally recognized dependent. Since domestic partners are not federally recognized as dependents, employees who take family coverage solely for the purpose of covering a domestic partner will incur additional tax liabilities.

If coverage for domestic partners is granted, the Department would recommend modifying the definition of "dependent" in s. 40.02(20).

Wis. Stat.§ 40.02 (25) (b) 3. currently provides eligible employee status to surviving spouses of employees or retired employees. If it is the intent of this proposal to grant spousal status to surviving domestic partners, this provision should be modified to include domestic partners. However, if domestic partners are only to be provided dependent status then the change to Wis Stat. § 40.02 (20) should be sufficient.

The practical effect of granting eligible employee status is to allow a surviving domestic partner access to family coverage if they later wish to establish another domestic-partner relationship or get married.

Domestic partner coverage presents administrative and risk issues that will raise cost issues for the State. Consequently, significant care should be taken when considering this proposal. ETF does not recommend granting status equivalent to that of a spouse that would provide benefits even after dissolution of a domestic partnership.

Estimated Annual Cost

$3.75 million to $7.5 million for coverage limited to same-sex partners.
$7.5 million to $15 million for coverage that includes both same-sex and opposite-sex partners

2. Establish a freestanding (statewide) comprehensive dental plan with employer participation.

Proposal submitted by:
Milwaukee Graduate Assistants Association
Teaching Assistants Association
Wisconsin State Employees Union
AFT-Wisconsin State Employee Council on behalf of:
Professional Employees in Research, Statistics & Analysis
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association

ETF Response:

Currently most health plans participating in the State group health insurance program provides some form of dental benefit. Additionally, as more serious consideration is given to a freestanding, statewide comprehensive dental plan, the Group Insurance Board's actuary recommends that a detailed analysis be performed for any plan considered for implementation, as this would provide an appropriate cost estimate of the dental plan in the current market place. A change in benefit structure, or employer share of premium can impact the premium amount, and the participation level, both would affect the total cost to the state. Generally, an employer can expect to see single premium rates estimated at $36 per month and estimated family premium rates at $110 per month.

Estimated costs for this proposal will be based on the following fee for service plan design, which was established for the previous bargaining session to be effective January 2005, and which is still applicable. This proposal provides:

- 100% coverage for routine examinations, cleanings, x-rays, fluoride treatment and space maintainers.
- Basic restorative services, periodontia, endodontics and oral surgery covered at 80%.
- Major restorative services, prosthodontics, for all covered individuals and orthodontics for dependent children under 19 years of age, covered at 50%.
- The annual deductibles are $25 for and individual and $75 for a family.

Using estimates provided by the Board's actuary, the net cost of dental is estimated at $8,746,098 seven and a half million dollars annually based on the benefit level summarized above, increasing the estimated premium since that time, and assuming:

- Estimated single premiums will be $36.00 per contract per month;
- Estimated family premiums will be $110.00 per contract per month;
- The state will pay 60% of the premium;
- HMOs currently offering dental benefits eliminate that benefit; and
- 73% of active employees, made up of approximately 68,000 state employees and approximately 8,000 graduate assistants as of 1/1/2006, choose to participate in the new dental plan.

Estimate Calculations:

	36,617	family contracts (73% of 76,000 * 66%)
x	$ 66.00	per month (60% of $110)
x	12	months per year
	$ 29,000,664	annual family premium

	18,308	single contracts (73% of 76,000 * 33%)
x	$ 21.60	per month (60% of $36)
x	12	months per year
	$ 4,745,434	annual single premium

$	29,000,664	annual family premium
$	4,745,434	annual single premium
$	33,746,098	total annual premium

The estimated 2006 dental premium costs that are included in the health plans premiums are $25,000,000. Subtracting this amount from the total annual premium of $33,746,098 above results in a net estimated annual cost of $8,746,098.

Estimated Annual Cost

$8,746,098

3. **Affordable, quality health care coverage for all employees, including the following:**
   - **Institute a formula to base the pro-ration of health insurance employee contribution based on the deciles of comparative pay.**
   - **Cap employee contribution based on proportion of annual income.**
   - **Create a formula that will bind future premium to future wage adjustments**
   - **Changing the ratio between single and family premiums**

Proposal submitted by:
Milwaukee Graduate Assistants Association
Teaching Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Professional Employees in Research, Statistics & Analysis

ETF Response:

The demand for “affordable, quality, health care” is too vague to make a cost estimate. Changing the ratio between single and family premiums is cost neutral and, furthermore, a more specific indication of how the ratio should be weighted would be required. A formula could be created that is based on the pro-ration of health insurance premium according to comparative pay and that could be designed to be cost neutral to the State. This appears to be a compensation issue or equity issue not a cost issue.

The cost of an employee cap on contribution can not be calculated without a more complete explanation of how that would be structured, and whether or not it is indexed.

Creating a formula that would bind future premium to future wage adjustments presumably would cost the State whatever the increase in future health premium would be. This can not be calculated.

Estimated Annual Cost

Unable to determine

4. Maintain at least one zero premium health plan for TA union members and expand access to zero premium plans outside of State and Country.

Proposal submitted by:
Teaching Assistants Association

ETF Response:

The State premium contribution for employees represented by the TAA currently is determined by using a three-tier system. The total 2006 projected annual employee cost for all graduate students is estimated to be approximately $1.3 million. If at least one zero-premium cost plan was available to all graduate students, the immediate employer cost would be something less than $1.3 million. This assumes at least some students would prefer, and choose a plan with some cost to the student. The exact cost of this change is can not be determined as it depends on unpredictable behavior. The cost depends on several criteria including the cost difference between the zero-cost and other tier contribution levels; individual considerations on choice of plan whether that be the lowest cost plan, the lowest risk-adjusted plan or other plans available; and any factor that eventually contributes to the make-up of the enrollment distribution.

The longer-term consequences should be also considered. The incentives of the three-tier system would be undermined. Bidders knowing that there must be at least one no-cost alternative would have less incentive to bid low, and would be less willing to negotiate to enter a lower tier.

Although the immediate cost can be considered less than $1.3 million annually, the cost will increase with the general increase in health premium. Longer range there are implications that costs would increase because bidding and negotiating incentives would be undermined.

Estimated Annual Cost

Unable to determine

5. Provide health insurance coverage for represented employees either on the first day of employment or within the first thirty days of employment.

Proposal submitted by:
Milwaukee Graduate Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Professional Employees in Research, Statistics & Analysis

ETF Response:

This proposal would require the state to pay health insurance premiums beginning on the first day of employment or within the first thirty days of

employment. Currently new employees must pay all such premiums or defer enrollment until the end of six months. Insurance coverage now begins on the first of the month following the receipt of the application.

In January 2006, the state's estimated average monthly contribution per insurance contract was $873.94. Contributions for the full six months not currently covered would average $5,243.64 per person. The Department cannot currently accommodate partial month premium collections so the estimate is based upon coverage becoming effective on the first of the month after employment begins. If coverage were to be effective mid-month, there would be additional cost and statutory changes would be required.

Using information provided by DOA Central Payroll and extrapolating that information to include the University of Wisconsin, for fiscal year 2004 it is estimated that there would be approximately 3,000 new employees each year. On the basis of average state contribution per contract, the annual cost to the state would be $15,730,920 ($5,243.64 x 3,000 new appointments = $15,730,920).

The long-term costs are a function of the number of new hires and can vary widely from year to year. The number of new hires estimated for this analysis was 3,000. A similar analysis completed in 2002 estimated new hires at 5,250, though it should be noted at that time U.W. faculty were not entitled to immediate pick-up.

This change would require statutory changes to Wis. Stat. § 40.05.

Estimated Annual Cost

$15,730,920

6. Establish a free standing vision benefit.

Proposal submitted by:
Wisconsin State Employees Union
Milwaukee Graduate Assistants Association
Teaching Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Wisconsin Physician and Dentist Association
Professional Employees in Research, Statistics & Analysis

ETF Response:

There is a wide variety of benefit levels among free standing vision programs. For this estimate, we assumed a program that provides:

- Benefits for in-network and out-of network providers.
- In-network exams, lenses and frames are paid in full with a $10 copay for exams and $25 copay for materials (lenses and frames).
- Exams and lenses are allowed every twelve months, new frames are allowed every 24 months.

- For out-of-network exams and materials there is a benefit schedule.
  Examinations are paid for up to $40.
  Lenses from $40 to $80 depending if they are single, bifocal, or trifocal.
  Frames are paid up to $105 and contact lenses up to $210.

Rates are based on full participation of the population. Rates would increase if not all the population were insured. The monthly rate is a composite based on the total number of employees, which provides coverage for all immediate family members. The composite rate is $7.45 per month.

For this estimate we assume 73% of active employees, made up of approximately 68,000 state employees and approximately 8,000 graduate assistants as of 1/1/2006, choose to participate in the new vision plan.

76,000 x 73% = 55,480

55,480 x $7.45 x 12 months = $4,959,912

Estimated Annual Cost

$4,959,912

7. Expand mental health coverage and expand preventative health coverage, e.g. health club membership, weight control programs, smoking cessation.

Proposal Submitted by:
Teaching Assistants Association

ETF Response:

The proposal is not specific regarding the level of benefit change and so the cost can not be estimated. Currently various non-healthcare benefits such as partial reimbursement for health club memberships are offered by some participating health plans, along with coverage for smoking cessation and prescription drugs for all employees under the pharmacy benefit coverage.

Estimated Annual Cost

Unable to determine

8. Guarantee coverage for transgender, and transsexual individuals to get surgery and follow-up hormone therapy.

Proposal Submitted by:
Teaching Assistants Association

ETF Response:

The Board's actuary estimates that in a population of the size of the state program there would be two procedures annually. There continues to be large ranges

reported for the costs of this surgery but data from current extensive studies of employers who cover these procedures show that costs are lower than earlier reported, ranging from approximately $20,000 to $25,000. This includes surgeon, anesthesia, hospitalization fees, therapy, hormones, and post-op doctor visits. This also assumes no complications.

Complication rates are difficult to determine. Research indicates most complications occur when Female-to-Male patients undergo either metoidioplasty or phalloplasty but the vast majority of Female-to-Male patients choose not to undergo either procedure. In general, for sex reassignment surgery, part of the risk lies in specific surgical techniques as each surgeon has varying experience and skills. Additionally, complications may also arise from other medical disorders or health concerns (e.g. HIV, Hepatitis C, diabetes, abnormal blood clotting, etc) that the patient may have.

The annual cost could be expected to rise at the rate of general increases in health care costs.

Estimated Annual Cost

$40,000 to $50,000

9. **Independent audit of performance of three-tier plan to evaluate success of plan in controlling health care cost increases. Independently audit and evaluate the effect of PBM in reducing pharmacy costs due to management and volume purchasing vs. cost shifting to employees, evaluate the quality of service and alternatives to the current benefits administered by Navitus.**

Proposal Submitted by:
Milwaukee Graduate Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Professional Employees in Research, Statistics & Analysis
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Wisconsin Professional Employees Council
Wisconsin Physician and Dentist Association

ETF Response:

Given the generic nature in which these demands are written and the size of the State group health insurance program an appropriate range of fees would be $75,000 - $100,000. The request appears to not only ask for an evaluation but also consultation (e.g. alternatives) The cost is also based on using an actuarial firm other than the five under contract to the Group Insurance Board. A firm unfamiliar with the intricacies of the state program and the rate setting process would require considerable research hours to validate previous data rate settings and develop the estimates proposed in the question.

Estimated Annual Cost

$75,000 - $100,000

10. Eliminate SHIP requirement for international students, and streamline the rebate procedure for erroneous enrollment.

Proposal Submitted by:
Teaching Assistants Association

ETF Response:
SHIP is a federally mandated program and its requirements can not be waived by the state.

Estimated Annual Cost
No fiscal impact

11. Create a "single plus one" family category to be priced less than family coverage.

Proposal submitted by:
Milwaukee Graduate Assistants Association
Wisconsin State Employees Union
Teaching Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Professional Employees in Research, Statistics & Analysis

ETF Response:

The costs associated with changing to a two-person family option are a result of the distribution of contracts between actively employed and retirees under age 65. The board's actuary has estimated the additional cost to be $3.5 million to $4.9 million annually.

The cost is due to the fact that the under 65 year old retiree group has a high percentage of the two-person family category contracts that are now included in the family category. When those contracts are extracted into a cheaper member+1 category, the family category must rise to make the shift cost neutral. This shift in cost does not affect the total amount of premium that will be collected as a whole, but it does affect the amount of premium that is collected by the active and under-65 retiree group independently. The change causes the amount of premium collected from the active group to rise. The actuary assumed that 95% of the cost of an active employee's premium is the responsibility of the State and that the State is not responsible for any portion of the under-65 premium. It should also be noted that graduate assistants were not included in the actuary's analysis.

This change will require a statutory change because the current single/family premium structure is established under s. 40.52(1)(a)

Estimated Annual Cost

$3.5 million to $4.9 million

12. Allow the use of sick leave credits to pay premium for voluntary benefit plans including Long-term Care, dental, and vision.

Proposal Submitted by:
Milwaukee Graduate Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Wisconsin Physician and Dentist Association
Wisconsin Professional Employees Council
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Professional Employees in Research, Statistics & Analysis

ETF Response:

It is assumed that this benefit would be first accessible at retirement when sick leave is converted to sick leave credits. The program's actuary roughly estimates that this will cost between 0.1% and 0.3% of total payroll for State employees, and between 0.3% and 0.5% for University employees. The cost of this is affected both by the fact that sick leave credits will be depleted more quickly, and there will be more members who use all their sick leave credits.
Estimated costs are based on the 2005 sick leave payroll.

State Employees (Non-University)
2005 Sick Leave Payroll: Cost:
$1,584,842,958 x .001 = $1,584,843
$1,584,842,958 x .003 = $4,754,529

University & University Hospital Employees
2005 Sick Leave Payroll: Cost:
$1,825,113,528 x .003 = $5,475,341
$1,825,113,528 x .005 = $9,125,568

It should be noted that these estimates were not based upon detailed actuarial valuations. The program's actuary strongly recommends that full valuations of the proposal be undertaken if the proposal is given further consideration.

Estimated Annual Cost

$7,060,184 to $13,880,097

13 Provide hospital services available within 30 miles at a Tier-1 price for all employees

Proposal Submitted by:
Milwaukee Graduate Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Professional Employees in Research, Statistics & Analysis
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Wisconsin Professional Employees Council
Wisconsin Physician and Dentist Association

ETF Response:

Difficulty in administering such a broad proposal makes the costs indeterminate. Such a proposal could require separate premium calculations for each individual based on residence and closest hospital Furthermore, there may be some members who currently have no hospital within 30 miles, which is not accounted for in this proposal, even though it is not possible to meet the requirement.

Estimated Annual Cost

Unable to Determine

14 Allow employees to use accumulated sabbatical leave and/or earned vacation from their last year of service prior to retirement to pay for medical insurance premiums after retirement.

Proposal Submitted by:
Milwaukee Graduate Assistants Association
AFT-Wisconsin State Employee Council on behalf of:
Professional Employees in Research, Statistics & Analysis
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Wisconsin Professional Employees Council
Wisconsin Physician and Dentist Association

ETF Response:

Currently the WSEU contract provides this benefit (refer to s. 13/6/5 of the WSEU contract ending June 30, 2007). Employees in other bargaining units, such as WPEC, can use this leave or receive lump-sum pay out for the unused leave. Since the cost of the final year of vacation leave or sabbatical leave is available in one form or another, there would be no additional fiscal impact to allowing other bargaining units to adopt this proposal.

Estimated Annual Cost

No Fiscal Impact

15 Consider "Add-Ons" to be part of base pay for sick leave conversion computation at retirement.

Proposal Submitted by:
AFT-Wisconsin State Employee Council on behalf of:
Professional Employees in Research, Statistics & Analysis
Wisconsin Science Professionals
Wisconsin State Public Defenders Association
Wisconsin Professional Employees Council
Wisconsin Physician and Dentist Association

ETF Response:

"Add-Ons" that increase base pay range from $0.30 per hour to $19.78 per hour. However, no information is available regarding the relationship between total compensation and base wages.

This program's actuary indicates that if total compensation is 4% higher than base wages, then the estimated cost of this proposal would be 0.2% of the base salary payroll. However, if future contributions to this program were made on total rather than base salaries, the increase in the contribution rate for this proposal would be only 0.1% of the higher covered payroll.

Thus, if total annual compensation is estimated at $3.4 billion, and base wages are at $3.27 billion (4% less), the estimated costs would be approximately $6.54 million ($3.27 billion x 0.2%). Likewise, if future contributions to this program were made on total annual compensation the estimated costs would be approximately $3.4 million ($3.4 billion x 0.1%).

It should be noted that these estimates were not based upon detailed actuarial valuations. The program's actuary strongly recommends that full valuations of the proposal be undertaken if the proposal is given further consideration.

Estimated Annual Cost

$3.4 million to $6.54 million

16. Clarify benefit enrollment procedures to avoid employees being unjustly denied healthcare.

Proposal Submitted by:
Teaching Assistants Association

ETF Response:

This request is not specific regarding what constitutes an employee being "unjustly denied healthcare". This request addresses procedural concerns for streamlining the process. ETF will need to see specific recommendations to assess cost or feasibility. ETF published information for employees on enrollment procedures. The annual "It's Your Choice" books provide a section entitled "Patient's Rights and Responsibilities", as well as a question and answer section to assist and guide employees in the enrollment process. Federal laws, such as the Health Insurance Portability and Accountability Act (HIPAA), effective January 1, 1998, and COBRA, help ensure employees have equitable opportunities to obtain healthcare. Additionally, State laws, such as 1999 Wisconsin Act 155, and this Department's complaint and grievance procedures that are in place, ensure employees have recourse should they face problems with healthcare coverage.

Estimated Annual Cost

No Fiscal Impact

17. Challenge the administration of the PBM to address inequities in cost of prescription drugs, in particular the blatantly sexist classification of various contraceptive options. Also "streamline" the appeals process or include such appeals in the grievance procedure.

Proposal Submitted by:
Teaching Assistants Association

ETF Response:

This request is not specific regarding what contraceptive options should be addressed or what appeals process is being referred to. This request addresses procedural concerns for streamlining the process. ETF will need to see specific recommendations to assess cost or feasibility.

Estimated Annual Cost

Unable To Determine and No Fiscal Impact

18. Provide graduate employees with benefit programs available to other state employees such as life, disability, and all other voluntary enrollment plans. [ie LTC, vision, dental, etc. No State Costs For These!!]

Proposal Submitted by:
Teaching Assistants Association

ETF Response:

The estimated costs for this proposal account for the life insurance and other optional benefit plans. A response for disability benefit plans is provided in the Income Continuation Insurance section of this document.

Regarding life insurance benefits through the State group life insurance program, currently employees must be participating in the Wisconsin Retirement System for at least six months per Wis. States. § 40.02 (25), in order to be eligible for benefits. The cost estimates provided here assume the employees are eligible for the life insurance benefit.

Based on data from health insurance contracts, there are approximately 8,650 in the grad assistant category. The bulk of the grad assistant population is age 35 and under and the average salary for the grad population is $24,000.

The employee cost for both Basic and Supplemental life insurance coverage is $0.05 per $1,000 of earnings for all ages under 40. The State contributes premium equal to 63% of employee contributions for basic coverage and 35% of employee contributions for supplemental coverage. Assuming that the graduate assistant population would be insured at the same rates and $24,000 as the average salary, the monthly cost for the employee and employer would be:

Basic coverage:
24 x $.05 = $1.20 (employee premium) x 63% = $0.76 (state cost)

Supplemental coverage:
24 x $.05 = $1.20 (employee premium) x 35% = $0.42 (state cost)

In the general State employee population, approximately 77% enroll for Basic coverage and 56% enroll for supplemental coverage. Given that the grad assistant population is younger and a greater proportion is single, expected participation would be lower.

The expectation is that one-half (approximately 4,325) would enroll for basic coverage and one-third (approximately 2,883) would enroll for supplemental coverage as well.

The calculation of the annual state cost of basic coverage would be:
$0.76 (state cost) x 4,325 x 12 (months) = $39,444

In order to have supplemental coverage the employee must also carry basic coverage.

The calculation of the annual Cost of Basic + Supplemental coverage would be:
$0.42 (state cost) x 2,883 x 12 (months) = $14,530 + $39,444 = $53,974

There would be no state premium contributions for the optional benefit plans offered to other state employees, such as long-term care, vision and dental insurance, as these are fully employee paid benefits. Current contracts and policies covering long-term care, vision, and dental insurance define eligible members as employees of participating employers and do not stipulate WRS participation as a requirement

Statutory modifications to Chapter 40 of the Wisconsin Statutes would be required for these proposals to be implemented.

Estimated Annual Cost

From $39,444 to $53,974

19. Expand benefits to include vision and dental care.

Proposal Submitted by:
State Engineering Association
Wisconsin Education Association Council

ETF Response:

Currently most health plans participating in the State group health insurance program provide some form of dental benefit. Additionally, the inclusion of vision and dental benefits in the uniform benefits would require a detailed analysis be performed for any plan considered for implementation, as recommended by the Group Insurance Board's actuary. This would provide an appropriate cost estimate of the dental and vision benefits in the current market place. A change in benefit structure, or employer share of premium can impact the premium amount. Likewise, the participation level would also affect the total cost to the state.

Dental Benefit:
Estimated dental costs for this proposal will be based on the following fee for service plan design, which was established for the previous bargaining session to be effective January 2005, with updated premium amounts. This plan design assumes a more tightly managed network plan than the freestanding dental plan addressed in demand number 2. This proposal provides:

- 100% coverage for routine examinations, cleanings, x-rays, fluoride treatment and space maintainers.
- Basic restorative services, periodontia, endodontics and oral surgery covered at 80%.
- Major restorative services, prosthodontics, for all covered individuals and orthodontics for dependent children under 19 years of age, covered at 50%.
- The annual deductibles are $25 for and individual and $75 for a family.

Using estimates provided by the Board's actuary, the net cost of dental is estimated at $28,450,400 annually based on the benefit level summarized above, increasing the premium since that time, and assuming:

- Estimated single premiums will be $28.00 per contract per month;
- Estimated family premiums will be $85.00 per contract per month;
- HMOs currently offering dental benefits eliminate that benefit and provide this benefit;
- An estimated population of 24,900 with single coverage (19,000 state employees + 5,900 graduate assistants) and 44,200 with family coverage (42,000 state employees + 2,200 graduate assistants)
- If these provisions are included in the health plan benefits then a higher percentage of employees will participate than with a "free-standing" dental benefit.

Estimate Calculations for Dental:

	44,200	family contracts
x	$ 85.00	per month
x	12	months per year
$	45,084,000	annual family premium

	24,900	single contracts
x	$ 28.00	per month
x	12	months per year
$	8,366,400	annual single premium

$	45,084,000	annual family premium
$	8,366,400	annual single premium
$	53,450,400	total annual dental premium

The estimated total 2006 dental premium rate that is included in the health plans' premiums is $25,000,000. Subtracting this amount from the total annual premium of $53,450,400 above, results in a **net estimated annual dental cost of $28,450,400**.

Vision Benefit:
For this request we assumed a vision program that provides:

- Benefits for in-network and out-of network providers.
- In-network exams, lenses and frames are paid in full with a $10 copay for exams and $25 copay for materials (lenses and frames).
- Exams and lenses are allowed every twelve months, new frames are allowed every 24 months.
- For out-of-network exams and materials there is a benefit schedule.
  Examinations are paid for up to $40.
  Lenses from $40 to $80 depending if they are single, bifocal, or trifocal.
  Frames are paid up to $105 and contact lenses up to $210.

As with the dental benefits it is assumed that if these provisions are included in the health plan benefits then a higher percentage of employees will participate than with a "free-standing" vision benefit.

Rates are based on the full participation of the population. To provide a cost for this proposal we will use the estimated participation of 69,100 (44,200 family + 24,900 single). The monthly vision benefit rate is a composite based on the total number of employees, which provides coverage for all immediate family members. The composite rate is $7.45 per month.

Estimate Calculations for Vision:

	69,100	Contracts (44,200 family + 24,900 single)
x	$7.45	per month
x	12	months per year
$	6,177,540	annual premium

The estimated annual vision benefits cost would be $6,177,540

Statutory modifications to Chapter 40 of the Wisconsin Statutes would be required for these proposals to be implemented.

Estimated Annual Cost

$28,450,400 (dental) + $6,177,540 (vision) = $34,627,940

20. ETF should become a purchaser of the "Leap Frog" system and share the information with the SEA.

Proposal Submitted by:
Teaching Assistants Association

ETF Response:

ETF is currently a member of, and endorses, the Leapfrog initiative, which is a nationwide effort to raise consumer awareness of three hospital safety practices or standards proven to reduce medical errors and save lives. The Leapfrog announcement is published annually in the “It’s Your Choice” books, under the Common Questions and Answers section, which is distributed annually during dual choice.

Because the data is updated regularly, specific information is not published by ETF. The most up-to-date information regarding Leapfrog results are available at: http://www.leafroggroup.org/consumer_intro.htm.

Estimated Annual Cost

No Fiscal Impact

21. Allow two State employees who are on a family plan to switch to two single plans upon retirement.

Proposal Submitted by:
Service Employees International Union-District 1199W/UP

ETF Response:

Currently one family policy can be split at any time into two single plans with the same carrier effective on the beginning of the month following receipt of a Health Insurance Application from both husband and wife. However, if each spouse has single coverage, no dependents are covered and if one spouse should die, that individual's sick leave credits will not be available for use by the surviving spouse. Under a family plan, sick leave credits are preserved for the surviving spouse regardless of which should die first.

If the intent of this request were to preserve the sick leave for the surviving spouse when each spouse has single coverage then a statutory change to Wisconsin Statutes, §40.05 (4) (b) would be required.

It should be noted that the named subscriber for the family coverage could be changed to the other spouse at any time. Coverage will be effective on the beginning of the month following receipt of a Health Insurance Application.

ETF has insufficient data to determine the number of retired State employees who are married to other retired State employees.

Estimated Annual Cost

Unable To Determine

22. No premium increases for health insurance

Proposal Submitted by:
Wisconsin Law Enforcement Association

ETF Response:

This estimate assumes that there would be no increase in the level of contribution to the employee in health insurance costs from 2006 to 2007. Employee share of health insurance would be maintained at the 2006 level.

Estimated 2006 annual employee costs for health insurance are $37,550,245. Assuming that the family and single coverage contracts will stay the same in 2007 and there will be an estimated 7.4% increase in 2007 premiums, the estimated 2007 employee costs would be approximately: $37,550,245 x 1.074 = $40,328,963

The difference between 2006 and 2007 costs would be the cost to the State as the result of no premium increases in 2007: $40,328,963 - $37,550,245 = $2,778,718

Estimated Annual Cost

$2,778,718

23. Reduce the amount paid for State group health insurance premiums for WSBT members as they are the only bargaining unit within the state that must purchase 100% of group health care

Proposal Submitted by:
Wisconsin State Building Trades

ETF Response:

This demand is not specific enough to provide cost estimates. Cost estimates would depend on what reduction amount WSBT members received.

Estimated Annual Cost

Unable To Determine

24. Provide more options at Tier-1 by diversification of health care plans.

Proposal Submitted by:
Wisconsin State Employees Union

ETF Response:

The number of health plans that are in Tier-1 is a product of the bid process in place with the health insurance plans participating in the State group health insurance program. In negotiations on behalf of the Group Insurance Board, health plans are encouraged to adjust their bids to reach the Tier-1 level. This is especially true when dealing with health plans in areas where plan options are limited for members, such as in northwestern Wisconsin. This proposal does not provide sufficiently specific details regarding what options are intended and what is meant by the phrase, "diversification of health care plans" to allow a cost to be determined.

Estimated Annual Cost

Unable To Determine

25. Enhance benefits under UB (e.g. bariatric surgery) using a portion of the increased premiums employees pay.

Proposal Submitted by:
Wisconsin State Employees Union

ETF Response:

Per information provided by the Group Insurance Board's actuary, recent research tells us gastric bypass/bariatric surgery costs have remained relatively stable as projected in earlier pricing. Incidence rates continue to increase and there are numerous articles citing significant increases when members are covered by insurance. The projected cost to the State is $5.39 PMPM for 100% coverage and $4.20 PMPM for 80% coverage, spread across the entire population of the program.

In general, annual costs for enhanced benefits cannot be determined without more specific information regarding what benefits are desired. Nonetheless, based on only the one specific example provided (gastric bypass/bariatric surgery) and based on an estimated, potential incidence rate of 60 procedures per a population of 100,000 members, a group of our size would have approximately 120 procedures annually.

200,000 x $4.20 x 12 = $10,080,00
200,000 x $5.39 x 12 = $12,936,000

Estimated Annual Cost

From $10,080,000,to $12,936,000

26. Procedural related demands, which include:
(a) Set up a system of justification for bargaining increases in premiums (e.g. utilization, increased cost of technology, increase cost of medications, etc), (b) bargain benefit design at the master table starting with plan year 2008, and (c) explore providing the "group" buying power to small businesses and non-state employee families without assuming significant unfunded risk.

Proposal Submitted by:
Wisconsin State Employees Union

ETF Response:

These demands reflect procedural issues, for which no direct fiscal impact can be estimated. However, staff believes that a cornerstone of our health insurance program is built upon Group Insurance Board oversight and administration. Opening negotiation of benefits in a collective bargaining context will very likely lead to increased administrative and cost pressures. In addition, past legislation (SB-108, 2005) proposed extending coverage to farmers in the State of Wisconsin. The fiscal note associated with this legislation, which was provided by ETF with guidance from the Board's actuary, indicated an increased cost of approximately $13 to $52 million to cover current state employees. This cost increase was due to the assumption of additional risk this population would bring to the program.

Estimated Annual Cost

Unable To Determine

27. Discuss post retirement health care benefit to career state employees WSEU represents.

Proposal Submitted by:
Wisconsin State Employees Union

ETF Response:

This proposal is not specific regarding post-retirement health care benefits or issues that need to be discussed. More detailed information is needed regarding specifically who this would impact, what levels of benefits were desired and how it would be different from what career state employees currently receive.

Estimated Annual Cost

Unable To Determine

28. Establish a process that provides economic incentives for state employees when cost savings initiatives are successful.

Proposal Submitted by:
Wisconsin State Employees Union

ETF Response:

This proposal is interpreted to mean that any cost savings would be used to increase benefits. Since this is dependent on the amount of cost savings, which is variable, and because this is procedural in nature, specific costs cannot be determined.

Estimated Annual Cost

Unable To Determine

29. Create economic incentive for employees that do not choose the state offered health care plan.

Proposal Submitted by:
Wisconsin State Employees Union

ETF Response:
In order to provide estimated costs more specific information is needed regarding what level of incentive would be required. However, allowing employees to opt out of the state group health insurance program will likely have a negative overall impact on the program. If employees with low-utilization of the health insurance program opt out, the ratio of employees with high utilization to employees with low utilization diminishes. This increases the risks that must be assumed by the participating health

plans. If the amount of the economic incentive were greater than the cost of the benefits used by the employees, it would increase overall costs to that extent.

Past legislation (AB-83, 2005) proposed a similar scenario with the payment of a stipend to certain state employees in lieu of health insurance coverage. The fiscal estimate associated with this legislation, which was provided by ETF with guidance from the Board's actuary, stated that, "It is the actuary's belief, and a common understanding, that offering employees money to opt out of an insurance program promotes adverse selection. This means that the healthiest people will opt out." Based on the claims experience of this healthier population, the result would be that up to 50% of the per-contract premium savings realized for those opting out would be absorbed to cover the increase in the health insurance premium for those who did remain in the program.

The legislation required the state to pay 25% of the cost of the lowest priced health insurance plan, which the employer would have paid otherwise, for any eligible employee who opted out of the state group health insurance program. The employee would have had to be covered by another health insurance plan. In addition, this stipend would be extended to approximately 5,000 additional employees who were eligible for the group health insurance program but who didn't participant, at an estimated cost of $10 million.

Furthermore, the fiscal note indicated that the state would assume a liability for FICA taxes estimated at between $1.4 million to $1.7 million annually, assuming the stipend qualified as part of a Section 125 plan. If it did not qualify, then the FICA liability would likely increase to approximately $13 million for the state. Likewise, the stipend would likely create a taxable event for all plan participants.

The cost of the stipend and the additional state share of FICA taxes associated with the stipend amount, less the net group insurance premium savings would create an increased, overall cost. The estimated costs would range from approximately $2.8 million if 5% of state employees opted out, to $6.0 million if 3% of state employees opted out.

Estimated Annual Cost
Unable To Determine

30. Freeze all co-pays at 2007 level and require the employer to justify the need for increases at the bargaining table.

Proposal Submitted by:
Wisconsin State Employees Union

ETF Response:
The Group Insurance Board establishes co-pay amounts based on recommendations from the board’s actuaries and ETF. This proposal is procedural in nature and specific costs cannot be determined.

Estimated Annual Cost
Unable To Determine

31. The employer will make available to bargainers' actuaries that are retained by the ETF for purposes of costing and "auditing" plans and plan design including benefits.

Proposal Submitted by:
Wisconsin State Employees Union

ETF Response:
This proposal would require more specific information as actuarial costs are based on specific services offered. Additionally, there would need to be more specific information regarding the relationship of the bargaining unit to the actuary. Potential conflicts may occur depending on whom was directing the actions of the actuary, which would determine whether an additional, independent actuary would need to be hired or the current actuary could be utilized.

Estimated Annual Cost
Unable To Determine

DEFERRED COMPENSATION

1. Provide an employer matching contribution for 457 Plan (deferred comp). 50% match up to between 6% to 10% of employee's annual salary.

Proposal submitted by: Wisconsin Law Enforcement Association

ETF Response
This proposal is permissible under current federal regulations. WI Statutes and Administrative Code are silent on matching contributions. It is feasible, as the Wisconsin Deferred Compensation Program (WDC) Board has provided for this option in Article 3.01 of the WDC Plan and Trust document, but the Plan and Trust would need review to determine if any revisions are required to provide specific procedures to address employer matching contributions.

Background
- Estimated number of state law enforcement participants: 885

DEPT	***Data***	***Total***
285 (UW)	Sum of FTE	119
	Count of EE	119
395 (DOT)	Sum of FTE	714.6
	Count of EE	737
505 (DOA)	Sum of FTE	28
	Count of EE	29
Total Sum of FTE		861.6
Total Count of EE		885

- Employer matching contributions can be dollar amounts or percentage, and are usually capped. (e.g., Indiana state employees who defer at least $15.00 of their income per pay period receive a $15.00 match to their deferred compensation account every (bi-weekly) payday)

Estimated Cost Calculation
Example of how to calculate cost: If all 885 state law enforcement participants took advantage of an employer match of $15 per paycheck throughout a year with 26 pay periods, the cost, which would be borne by the employer, would be:

(885 x 15) x 26 pay periods = $345,150.

Estimated Annual Cost:
- Cost to WDC – unable to determine. No cost to the Department, but likely a cost to the participants of the WDC (program is self-funded). The third party administrator for the WDC currently has programming to permit this but they may charge a fee to implement this feature.
- Cost to Employers -- unable to determine – cost depends on the match amount agreed upon and would be borne by the employers. See example estimated cost calculation above.

Exhibit L

From: Bogardus, Jeff
Sent: Monday, April 27, 2015 9:42 AM
To: Larson; Arlene; Pray; Tara
Subject: FW: 2016 Program Considerations
Attachments: 2015 study group memo.pdf

First – nice job putting the memo together!

Second – I proposed adding "expired" drugs to the exclusions language for prescription drugs but I am not seeing it in any of the documentation.
Is this simply going to be a technical change that doesn't need to go through the study group?

IV. EXCLUSIONS AND LIMITATIONS

A. Exclusions

[…]

11. Outpatient Prescription Drugs – Administered by the PBM

[…]

n. Charges for spilled, stolen, expired or lost prescription drugs.

Jeff B

From: Pray, Tara
Sent: Friday, April 24, 2015 5:46 PM
Subject: 2016 Program Considerations

Good afternoon –

Please find the attached Study Group memo related to program considerations for 2016. We wanted to give you a chance to review and provide feedback.

Please reply to Tara Pray no later than Friday, May 1 if you have any feedback you want to be taken into consideration for 2016.

Health Plans: We are currently working with Segal to finalize the bid submission tools based on the feedback we received from you. We are targeting May 4 to send you the Key Dates Memo along with the bid submission information.

Feel free to contact me with any questions.

Thank you,

Tara Pray | Alternate Health Plan Manager
Office of Strategic Health Policy
State of Wisconsin - Department of Employee Trust Funds
p: 608.266.1423

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

CORRESPONDENCE MEMORANDUM

Confidential

DATE: April 24, 2015

TO: Guidelines Advisory Study Group

FROM: Tara Pray, Alternate Health Plan Manager

SUBJECT: 2016 Group Health Insurance Program Considerations

Thank you for participating in the 2015 Guidelines Advisory Study Group (Study Group). We appreciate your time in reviewing this information prior to the upcoming meeting on April 28, 2015 at 9:00 a.m. to be held in the Events Room of the Department of Revenue building located at 2135 Rimrock Rd., Madison, WI.

This memo provides information related to the proposed changes to the Group Health Insurance Program (Program) for 2016. This year, the Study Group's role and process will be different than in previous years due to the Group Insurance Board (Board) hiring Segal Consulting (Segal), a Benefits Consultant, to develop and recommend changes to the Program for 2016 and beyond. Segal presented potential Program changes for 2016 at the Board's March 25, 2015 meeting.

The Board is relying on Segal and Department of Employee Trust Funds (ETF) staff to bring forth recommendations to achieve cost savings that meet the requirements of the Governor's 2015-2017 Biennial Budget (detailed in section I, below). Segal and ETF recommendations also take into consideration the impending Affordable Care Act (ACA) "Cadillac Tax" that will go into effect in 2018, as the program is in danger of meeting the thresholds that would trigger the tax at current benefit levels.

The upcoming meeting of the Study Group will focus on benefits for 2016 only. We will discuss the recommendations that are supported by ETF and Segal at the meeting and collect feedback which will be summarized and shared with Segal and the Board prior to the May 19, 2015 Board meeting.

In addition to biennial budget provisions and Segal's recommendations, ETF staff collected benefit change suggestions from its typical sources over the past year: health plans, members, employers, and ETF Ombudsperson Services staff. These suggestions have also been summarized in this memo and will be discussed at the April 28 Study Group meeting.

I. Biennial Budget Changes

The 2015-2017 State Budget currently includes a provision requiring the Board to work with Segal to identify $25 million (General Purpose Revenue funds) in cost savings over the next two years. This amount equates to a needed savings $54 million in all funds over the 2015-2017 biennium.

Note: Due to the health insurance program operating on a calendar year, versus the State Budget operating on a state fiscal year (July 1 – June 30), required program cost savings will begin one quarter of the way into the biennium.

The State Budget also calls for an employee opt-out incentive, where those who opt-out of the state employee health insurance plan will receive an annual $2,000 stipend.
Note: Segal's analysis of the opt-out provision concluded that there will be a negligible financial impact overall on the program.

II. Segal Recommendations (presented at the March 25, 2015 Board meeting)

A. Medical Benefits - Projected 2016 savings: $45 million

1. Coinsurance Uniform Benefits Plan
   a. Modify deductible and out-of-pocket limits

	Single		Family	
	Current	Proposed	Current	Proposed
Deductible	$0	$250	$0	$500
Out-of-Pocket Limit	$500	$1,000	$1,000	$2,000

   b. Replace coinsurance with copays for office visits. The deductible would not need to be met for the copay amounts to apply for office visits.

	Current	Proposed
Primary Care Physician (PCP) Office Visit*	10%	$15
Specialist Office Visits	10%	$25

**copay will also apply to visits for chiropractic services*

2. Standard Plan

	Single		Family	
	Current	Proposed	Current	Proposed
Deductible (Preferred Provider)	$200	$500	$400	$1,000
Out-of-Pocket Limit	$800	$1,000	$1600	$2,000

3. High Deductible Health Plan (HDHP) and Health Savings Account (HSA)

	Single		Family	
	Current	Proposed	Current	Proposed
HSA Employer Contribution	$170	$750	$340	$1,500

B. Pharmacy Benefits – Projected 2016 savings: $7 million

1. Convert to a coinsurance structure for cost sharing for Tiers 2-4

2. The following drug cost changes:

Level	Current	Proposed
	Member Costs	
Level 1	$5	$5

Level 2	$15	20% ($50 max)
Level 3	$35[1]	40% ($150 max)[1]
Level 4 • Preferred • Non-preferred	 $15[2] $50	 $50[2] 40% ($200 max)

[1]Level 3 copays do not apply toward out-of-pocket limits
[2]Reduced copay applies when Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy

3. No 2016 increase in member out-of-pocket limits for prescription drugs

C. No 2016 increase to employee percentage share of premium.
Note: Employee premiums are established by OSER.

III. Other Potential Benefit Recommendations with Minimal Cost or Savings Impact

Segal has projected that all of the following benefit changes would have a minimal cost or savings impact on the program.
Note: ETF is awaiting final Segal pricing information. Pricing estimates are subject to change.

a) Implement a $50 copay for urgent care.

Rationale: This change could help drive members to urgent care vs. the emergency room.

b) Add coverage for residential services for patient needs beyond Alcohol and Other Drug Abuse (AODA) treatment for up to 30 days.

Rationale: Residential counseling for a short period can be beneficial to help ensure issues are appropriately diagnosed and treated.

c) Plans/providers will administer a patient satisfaction survey to all ETF members participating in a Shared Decision Making (SDM) program.

Rationale: Surveying members who have engaged in the SDM process will help document the impact of the SDM program on patient outcomes and satisfaction.

d) Add coverage for Suboxone in the Detoxification Services section of the Uniform Benefits.

Rationale: Suboxone is the #1 detoxification drug, and is becoming more popular. On our pharmacy benefit side, Suboxone is currently used more often than Methadone. Currently the Detoxification Services section of Uniform Benefits only specifically lists Methadone Treatment.
Note: ETF is still investigating this recommendation.

e) Reduce the bitewing x-ray frequency to one set per year.

Rationale: The American Dental Association recommends that patients at low risk for cavities and periodontal disease receive less frequent dental x-rays. This helps keep costs down and lowers exposure to radiation, while still ensuring diagnostic accuracy**.**

IV. Other Benefit Recommendations with Low/Moderate Cost Impact

Segal has projected that all of the following benefit changes would have a low to moderate cost impact on the program.
Note: ETF is awaiting final Segal pricing information. Pricing estimates are subject to change.

a) **Members with serious disease and a likely survival of < 6 months will be offered Advanced Care Planning (ACP) and/or a palliative care consultation. When appropriate, such individuals will receive multidisciplinary palliative care in their homes.**

Rationale: ETF supports expansion of ACP to ensure that members facing serious illness are informed of care options and are able to make treatment decisions based on their individual values and goals of care.

b) **Add coverage for therapies associated with habilitative services**

Rationale: This is the only federal Essential Health Benefit that the program does not cover.
Note: If Board does not approve this benefit, we will consider adding clarification that therapies for developmental delay (not just disabilities) are also excluded.

c) **Bariatric surgery with strict treatment protocols.**

Rationale: Certain surgical procedures are proven in adults for the treatment of clinically severe obesity.

V. Technical/Administrative Recommendations

This section explains minor contract and Guidelines updates that staff plan to recommend to the Board. We will not take the time to discuss these at the Study Group meeting unless there are significant concerns regarding any of these items. Study Group members can contact Tara Pray to discuss any of these issues.

a) Health plans may offer a conversion policy or a Marketplace plan in the event of exhaustion of COBRA coverage. Current guidelines require a conversion policy only. The Office of the Commissioner of Insurance (OCI) interprets Marketplace plans to meet state law (§632.897).
b) Add a due date for Summary of Benefits & Coverage (SBC) documents required by the ACA to the timeline in the Guidelines.
c) Clarify that the Standard Plan and the HDHP Standard Plan are two separate plans.
d) Require employers to pay the invoice amount and adjust for discrepancies prospectively.

e) Allow Wisconsin Public Employers (WPE) to offer opt-out incentives, as provided for state employees in the biennial budget proposal.
f) Clarify that we allow retroactive terminations of coverage in cases where a dependent was enrolled in Medicaid but the employer was not notified timely.
g) Clarify that we allow participants to enroll within 30 days of *notice* of loss of eligibility for coverage.
h) Clarify that new hires must file an application for the HDHP at the same time as creating an HSA account. This is implied, but not specifically stated.
i) Align WPE language with that in the state contract for consistency as appropriate.
j) Add "employer paid local annuitants" to the 2016 contract clarification requiring all Medicare eligible annuitants to enroll when first eligible. This is a clarification of current policy.
k) Clarify that an implanted special lens, such as a multi-focal lens, is not medically necessary for cataract surgery.
l) Clarify that the autism benefit limits are adjusted annually by OCI based on inflation. This is confusing now because the stated limits are $50,000/$25,000 and the related statute regarding inflationary increases is also referenced.
m) Update the surgical exclusion language from "sex transformation" to "gender reassignment".
n) Clarify that exclusion for out of area prior authorized maternity services also applies to births that take place after the due date.
o) Allow subscribers who move from a county to change to any health plan, not limited to the health plans offered in the new county.
p) Refine health plan data submission requirements.

VI. Changes <u>not</u> to be recommended to the Board for 2016

The following proposed changes will not be recommended for 2016 implementation at this time. Many of these changes will be considered as a part of a broader program redesign for 2017 or beyond. We will not take the time to discuss these at the Study Group meeting, but wanted to inform the group of the status of these proposals. Study Group members can contact Tara Pray to discuss any of these issues.

a) Create a member incentive to participate in SDM.
b) Modify hospice care language to expand to include those who have less than 1 year life expectancy, rather than 6 months.
c) Increase the Emergency Room copay to a market standard of $150-$200.
d) Align all coinsurances at either 10% or 20% (member responsibility).
e) Add coverage for 3D mammography.
f) Add coverage for tooth root removal (D7250) under Oral Surgery benefits.
g) Add specific contract language on coverage for telemedicine.
h) Add coverage for gender reassignment benefits with strict protocols.
i) Modify current exclusion language on genetic testing to exclude genetic testing that is not proven to affect medical management.
j) Administer the Well Wisconsin program through a Third Party Administrator.
k) Add a "Tier 0" where health plans could offer a narrow "value based" network built on an Accountable Care Organization or a Patient-Centered Medical Home.
l) ETF creates SBC documents instead of the health plans.

m) Codify in contract that members have up to one year to add a child due to birth per Wis. §632.895.
n) Exemption from participation in WHIO.
o) Create a lower Rx copay to incent members to disease management.
p) Modify the Miscellaneous Hospital Expense definition to specifically exclude convenience items. This would be duplicative of existing exclusion.
q) Include shingles vaccine for individuals as early as age 50. Not recommended for this group per the Centers for Disease Control.
r) Add 50% coverage for out of area care that is medically necessary, non-emergent, non-urgent follow up care. It would require prior authorization and be subject to the usual, customary and reasonable health plan charges.
s) Shift SDM requirements to the providers instead of the health plans.
t) Shift End of Life Care and Advance Care Planning requirements to providers instead of the health plans.
u) Add a spousal surcharge.
v) Limit hearing aids to every three years, counted even if member changes health plans.
w) Remove the $1,000 maximum health plan hearing aid payment for members ages 18 and older (covering 90% with the limit of 1 aid per ear no more than once every 3 years).
x) Limit the number of Cardiac Rehabilitation visits covered per calendar year.
y) Remove the authorization requirement for standard Corneal Transplants (prior authorization will still be necessary for artificial corneal transplant or keratoprosthesis).
z) Limit chiropractic visits to 15 per year and allow additional visits only when prior authorized by the health plan, up to a maximum of additional 15 visits.
aa) Allow transgender people to change their sex in the ETF system with or without surgery.
bb) Allow members to select a gender other than male of female on their health insurance application.
cc) Add an exclusion for the additional cost of robotic surgery.
dd) Add an exclusion for the removal of skin tags.
ee) Add an exclusion for the routine foot care.
ff) Add an exclusion for hair removal.
gg) Add “unproven” to the experimental exclusion (alternative – add “unproven” to the definition of “Experimental”).
hh) Remove the “hold harmless” provision.
ii) Limit coverage of minor dependents to only be covered once with program.
jj) WPE Deductible Program Option (PO) 4 for Medicare eligible & enrolled. Deductible is applied. Most Medicare retiree plans would have $0 deductible apply.
kk) Increase the age for tooth sealant coverage from 16 to 18 years old.

Exhibit M

DRAFT

MINUTES

JULY 12, 2016

Group Insurance Board
State of Wisconsin

Location:
State Revenue Building – Events Room
2135 Rimrock Road, Madison, WI 53713

BOARD MEMBERS PRESENT:

Michael Farrell, Chair
Bonnie Cyganek, Vice Chair
Herschel Day, Secretary (via telephone)
Terri Carlson
Chuck Grapentine
Michael Heifetz
Stacey Rolston
Nancy Thompson
JP Wieske
Bob Ziegelbauer

BOARD MEMBERS ABSENT:

Ted Neitzke

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Bob Conlin, Secretary
John Voelker, Deputy Secretary
Office of Strategic Health Policy:
Lisa Ellinger, Director
Eileen Mallow, Jeff Bogardus, Sarah Bradley, Tara Pray
Office of the Secretary:
Sara Brockman, Board Liaison

OTHERS PRESENT:

ETF Budget & Procurement:
Rita Black-Radloff, Beth Bucaida, Michael McNally, Joe Schneider
ETF Department of Trust Finance:
Cindy Klimke, Bob Willett
ETF Information Technology Services:
Ryan Perkins
ETF Legal Services:
Diana Felsmann, David Nispel
ETF Office of Communications:
Nancy Ketterhagen, Mark Lamkins
Martin Schreiber & Associates:
Annie Early
MercyCare:
Tracy Craker
Momentum Insurance:
Stephanie Steel
Office of the Commissioner of Insurance:
Jennifer Stegall
Physicians Plus:
Ron Sebranek
Securian:
Kjirsten Elsner, Chris Schmelzer

Board	Mtg Date	Item #
GIB	8.16.16	1

ETF Office of the Secretary:
Pam Henning, Tarna Hunter, Cheryllynn Wilkins
ETF Office of Strategic Health Policy:
Rachel Carabell, Sherry Etes, Roni Harper, Arlene Larson, Shayna Schomber, Joan Steele
Baraboo Ambulance:
Troy Snow
Dean Health Plan:
Angie Dalton
Delta Dental:
Sunshine Mikulak
Department of Administration:
Nicole Zimm
EPIC Life Insurance Company:
Wendy Hougan
General Public:
Hickory Hurie
Group Health Cooperative – South Central Wisconsin:
Elizabeth Dye
Health Choice:
Bob Pearson
Humana:
Mary Haffenbredl
Legislative Audit Bureau:
Emily Pape
M3 Insurance:
Tim Byrne, Nathan Janke
State Engineering Association:
Bob Schaefer
UnitedHealth Group:
JodieTierney
Unity Health Insurance:
Cari Alexander
University of Wisconin – Madison:
Deanne DeSlover, Molly Heisterkamp, SE Hutchinson
UW Health:
Liz Melin
UW Hospital and Clinics:
Anthony Dix
UW System Administration:
LaDonna Steinert
WEA Trust:
Greg Cieslewicz
WisBusiness.com:
Polo Rocha
Wisconsin Association of Health Plans:
Phil Dougherty
Wisconsin Health News:
Tim Stumm
Wisconsin Hospital Association:
Joanne Alig
Wisconsin Medical Society:
Chris Rasch
WPS Arise:
Carrie Helms

Bonnie Cyganek, Vice Chair, called the meeting of the Group Insurance Board (Board) to order at 9:01 a.m.

ANNOUNCEMENTS

Ms. Ellinger made the following announcements:

- JP Wieske, Deputy Commissioner of Insurance, will replace Daniel Schwartzer as a member of the Board.
- Rachel Carabell has accepted the position of Strategic Health Policy Advisor with the Office of Strategic Health Policy.
- WisconsinEye was not invited to record the meeting due to the short duration of open session.

ELECTION OF OFFICERS

MOTION: Ms. Carlson moved to nominate Michael Farrell as Chair of the Group Insurance Board. Mr. Grapentine seconded the motion, which passed unanimously on a voice vote, with Mr. Farrell abstaining.

MOTION: Mr. Grapentine moved to nominate Herschel Day as Secretary of the Group Insurance Board. Ms. Thompson seconded the motion. The motion passed unanimously on a voice vote, with Mr. Day abstaining.

Mr. Farrell assumed the duties of the Chair upon his election.

HEALTH INSURANCE

Guidelines and Uniform Benefit Changes for 2017

Ms. Pray referred the Board to the memo, Guidelines and Uniform Benefit Changes for 2017 (Ref. GIB | 7.12.16 | 3A). At the May 18, 2016 meeting, the Board approved initial Guidelines and Uniform Benefit change recommendations as presented, and granted the staff the authority to make additional technical changes as necessary.

Additional changes to the Guidelines Contract are necessary, due to the federal Department of Health and Human Services (HHS) issuing final regulations pertaining to Section 1557 of the Affordable Care Act (ACA) on May 18, 2016.

The Section 1557 regulations apply to "covered entities," which are prohibited from discriminating on the basis of race, color, national origin, age, disability, or sex, including discrimination on the basis of gender identity.

The regulations list the following as prohibited activities:

1. Deny, cancel, limit, or refuse to issue health coverage.
2. Deny or limit a claim.
3. Impose additional cost-sharing or other limitations.
4. Deny or limit coverage or impose additional cost-sharing or other limitations for sex-specific health services provided to transgender individuals based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.
5. Categorically excluding coverage for services related to gender transition.
6. Otherwise limit services related to gender transition if the limitation would result in discrimination against a transgender individual.

After analyzing the new law, ETF's Office of Legal Services recommended two changes to bring ETF into compliance:

1. Remove the current exclusion related to benefits and services related to gender

reassignment or sexual transformation. Required effective date is January 1, 2017.

2. Include the federally-required nondiscrimination notification language on all significant communications related to ETF's health programs. Required effective date is October 16, 2016.

These provisions are required for covered entities, which is defined as:

- An entity that operates a health program or activity that receives federal financial assistance through HHS;
- An entity established under Title I of the ACA that administers a health program or activity, such as state-based marketplaces; or
- HHS and the programs it administers, such as the federal marketplace.

ETF's Office of Legal Services and Segal Consulting analyzed the new law and recommend that ETF consider itself a covered entity due to offering self-insured plans, providing and administering health insurance coverage, and accepting Medicare Part D subsidies.

If the changes are not adopted, ETF anticipates issues contracting with health plans, which are covered entities and as such are prohibited from contracting away nondiscrimination obligations. Secondly, the HHS Office of Civil Rights has indicated its intent to actively refer discrimination complaints to the Equal Employment Opportunity Commission, which has enforcement authority over general nondiscrimination laws, including gender discrimination.

No further substantial changes to the 2017 Guidelines Contract and Uniform Benefits are anticipated, and final change recommendations will be presented at the November 15, 2016 Board meeting.

MOTION: Ms. Carlson moved to approve the changes to the Guidelines Contract and Uniform Benefits as detailed in Attachment A, and grant ETF staff the authority to make additional technical changes necessary. Ms. Thompson seconded the motion, which passed unanimously on a voice vote.

Request for Proposals Implementation Plan Update

Ms. Ellinger referred the Board to the Requests for Proposals Implementation Plan Update memo (Ref. GIB | 7.12.16 | 3B) and provided a brief update on the development and distribution of various RFPs.

The RFP to Evaluate Self Insurance and Regional/Statewide Program Structure and the RFP for a Data Warehousing/Visual Business Intelligence Vendor were both on schedule to be released July 22, 2016, after incorporating Request for Information feedback. Vendor selection for both RFPs is scheduled to occur at the Board meeting

on November 15, 2016. There were no pertinent updates to the Pharmacy Benefit Manager RFP.

OPTIONAL PLANS

Optional Dental Plans Rates

Ms. Mallow referred the Board to the Optional Dental Plans Rates memo (Ref. GIB | 7.12.16 | 4A) and provided a brief overview the recommended dental rates for 2017 from Anthem DentalBlue, EPIC Dental Wisconsin, and EPIC Benefits +.

> ***MOTION: Ms. Cyganek moved to approve the proposed premium changes for existing plans, per the amended proposals, effective January 1, 2017. Ms. Thompson seconded the motion, which passed unanimously on a voice vote.***

The Chair announced the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat § 19.85 (1) (e) for the purpose of deliberating the potential investment of public funds and to review proposals for services for which competitive and bargaining reasons required a closed session. Staff from the Department of Employee Trust Funds, Office of the Commissioner of Insurance, the Department of Administration , and members of the proposal adjudication committee were invited to remain during the closed session.

> ***MOTION: Ms. Cyganek moved to convene in closed session, pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (e) to deliberate or negotiate the investing of public funds or to conduct other specified public business. Ms. Thompson seconded the motion, which passed on the following roll call vote:***
>
> ***Members Voting Aye: Carlson, Cyganek, Day, Farrell, Grapentine, Heifetz, Rolston, Thompson, Wieske, Ziegelbauer***
>
> ***Members Absent: Neitzke***

The Board convened in closed session at 9:32 a.m. and reconvened in open session at 12:08 p.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Mr. Farrell announced the Board reviewed and deliberated on RFPs for the Third Party Administration of Wellness and Disease Management Programs (RFP#ETG0005) during closed session.

Motion: Ms. Cyganek moved to grant authority to the Secretary of the Department of Employee Trust Funds to issue an intent to award the contract for Third Party Administrative Services for Wellness and Disease Management Programs to The StayWell Company, LLC, for the period of August 15, 2016 through December 31, 2018, with the potential for two (2), two (2) year extensions, subject to successful contract negotiations.

In addition, if the contract negotiations fail or extend beyond a reasonable period of time, the Secretary has the authority to issue an intent to award the contract for Third Party Administrative Services for Wellness and Disease Management Programs to Limeade. Should these negotiations fail or extend beyond a reasonable period of time with Limeade, staff recommends that the Secretary be allowed to issue an intent to award to ActiveHealth Management, Inc.

ADJOURNMENT

MOTION: Mr. Heifetz moved to adjourn the meeting. Mr. Grapentine seconded the motion, which passed unanimously on a voice vote.

The meeting adjourned at 12:15 p.m.

Date Approved: _____

Signed: _____
Herschel Day, Secretary
Group Insurance Board

Exhibit N

From: Schatten, Kirsten R. <Schatten, Kirsten R. <kschatten@segalco.com>> on behalf of Schatten, Kirsten R.
Sent: Wednesday, June 29, 2016 10:32 AM
To: Ellinger; Lisa - ETF
Subject: FW: Gender Identity
Attachments: GID Coverage Segal Response 20140303.pdf

Kirsten R. Schatten, ASA, FCA, MAAA
Vice President, Consulting Actuary
The Segal Group
2018 Powers Ferry Road Suite 850 | Atlanta, GA 30339-7200
T 678-306-3129 | **F** 678-669-1887
kschatten@segalco.com

Members of The Segal Group include:
Segal Consulting, Sibson Consulting,
Segal Rogerscasey and Segal Select Insurance.

From: Schatten, Kirsten R.
Sent: Wednesday, June 29, 2016 10:29 AM
To: 'Ellinger, Lisa - ETF'
Cc: Vieira, Kenneth C.
Subject: Gender Identity

Lisa,

Here is the report on Gender Identity Dysphoria we did for Maryland that we discussed.

Kirsten R. Schatten, ASA, FCA, MAAA
Vice President, Consulting Actuary
The Segal Group
2018 Powers Ferry Road Suite 850 | Atlanta, GA 30339-7200
T 678-306-3129 | **F** 678-669-1887
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Segal Rogerscasey and Segal Select Insurance.

Segal Consulting

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MEMORANDUM

To: Anne Timmons

From: Richard Ward, FSA, FCA, MAAA

Date: March 3, 2014

Re: Fiscal Impact and Commentary for Covering Services and Drugs Related to Gender Dysphoria

In your January 27, 2014 email, you requested Segal to analyze the effect of the Program adding coverage for services and drugs related to gender reorientation. Three scenarios were requested:

1) Coverage is provided without plan limitations,

2) Coverage is provided with the following requirements,
   a) The candidate is at least 18 years of age; and
   b) Has been diagnosed with GID, including meeting all of the following indications:
      i) The desire to live and be accepted as a member of the opposite sex, typically accompanied by the desire to make the physical body as congruent as possible with the identified sex through surgery and hormone treatment; and
      ii) The new gender identity has been present for at least 24 months; and
      iii) The gender identity disorder is not a symptom of another mental disorder or a chromosomal abnormality; and
      iv) The gender identity disorder causes clinical distress or impairment in social, occupational, or other important areas of functioning.
   c) For those candidates without a medical contraindication, the candidate has undergone a minimum of 12 months of continuous hormonal therapy that is:
      i) Recommended by a mental health professional and
      ii) Provided under the supervision of a physician; and the supervising physician indicates that the patient has taken the hormones as directed.
   d) For candidates requesting female to male surgery only:
      i) When the initial requested surgery is solely a mastectomy, the treating physician may indicate that no hormonal treatment (as described in criteria c. above) is required prior to performance of the mastectomy.

3) Coverage provided with various lifetime maximums that may be allowable under ACA.

MEDICALLY NECESSARY VERSUS NON-MEDICALLY NECESSARY BENEFITS

According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), any individual whose birth gender is different from the gender they identify with will be diagnosed with gender dysphoria. Once referred to as gender identification disorder (GID), gender dysphoria is a mental health disorder in which an individual identifies with a gender that is contrary to the gender assigned to him/her. The disorder must present for at least six months. Treatment options for this condition may include psychotherapy/counseling, hormone replacement therapy (HRT), gender reassignment surgery, cosmetic surgery and social and legal transition to the desired gender.[1]

Generally, there are three services/procedures commonly considered the most crucial to address gender dysphoria and produce optimal outcomes for the individual - psychotherapy, HRT and gender reassignment surgery. These treatments are usually regarded as "medically necessary." Health plans typically require that an expense be medically necessary in order to be payable under the terms of the plan. The determination of medically necessary should be made by the State based on consultation with medical experts and be consistent with the Program's definition of "medically necessary."

Based upon our research on gender reassignment surgery specifically, the following procedures are normally considered medically necessary:

- Hysterectomy – removal of the uterus
- Oophorectomy – removal of the ovaries
- Metoidioplasty – construction of a penis out of a clitoris
- Vaginoplasty – construction of a vagina
- Orchiectomy – removal of the testicles
- Penectomy – removal of the penis
- Clitoroplasty – construction of the clitoris
- Labiaplasty – cosmetic refining of the outer vulva
- Scrotoplasty – construction of scrotum using implants
- Phalloplasty – construction of penis through tissue graft

The following gender reassignment-associated surgeries are considered cosmetic procedures and would generally not be considered medically necessary:

- Breast augmentation
- Facial feminization surgery
- Trachea shave
- Electrolysis
- Voice modification surgery

[1] Gender Dysphoria Fact Sheet, American Psychiatric Association, 2013.

A LOOK AT OTHER EMPLOYERS COVERING GENDER DYSPHORIA

Major Insurance Carriers

Reviewing what major insurance carriers consider medically necessary regarding gender dysphoria is a good litmus test for benefits coverage and provides guidance as to which services are and are not regarded as medically necessary. Research of the major insurance carriers covering gender dysphoria or some type of transgender benefit indicates that carriers typically view some combination of psychotherapy, HRT and gender reassignment surgery as "medically necessary" services/procedures. In addition, medically necessary services are generally covered without limitations such as annual or lifetime maximums. The major carriers often regard cosmetic surgery and other procedures that enhance overall appearance as non-medically necessary services and therefore, are not typically covered. Specific coverage policies of four large carriers (Aetna, Anthem, Cigna, and United HealthCare) appear as an attachment to this letter and provide specific detail about their individual insurance policies.

State and Local Governments

There are also five State Governments that have already mandated health coverage for transgender individuals. Coverage is mandated for insured plans offered in California, Oregon, Colorado, Vermont, and Connecticut (listed in order of enactment). Although the language amongst the States varies, generally, the mandates dictate that health insurers must cover medically necessary treatments related to gender dysphoria if those same treatments are covered for other conditions. Again, these benefits are covered without caps such as annual or lifetime maximums.

In addition to State Governments, the City and County of San Francisco, which is recognized as the first U.S. municipality to remove transgender access exclusions in its employee health plans, covers transgender benefits as follows:

- Plan Option A: Lifetime maximum of $75,000 per Covered Person; 85% after Deductible has been met (in network); 50% after Deductible has been met (out-of-network)
- Plan Option B: Lifetime maximum of $75,000 per Covered Person; transgender and related surgical services:
    - Consultation and exams - $15 co-pay per visit
    - Outpatient surgery and other outpatient procedures - $15 co-pay per procedure
    - Hospital inpatient care (including room and board, drugs, and plan physician services) - $100 co-pay per admission
    - Surgery or services designed to change or maintain appearance, voice or other characteristics are excluded
- The City and County of San Francisco offers a third plan option to active employees but transgender or gender identity benefits were not specifically addressed in the Benefits Booklet.

Additionally, a study of employers[2] that cover some type of transgender benefit shows that these employers are also in alignment with the major carriers' coverage position on treatment for this disorder. Most employers that elect to cover this benefit, do not place annual or lifetime limits on the coverage but do restrict the benefit to those services considered medically necessary. Additional benefit design elements that have been implemented by these employers include:

- excluding treatment that is considered cosmetic,
- limiting the coverage to in-network only providers and facilities and/or restricting access to out of network care,
- restricting coverage for services provided outside the U.S.

Maryland Insurance Administration

As the State is aware, the Maryland Insurance Administration issued a bulletin on January 27, 2014, indicating that Maryland insurance law prohibits a carrier from discriminating among insureds under a health benefit plan on the basis of the insured's actual or perceived gender identity, or on the basis that the insured is a transgender individual. That means that these individuals cannot be denied services due to the transgender or gender identity status.

The Bulletin also states that although the Maryland Benchmark plan for essential health benefits (EHB) excludes "treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery", that exclusion cannot serve to deny services for medically necessary items or services, including medically necessary preventive services, solely on the grounds that the person receiving the services is a transgender individual. In other words, insurance carriers that offer the comprehensive standard health benefit plan in the small employer market for plan years prior to 2014, cannot discriminate against an individual because they are transgender, but the plan does not have to cover gender modification surgery.

District of Columbia's Department of Insurance, Securities and Banking

On February 27, 2014, the District of Columbia's Department of Insurance, Securities and Banking issued a revised bulletin to all health insurance companies that write health insurance in the District concerning discrimination based on gender identity or expression. Per the revised bulletin, the Department concluded that treatment for gender dysphoria, including gender reassignment surgeries, is a covered benefit, and individuals diagnosed with gender dysphoria are entitled to receive medically necessary benefits and services under individual and group health insurance policies covering medical and hospital expenses.

[2] See "Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans" at: http://williamsinstitute.law.ucla.edu/research/transgender-issues/costs-benefits-providing-transition-related-health-care-coverage-herman-2013/

To determine medical necessity, health insurance companies are required to follow the standards of care in the most recent edition of the World Professional Association for Transgender Health Standards of Care[3] —the most current edition was released on September 25, 2011. According to the revised bulletin, the appropriate treatments for gender dysphoria under the WPATH standards vary from patient to patient. Therefore, medical necessity determinations must be guided by providers in consultation with individual patients. The bulletin does not cover qualified plans under ERISA, which remain exempt from state insurance laws.

COMPLIANCE IMPLICATIONS

Mental Health Parity and Addiction Equity Act (MHPAEA)

As previously noted, the DSM-5 classifies gender dysphoria as a mental health condition. Thus, it follows that the treatment of gender dysphoria would be considered mental health treatment subject to the MHPAEA. The MHPAEA does not require the State to cover treatment related to gender dysphoria. As indicated in the preamble to the final MHPAEA regulations, "the provision of benefits for one or more mental health conditions or substance use disorders does not require the provision of benefits for any other condition or disorder." However, since the State chooses to comply with the MHPAEA, if the State elects to cover gender dysphoria treatment, such treatment must be in compliance with the MHPAEA.

In general, the MHPAEA prohibits plans from imposing a financial requirement or quantitative treatment limitation (e.g., a lifetime or annual dollar limit) on mental health and substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification. Since the Program does not impose lifetime or annual dollar limits on any medical/surgical benefits, we believe it is impermissible to impose a lifetime or annual dollar limit on any mental health service, including treatment of gender dysphoria. The Program can choose to exclude from coverage non-medically services such as cosmetic surgery and related treatments designed to enhance the appearance of the individual.

The MHPAEA regulations also prohibit disparities in non-quantitative treatment limits. This includes medical management tools such as prior authorization and medical necessity determinations, formulary design for prescription drugs, step therapy protocols, and certain plan exclusions. The MHPAEA final regulations prohibit such limits on mental health and substance use disorder treatment unless the standards used to apply the limitation are comparable to, and not more stringently applied than, the standards used for medical benefits. Non-quantitative limits must be reviewed both as written and in actual operation to determine if parity is achieved.

[3] See, "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7 at: http://www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf

Affordable Care Act (ACA)

We do not anticipate any implications under the ACA if the State chooses to add coverage for gender dysphoria, without limitations, for medically necessary services and treatments. PHS Act section 2711, as added by the ACA, does not permit annual or lifetime dollar limits on essential health benefits (EHBs). The State could go through the process of determining whether gender dysphoria benefits are EHBs. However, as noted above, we believe that annual and lifetime limits on gender dysphoria treatment are impermissible under the MHPAEA.

PROJECTED FISCAL IMPACT

The following table shows the projected costs for a single occurrence and includes treatment for counseling, HRT and reassignment surgery. It should be noted that treatment for individuals with gender dysphoria may also include health costs associated with living full-time as the target sex, post-surgical care, and ongoing costs such as hormone therapy, follow-up doctor visits, and psychotherapy.

	Estimated Costs[4]
Counseling/Therapy	$2,000 - $7,000*
HRT	$3,000 - $13,000*
Reassignment Surgery	$20,000 - $80,000
Total Cost (up to, and including procedure)	$25,000 - $100,000
Ongoing Annual Cost "Post Procedure"**	$2,500 - $10,000

* Includes related counseling and therapies in the 24 months leading up to the initial procedure(s).
** Includes ongoing therapy and increased overall morbidity.

The Program's current annual costs are approximately $1.3B. The largest estimated cost, $100,000 represents less than a 0.01% increase in annual costs for the cost of the initial procedure(s) and related drug therapy and counseling.

Several years after implementing this coverage, it is possible the Program may be providing coverage for several members on a "post-procedure" basis. At that point, when another member undergoes the initial procedure(s), it is conceivable the Program's costs for that year could be $200,000-$300,000 higher than if coverage were not provided. In this instance, the increase in annual costs would be approximately 0.02%-0.03%.

[4] Cost estimates based in part on information from
(1) Transgender At Work, see "The Cost of Transgender Health Benefits" at: http://www.tgender.net/taw/thb/THBWorkshopOE2008.pdf
(2) CostHelper.com, see "How Much Does Sex Reassignment Surgery Cost?" at: http://health.costhelper.com/sex-reassignment-surgery.html and
(3) TSRoadmap.com, see "Transsexual Road Map" at: http://www.tsroadmap.com/index.html

Annually, approximately 300-500 adults in the US undergo gender reorientation procedure(s). With approximately 225,000,000 adults in the US and approximately 150,000 adults coverage in the Program, this suggests an annual utilization rate well below 1.0 procedures annually:

$$500/225{,}000{,}000 \times 150{,}000 = 0.33$$

However, employers and plans that provide this coverage are still in the minority. Therefore, there is the likelihood the State could become an "employer of choice" for individuals seeking to undergo treatment for gender dysphoria. As a result, it would be reasonable to conservatively estimate that there may be one adult annually that undergoes the procedure(s).

The State may also want to consider the costs that the individual receiving treatment will incur. In the year that the individual receives gender reassignment surgery, costs to the member would be subject to and capped at the Program's maximum out-of-pocket limit. In the years, leading up to the surgery and in the years post-surgery, we estimate that the cost to the member will range from $250 to $750 annually, assuming the current out-of-pocket maximum. If the maximum out-of-pocket is increased, the member costs associated with gender dysphoria are expected to increase.

IMPLICATIONS TO THE PROGRAM

Choosing to cover gender dysphoria as a health benefit will have implications to the Program and therefore should be examined. First, the State must consider the overall cost impact. As noted above, Segal projects a 0.01% increase in annual costs to the Program for the cost of the initial procedure(s) and related drug therapy and counseling. Also, it is reasonable to assume that costs may increase as medical technology and treatments for gender dysphoria advance. Additionally, as any possible stigma associated with this disorder decreases, the prevalence of individuals requesting such treatments may increase.

Additionally, the language in the Program's plan documents concerning this matter will need to be updated. The State will need to review the Program's current plan language and any other relevant documents and develop clear and consistent language that defines the added benefit and outlines exactly what the Program will and will not cover.

RECOMMENDATIONS

The addition of any health benefit will result in claims that will likely translate to additional costs for the Program. In the case of gender dysphoria, the costs associated with the benefit will vary based upon the treatments that are sought by each individual using the benefit. It will also vary based upon which treatment elements the State chooses to cover.

The State asked Segal to analyze the effect of the Program adding coverage for gender dysphoria for three different scenarios. With regard to the State's first scenario: "Coverage is provided without plan limitations," our research and analysis indicate that covering gender dysphoria services that are considered medically necessary, without plan limitations, will have a minimal financial impact on the Program's cost and utilization for this benefit. Providing coverage in this manner will limit the Program's overall spending only to treatments that are medically necessary

and supported by evidenced-based medicine guidelines. This is consistent with coverage of services and benefits not associated with gender dysphoria. Providing coverage without annual, lifetime or other similar utilization and cost-based limitations will enable the Program to continue to be in compliance with MHPAEA.

Segal recommends this approach. We drafted plan language for the State to consider as it determines whether to implement this benefit. Please see the "Plan Document Language for Treatment of Gender Dysphoria" as an attachment to this memo. This language is an amalgamation of plan and policy language currently used by the major carriers.

We believe that the State's second scenario: "Coverage is provided with requirements," is extremely specific and may exclude individuals or include limitations and restrictions that we do not see currently present in coverage language provided by the major carriers or State Governments that elect to provide coverage for gender dysphoria. As a result, we do not recommend that the State explore this option further. A policy with such specific requirements may be difficult to administer.

We have determined that the State's third scenario to cover the benefit "with various lifetime maximums that may be allowable under ACA" would not be in compliance with MHPAEA since the Program does not impose any lifetime dollar limits on any medical/surgical benefits. It is our understanding that the State intends to continue to comply with MHPAEA. Therefore, we do not believe that this scenario is a viable option.

As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for authoritative advice on the MHPAEA and the regulations promulgated thereunder.

cc: Kirsten Schatten, ASA, MAAA, Segal
Noel Cruse, Segal

SUGGESTED COVERAGE LANGUAGE FOR GENDER DYSPHORIA

Based upon our research of major carriers, State governments and employers that provide coverage for transgender benefits, we crafted the following policy language for your consideration as you decide whether to provide coverage for gender dysphoria:

Plan Document Language for Treatment of Gender Dysphoria

Covered Services:

1) Psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses. The benefits are the same as any other outpatient mental health service in the Program.

2) Continuous hormone replacement therapy. The benefits are the same as any other eligible drug in the Program. Note the following clarifications:

   - Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design.

   - Oral and self-injected hormones from a pharmacy are not covered under the medical plan. Refer to the SPD for self-funded plans, for specific prescription drug product coverage and exclusion terms.

3) Laboratory testing to monitor continuous hormone therapy. The benefits are the same as any other outpatient diagnostic service on the plan.

4) For individuals undergoing gender reassignment surgery*, consisting of any combination of the following; hysterectomy, salpingo-oophorectomy; ovariectomy, or orchiectomy, are considered **medically necessary** when *all* of the following criteria are met:

   1) The individual is at least 18 years of age; and

   2) The individual has capacity to make fully informed decisions and consent for treatment; and

   3) The individual has been diagnosed with gender dysphoria, and exhibits all of the following:

      a) The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and

      b) The transsexual identity has been present persistently for at least two years; and

      c) The disorder is not a symptom of another mental disorder; and

d) The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

4) Individuals without a medical contraindication or otherwise unable or unwilling to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and

5) If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

6) Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required.

For individuals undergoing gender reassignment surgery*, consisting of any combination of the following; metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses, are considered medically necessary when *all* of the following criteria are met:

1) The individual is at least 18 years of age; and

2) The individual has capacity to make fully informed decisions and consent for treatment; and

3) The individual has been diagnosed with gender dysphoria and exhibits all of the following:

a) The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and

b) The transsexual identity has been present persistently for at least two years; and

c) The disorder is not a symptom of another mental disorder; and

d) The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

4) The individual is an active participant in a recognized gender identity treatment program; and

5) Individuals without a medical contraindication or otherwise unable or unwilling to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and

6) Documentation that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Note:

- The medical documentation should include the start date of living full time in the new gender.

- Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases; and

1) Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; and

2) If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

3) Two referrals from qualified mental health professionals** who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required.

** At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above.

Gender reassignment surgery is considered not medically necessary when one or more of the criteria above have not been met.

Note on gender specific services for transgender persons:

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
- Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

The State considers gonadotropin-releasing hormone medically necessary to suppress puberty in transgender adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria (see CPB 501 - Gonadotropin-Releasing Hormone Analogs and Antagonists).

Note: For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months continuous hormonal sex reassignment is required. An additional 12 months of hormone therapy is not required for vaginectomy or vaginoplasty procedures.

Note: Cryopreservation, storage, and thawing of reproductive tissue (i.e., oocytes, ovaries, testicular tissue) is considered experimental, investigational, unproven and not medically necessary.

See Coverage Limitations and Exclusions section below for gender reassignment surgery exclusion.

Coverage Limitations and Exclusions

The following associated gender reassignment surgeries are considered cosmetic in nature, when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery, and not medically necessary (this list may not be all-inclusive):

1) Reduction thyroid chondroplasty
2) Liposuction
3) Rhinoplasty
4) Facial bone reconstruction
5) Face/forehead lift
6) Blepharoplasty
7) Voice modification surgery
8) Hair removal/hairplasty

9) Breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast
10) Abdominoplasty
11) Chin/nose implants
12) Collagen injections
13) Electrolysis
14) Brow lift
15) Cheek implants
16) Hair removal/hair transplantation
17) Penile prosthesis (noninflatable /inflatable)
18) Testicular expanders
19) Jaw shortening/sculpturing/facial bone reduction
20) Laryngoplasty
21) Lip reduction/enhancement
22) Liposuction
23) Mastopexy
24) Neck tightening
25) Nipple/areola reconstruction
26) Removal of redundant skin
27) Replacement of tissue expander with permanent prosthesis testicular insertion
28) Scrotoplasty
29) Second stage phalloplasty
30) Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir
31) Testicular prostheses
32) Trachea shave/reduction thyroid chondroplasty
33) Voice therapy/voice lessons

WHAT THE CARRIERS COVER

Aetna

Most Aetna plans exclude coverage of sex change surgery (gender reassignment surgery, transgender surgery). Please check benefit plan descriptions.

Aetna considers sex reassignment surgery medically necessary when all of the following criteria are met:

1) Requirements for mastectomy for female-to-male patients:

    a) Single letter of referral from a qualified mental health professional
    b) Persistent, well-documented gender dysphoria
    c) Capacity to make a fully informed decision and to consent for treatment
    d) Age of majority (18 years of age or older)
    e) If significant medical or mental health concerns are present, they must be reasonably well controlled.

    Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

2) Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):

    a) Two referral letters from qualified mental health professionals, one in a purely evaluative role
    b) Persistent, well-documented gender dysphoria
    c) Capacity to make a fully informed decision and to consent for treatment
    d) Age of majority (18 years or older)
    e) If significant medical or mental health concerns are present, they must be reasonably well controlled
    f) Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)

3) Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female)

    a) Two referral letters from qualified mental health professionals, one in a purely evaluative role
    b) Persistent, well-documented gender dysphoria
    c) Capacity to make a fully informed decision and to consent for treatment
    d) Age of majority (age 18 years and older)
    e) If significant medical or mental health concerns are present, they must be reasonably well controlled

f) Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)
g) Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.

Note on gender specific services for transgender persons: Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1) Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
2) Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in transgender adolescents if they meet World Professional Association for Transgender Health.

Aetna considers the following procedures that may be performed as a component of a gender reassignment as cosmetic (not an all-inclusive list)

- Abdominoplasty
- Blepharoplasty
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Drugs for hair loss or growth
- Forehead lift
- Hair removal
- Hair transplantation
- Lip reduction
- Liposuction
- Mastopexy
- Neck tightening
- Pectoral implants
- Removal of redundant skin
- Rhinoplasty
- Voice therapy/voice lessons

Anthem

Medically Necessary:

For individuals undergoing gender reassignment surgery*, consisting of any combination of the following; hysterectomy, salpingo-oophorectomy; ovariectomy, or orchiectomy, are considered **medically necessary** when *all* of the following criteria are met:

1) The individual is at least 18 years of age
2) The individual has capacity to make fully informed decisions and consent for treatment
3) The individual has been diagnosed with gender dysphoria, and exhibits all of the following:
    a) The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment
    b) The transsexual identity has been present persistently for at least two years; and
    c) The disorder is not a symptom of another mental disorder
    d) The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
4) Individuals without a medical contraindication or otherwise unable or unwilling to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician
5) If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated
6) Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required.

For individuals undergoing gender reassignment surgery*, consisting of any combination of the following; metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses, are considered **medically necessary** when *all* of the following criteria are met:

1) The individual is at least 18 years of age
2) The individual has capacity to make fully informed decisions and consent for treatment

3) The individual has been diagnosed with gender dysphoria and exhibits all of the following:
    a) The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment
    b) The transsexual identity has been present persistently for at least two years; and
    c) The disorder is not a symptom of another mental disorder
    d) The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
4) Individuals without a medical contraindication or otherwise unable or unwilling to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician
5) Documentation that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings). *Note***:**
    a) The medical documentation should include the start date of living full time in the new gender.
    b) Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases
6) Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner
7) If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated
8) Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required.

** At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above.

Not Medically Necessary:

Gender reassignment surgery is considered not medically necessary when one or more of the criteria above have not been met.

Cosmetic:

The following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery:

1) Reduction thyroid chondroplasty
2) Liposuction
3) Rhinoplasty
4) Facial bone reconstruction
5) Face lift
6) Blepharoplasty
7) Voice modification surgery
8) Hair removal/hairplasty
9) Breast augmentatio

Cigna

Gender reassignment surgery is considered medically necessary when the individual is age 18 or older, has confirmed gender dysphoria, and is an active participant in a recognized gender identity treatment program:

1) Female-to-male gender reassignment

   a) breast surgery (i.e., initial mastectomy, breast reduction) when there is one letter of support from a qualified mental health professional
   b) .hysterectomy and salpingo-oophorectomy when BOTH of the following additional criteria are met:

      - documentation of at least 12 months of continuous hormonal* sex reassignment therapy
      - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report. Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist.)

   c) vaginectomy (including colpectomy, metoidioplasty with initial phalloplasty, urethroplasty, urethromeatoplasty) when ALL of the following criteria are met:

      - documentation of at least 12 months of continuous hormonal* sex reassignment therapy (May be simultaneous with real life experience.)
      - the individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender
      - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report. Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist.)

2) Male-to-female gender reassignment

   a) orchiectomy when BOTH of the following additional criteria are met:

      - documentation of at least 12 months of continuous hormonal* sex reassignment therapy
      - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report. Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is

acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist.)

b) vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy), when ALL of the following criteria are met:

- documentation of at least 12 months of continuous hormonal* sex reassignment therapy,(May be simultaneous with real life experience.)
- the individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender
- recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (At least one letter should be a comprehensive report. Two separate letters or one letter with two signatures is acceptable. One letter from a Master's degree mental health professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist.)

Note: For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months continuous hormonal sex reassignment is required. An additional 12 months of hormone therapy is not required for vaginectomy or vaginoplasty procedures.

Cryopreservation, storage, and thawing of reproductive tissue (i.e., oocytes, ovaries, testicular tissue) is considered experimental, investigational, unproven and not medically necessary.

The following associated gender reassignment surgeries are considered cosmetic in nature and not medically necessary (this list may not be all-inclusive):

- abdominoplasty
- blepharoplasty
- breast enlargement procedures, including augmentation mammoplasty, implants, and silicone injections of the breast
- chin/nose implants
- collagen injections
- electrolysis
- face/forehead lift
- brow lift
- cheek implants
- hair removal/hair transplantation
- penile prosthesis (noninflatable /inflatable)
- testicular expanders
- jaw shortening/sculpturing/facial bone reduction
- laryngoplasty
- lip reduction/enhancement
- liposuction

- mastopexy
- neck tightening
- nipple/areola reconstruction
- removal of redundant skin
- replacement of tissue expander with permanent prosthesis testicular insertion
- rhinoplasty
- scrotoplasty
- second stage phalloplasty
- surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir
- testicular prostheses
- trachea shave/reduction thyroid chondroplasty
- voice modification surgery
- voice therapy/voice lessons

Plan Document Language
Before using this guideline, please check enrollee's specific plan document and any federal or state mandates, if applicable.
Note: Sex transformation surgery is also referred to as: sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex or gender reassignment.

Essential Health Benefits for Individual and Small Group:
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the enrollee's specific plan document to determine benefit coverage.

Indications for Coverage

1) Covered Services:

Standard plans include coverage for the following services for gender identity disorder:

a) Psychotherapy for gender identity disorder and associated co-morbid psychiatric diagnoses. The benefits are the same as any other outpatient mental health service on the plan. Note the following:

- If mental health services are not covered on the UHC plan (for example when mental health services are carved out of the plan design) the plan will not cover psychotherapy for gender identity disorder.

b) Continuous hormone replacement therapy. The benefits are the same as any other eligible drug on the plan. Note the following clarifications:

- Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design.
- Oral and self-injected hormones from a pharmacy are not covered under the medical plan. Refer to the Outpatient Prescription Drug Rider or SPD for self-funded plans, for specific prescription drug product coverage and exclusion terms.

c) Laboratory testing to monitor continuous hormone therapy. The benefits are the same as any other outpatient diagnostic service on the plan.

See Coverage Limitations and Exclusions section below for sex transformation operations exclusion.

Coverage Limitations and Exclusions
Standard plans exclude coverage for sex transformation operations. Examples that apply to this exclusion include, but are not limited to:

1) Genital surgery:

- Complete hysterectomy
- Orchiectomy
- Penectomy
- Vaginoplasty
- Vaginectomy
- Clitoroplasty
- Labiaplasty
- Salpingo-oophorectomy
- Metoidioplasty
- Scrotoplasty
- Urethroplasty
- Placement of testicular prosthesis
- Phalloplasty

2) Surgery to change specified secondary sex characteristics, specifically:

- thyroid chondroplasty (removal or reduction of the Adam's Apple); and
- bilateral mastectomy; and
- augmentation mammoplasty (including breast prosthesis)

Related Services:
In addition to the surgeon fees, this exclusion applies to the services related to the surgery, including, but not limited to: anesthesia, laboratory testing, pathology, radiologic procedures, hospital and facility fees, and/or surgical center fees.

See Indications for Coverage section above for covered services for gender identity disorder.

Plans that cover surgical treatment of gender identity disorder:
Most plans exclude coverage for sex transformation surgery. Please refer to the Enrollee's Plan Specific benefit document to verify. For ASO plans that cover Gender Identity Disorder Treatment, if there is a difference between an Enrollee's plan documents and the information below, the Enrollee's plan document should be used for making benefit determinations.

The following is the UnitedHealthcare standard for plans that cover treatment of gender identity disorder:

COVERED SERVICES:

If a plan covers treatment of Gender Identity Disorder, it includes coverage for the following:

1) Psychotherapy for gender identity disorders and associated co-morbid psychiatric diagnoses;
2) Continuous hormone replacement - hormones of the desired gender;

   - Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design.
   - Oral and self-injected hormones from a pharmacy are not covered under the medical plan. Refer to the Outpatient Prescription Drug Rider, or SPD for self-funded plans, for specific prescription drug product coverage

3) Genital Surgery (by various techniques which must be appropriate to each patient), including:

   - Complete hysterectomy
   - Orchiectomy
   - Penectomy
   - Vaginoplasty
   - Vaginectomy
   - Clitoroplasty
   - Labiaplasty
   - Salpingo-oophorectomy
   - Metoidioplasty
   - Scrotoplasty
   - Urethroplasty
   - Placement of testicular prosthesis
   - Phalloplasty

4) Surgery to change specified secondary sex characteristics, specifically:

   - thyroid chondroplasty (removal or reduction of the Adam's Apple); and
   - bilateral mastectomy; and
   - augmentation mammoplasty (including breast prosthesis if necessary) if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role;

5) Laboratory testing to monitor the safety of continuous hormone therapy.

Related Services:
In addition to the surgeon fees, the benefit applies to the services related to the surgery, including, but not limited to: anesthesia, laboratory testing, pathology, radiologic procedures,hospital and facility fees, and/or surgical center fees.

Note: Certain ASO plans may have a different list of Covered Services for Treatment of Gender Identity Disorder and may not cover all services listed above. Check the plan specific SPD to determine.

HORMONE REPLACEMENT ELIGIBILITY QUALIFICATIONS:
The Covered Person must meet all of the following eligibility qualifications for hormone replacement (in addition to the plan's overall eligibility requirements as shown in the plan document).

1) Age 18 years or older for hormones to change physical characteristics
2) Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks
3) The Covered Person must meet the definition of Gender Identity Disorder (see definition below)
4) Initial hormone therapy must be preceded by:

    a) A documented real-life experience (living as the other gender) of at least three months prior to the administration of hormones; or
    b) A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

Note: Oral hormones are not generally covered as a medical benefit. Refer to prescription benefits.

GENITAL SURGERY AND SURGERY TO CHANGE SPECIFIED SECONDARY SEX CHARACTERISTICS ELIGIBILITY QUALIFICATIONS:
The Covered Person must meet all of the following eligibility qualifications for genital surgeryand/or surgery to change specified secondary sex characteristics (in addition to the plan's overall eligibility requirements as shown in the plan document):

1) The surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder;
2) The treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards (WPATH 6th edition)*;
3) The Covered Person must be age 18 years or older for irreversible surgical interventions;
4) The Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender;
5) The Covered Person may be required to complete continuous hormone therapy (for those without contraindications). In consultation with the patient's physician, this should be

determined on a case-by-case basis through the Notification process. Note the following clarifications:

a) A biologic female patient that is only requesting a bilateral mastectomy does not need to complete hormone therapy in order to qualify for the mastectomy. However, UnitedHealthcare recommends that the patient complete at least 3 months of psychotherapy before having the mastectomy. (**Note:** WPATH Version 6 recommends that the patient complete 3 months of psychotherapy and/or 3 months of hormone therapy.)
b) A biologic male patient that is able to take female hormones and is considering breast augmentation surgery should take the female hormones for at least 18 months before being considered for bilateral breast augmentation since the patient may achieve adequate breast development without surgery.

6) The Covered Person must meet the definition of Gender Identity Disorder (see definition below)
7) The Covered Person's Physician(s) who is/are performing the surgical procedures must follow the Notification process prior to performing the procedures.

* The World Professional Association for Transgender Health Association (WPATH) is an advocacy group.

Notes:

- Benefits are limited to one sex transformation reassignment per lifetime, which may include several staged procedures.
- Check the benefit plan document for any applicable limits and maximum dollar amounts to this coverage.
- Sterilization surgery is not required in order to receive the covered services under this benefit.

EXCLUSIONS:

The following treatments are not covered:

1) Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
2) Sperm preservation in advance of hormone treatment or gender surgery.
3) Cryopreservation of fertilized embryos.
4) Voice modification surgery.
5) Facial feminization surgery, including but not limited to: facial bone reduction, face "lift", facial hair removal, and certain facial plastic reconstruction.
6) Suction-assisted lipoplasty of the waist.
7) Rhinoplasty (except if rhinoplasty criteria are met. See the Rhinoplasty, Septoplasty, and Repair of Vestibular Stenosis Coverage Determination Guideline.)
8) Blepharoplasty (except if blepharoplasty criteria are met. See the Blepharoplasty, Blepharoptosis and Brow Ptosis Repair Coverage Determination Guideline.)

9) Abdominoplasty (except if abdominoplasty criteria are met. See the Panniculectomy and Body Contouring Procedures Coverage Determination Guideline.)

10) Surgical or hormone treatment on enrollees under 18 years of age.

11) Surgical treatment not prior authorized by UnitedHealthcare.

12) Drugs for hair loss or growth.

13) Drugs for sexual performance or cosmetic purposes (except for hormone therapy described above.

14) Voice therapy.

15) Services that exceed the maximum dollar limit on the plan.

16) Transportation, meals, lodging or similar expenses.

Note: Certain plans may have a different list of exclusions. Check the plan-specific documents before making a determination

Exhibit O

From: Steele, Joan M - ETF
Sent: Monday, January 30, 2017 11:42 AM
To: Larson; Arlene - ETF
Subject: FW: ACTION REQUESTED 1/27: GIB item #4 -- transgender exclusion
Attachments: Item 4_GIB 02 08 17_LE.docx; Wisconsin - Transgender Cost Estimate - Memorandum_ 012317.pdf; Memo to GIB re Fiduciary duties [FINAL].docx; Addendum to 2017 Uniform Benefits.docx

Importance: High

FYI

From: Ellinger, Lisa - ETF
Sent: Friday, January 27, 2017 10:20 AM
To: Pray, Tara - ETF <Tara.Pray@etf.wi.gov>; Steele, Joan M - ETF <Joan.Steele@etf.wi.gov>
Subject: FW: ACTION REQUESTED 1/27: GIB item #4 -- transgender exclusion
Importance: High

fyi

From: Ellinger, Lisa - ETF
Sent: Friday, January 27, 2017 10:19 AM
To: Conlin, Bob - ETF <Bob.Conlin@etf.wi.gov>; Voelker, John - ETF <John.Voelker@etf.wi.gov>; Nispel, David - ETF <David.Nispel@etf.wi.gov>
Cc: Mallow, Eileen K - ETF <Eileen.Mallow@etf.wi.gov>; Brockman, Sara - ETF <Sara.Brockman@etf.wi.gov>; Felsmann, Diana M - ETF <Diana.Felsmann@etf.wi.gov>
Subject: ACTION REQUESTED 1/27: GIB item #4 -- transgender exclusion
Importance: High

Hi all. My proposed Board memo on the transgender issue is attached. Please let me know if you have any concerns or edits today. Upon your approval, I will be sharing this with Mike Farrell for feedback before it goes to the full Board. Similar language will be in the message to health plans, which we are planning to send 1/31. David: in the final attachment (contract amendment), I removed references to “Addendum 5”, which I did not understand. If there was a reason we framed it that way, please let me know and we can edit it back in. Thank you.
LE

Segal Consulting

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MEMORANDUM

To: Lisa Ellinger

From: Kirsten R. Schatten, ASA, MAAA
Kenneth C. Vieira, FSA, MAAA

Date: January 23, 2017

Re: Transgender Cost Estimate

Section 1557 of the ACA prohibits group health plans from discriminating on the basis of race, color, national origin, sex, age, or disability in health programs, consistent with existing federal laws, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; and Sections 504 and 508 of the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 (ADA). Group health plans and employers that accept federal funding from HHS are covered entities under the law.

The Section 1557 regulations defined discrimination on the basis of "sex" to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity. This interpretation was challenged by the plaintiffs as being an impermissible definition of the term "sex."

In Franciscan Alliance, Inc. v Burwell, et al, several plaintiffs challenged regulations issued by the Department of Health and Human Services (HHS) implementing Section 1557 of the Affordable Care Act (ACA). Plaintiffs included eight states (Texas, Wisconsin, Nebraska, Kansas, Louisiana, Arizona, Mississippi, and the Commonwealth of Kentucky) and three private health care providers. On December 31, 2016, Judge Reed O'Connor of the US District Court for the Northern District of Texas issued a nationwide preliminary injunction enjoining HHS from enforcing the regulation's prohibition against discrimination on the basis of gender identity or termination of pregnancy.

This brief memo is focused on the calculation of potential cost impact to the State of Wisconsin Group Health Insurance Plan for adding transgender dysphoria benefits in 2017. Please note that there is a lack of information and data to provide specific information on estimated cost to the Plan. Therefore, we have provided a range of estimates based on potential utilization information gathered from research and treatment cost estimates from BCBS. Please also note there are wide variations in some of these studies, and past experience from various counties that have provided coverage long enough to have data to review have shown the prior estimates to be overstated.

Key Assumptions

Three key assumptions drive our cost estimates: prevalence of transgender members, percentage of those who seek benefits (including surgery) and the cost of the various treatment options.

Prevalence – According to the Centers for Disease Control and Prevention (CDC) 2015 Behavioral Risk Factor Surveillance System (BRFSS), approximately 0.58% of adults in the United States self-identify as transgender. This has increased slightly from 2014 & 2013.

The Williams Institute in June of 2016 published a paper entitled "How Many Adults Identify as Transgender in the United States?" which goes a little further by drilling down on prevalence by state and also providing ranges. This paper estimated a prevalence range of 0.31% to 0.62% for Wisconsin adults ages 18-64.

Percentage Who Seek Benefits – The number of transgender people seeking benefits is difficult to predict since a new benefit may alter past patterns. One study was published by Olyslager, F. & Conway, L. (September 2007) entitled “On the Calculation of the Prevalence of Transsexualism.” This paper was presented at the WPATH 20th International Symposium, Chicago, Illinois. This study from 2007 estimates that, of those who identify as transgender, between 0.1% and 0.5% have taken some steps to transition from one gender to another.

The State of Wisconsin Group Health Insurance Plan membership from age 18 through 64 is approximately 159,000. Applying the prevalence and utilization assumptions above, we would expect 2 to 5 members to use transgender benefits.

For those who seek benefits, the vast majority of cost comes from members choosing to have gender reassignment surgery. There are a couple of sources we found (Mohammed A. Memon, MD; February 22, 2016; “Gender Dysphoria and Transgenderism: Epidemiology” Medscape, as well as HealthResearchFunding.Org) that site prevalence rates for adults seeking reassignment surgery of 1 in 30,000 for males and 1 in 100,000 for females. Using these statistics, we would expect 3 males and 1 female in our expected scenario, and we have applied a range of +/- 50% to get a range of 2-5 adults in total.

Cost of Treatment – Information was provided at a very high level from a national medical vendor. Their pricing analysis was based entirely on external studies and sources:

- For male to female surgery they assumed roughly $28K, with $3,600 in hormonal therapy
- For female to male surgery they assumed about $56K, with $7,200 in hormonal therapy

They also noted that there would be fairly substantial counseling costs associated with the surgery—roughly $10K in a given year.

Financial Impact

Using the above, we have estimated the annual cost to range from $100,000 to $250,000. The costs are highly variable based on the assumptions described above. Below is brief summary;

		Prevalence		Estimated Cost	Cost Estimate	
		Low	High	(per Treatment)	Low	High
Surgical Benefits	Male	1.26	3.79	$ 41,600	$ 52,569	$ 157,706
	Female	0.42	1.13	$ 73,200	$ 30,460	$ 82,738
	Total	1.68	4.92		$ 83,028	$ 240,443
Non-Surgical Benefits	Male	0.61	0.02	$ 17,200	$ 10,525	$ 370
	Female	0.14	-	$ 13,600	$ 1,903	$ -
	Total	0.75	0.02		$ 12,428	$ 370
Total Using Benefits	Male	1.88	3.81	$ 58,800	$ 63,094	$ 158,076
	Female	0.56	1.13	$ 86,800	$ 32,363	$ 82,738
	Total	2.43	4.94		**$ 95,456**	**$ 240,814**
Adult Members (18-64)						159,043
Total PMPM					$ 0.05	$ 0.13

There are a few other sources we found and reviewed that provide similar information and would bring us to a similar range of cost estimates. Based on approximately $1.3 billion of non-Medicare premiums, the cost for the State of Wisconsin Group Health Insurance Plan is estimated to be 0.007% to 0.018% of premium.

The cost to cover services related to transgender dysphoria was not anticipated during rate development and negotiations for 2017; therefore, the 2017 premiums were not changed to reflect potential transgender claims. Also note that many vendors' increases were capped at 5%, leaving no margin to add additional benefits within their current contractual rates. Reinstating the exclusion for coverage of transgender services should have no impact on program costs for 2017.

Exhibit P

State of Wisconsin
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

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Madison WI 53707-7931

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Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: August 12, 2016

To: Group Insurance Board

From: Sara Brockman, Health Policy Advisor
Office of Strategic Health Policy

Subject: Group Insurance Board Correspondence

On occasion, the Department of Employee Trust Funds (ETF) receives correspondence on behalf of the Group Insurance Board (Board) regarding proposed or recent changes to the state health insurance program.

Since the July 12, 2016 Board meeting, the following communications have been submitted for the Board's consideration:

1. August 10, 2016 Correspondence – Wisconsin Department of Justice (DOJ)

The attached DOJ memorandum (Attachment A) is in regard to the July 12, 2016 motion to approve changes to the Guidelines Contract and Uniform Benefits for 2017 (Ref. GIB | 07.12.16 | 3A). ETF has reviewed the DOJ memo and provided additional information for Board consideration (Attachment B).

Staff will be at the Board meeting to answer any questions.

Attachment A: DOJ Memo – ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services
Attachment B: ETF Memo – Uniform Benefit Provisions Related to Sex Discrimination

Reviewed and Approved by John Voelker, Deputy Secretary

Lisa Ellinger Electronically Signed: 8/12/16

Board	Mtg Date	Item #
GIB	8.16.16	7A

WISCONSIN DEPARTMENT OF JUSTICE
MEMORANDUM

Date: August 10, 2016

To: Group Insurance Board

From: Andy Cook, Deputy Attorney General

Subject: ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services

Executive Summary

The Department of Justice writes to you regarding proposed revisions to the State of Wisconsin Department of Employee Trust Funds' ("ETF") current Uniform Benefits policy. As you know, the current policy excludes coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment" and for "sexual counseling services . . . related to sexual transformation." ETF has recommended that the Group Insurance Board ("Board") remove these exclusions in order to comply with rules recently promulgated by the federal Department of Health and Human Services ("HHS"). Those rules purport to implement the Affordable Care Act's anti-discrimination provisions, and they generally ban discrimination based on "gender identity" in the provision of health services. *See* 45 C.F.R. §§ 92.206-207.

To the extent the Board believes that the new HHS rules compel it to accept ETF's recommended changes, it should reconsider for two reasons. First, HHS's rules are unlawful, at least as applied to coverage provisions that classify health services based on "gender identity." The Affordable Care Act's anti-discrimination provisions incorporate Title IX's prohibition against discriminating on the basis of "sex." *See* 42 U.S.C. § 18116; 20 U.S.C. § 1681. But HHS's rules improperly reinterpret Title IX to cover "gender identity" – an expansion Congress has never adopted and that HHS may not effect on its own.

Even if HHS had not misread Title IX, its "gender identity" rules improperly intrude on powers reserved to the State of Wisconsin to administer its own health policy. The United States Constitution prohibits the federal government and HHS from threatening to withhold ETF's receipt of Medicare Part D subsidies if ETF does not comply with the federal mandate. Separately, the Fourteenth Amendment does not authorize HHS to issue these rules, since ETF's policies do not violate that Amendment.

Second, even if HHS's rules were lawful, they do not mandate coverage for any particular procedures – which is effectively what ETF's proposed revisions accomplish. Instead, those rules allow coverage exclusions based on neutral

reasons, such as whether medical necessity demands the services at issue. This allows a narrower revision to the provision regarding gender reassignment services than ETF has proposed. And the Board likely need not revise the provision regarding sexual transformation counseling at all. Since non-transgender patients cannot receive such counseling, no discrimination exists by denying coverage for it. Alternatively, a blanket exclusion for all sexual counseling services would further protect the Uniform Benefits from challenge. Specific alternative proposals are presented at the end of this memorandum.

Analysis

I. HHS's Rules Improperly Require the State of Wisconsin To Enforce A Misreading of the Affordable Care Act and Title IX.

HHS's rules are unlawful because they rest on a misreading of the Affordable Care Act and Title IX. *See* 5 U.S.C. § 706 (agency actions are unlawful if undertaken "in excess of statutory jurisdiction, authority, or limitations"). The Affordable Care Act only prohibits discrimination coextensive with Title IX. But Title IX's prohibition against discrimination on the biological basis of "sex" does not extend to the distinct concept of "gender identity." Since HHS cannot issue rules that amend the Affordable Care Act and Title IX – which is what these rules effectively do – the Board need not conform ETF's Uniform Benefits to them.

First, nothing in Title IX's text suggests that the statute covers "gender identity." The statute's plain language is clear: "No person in the United States shall, ***on the basis of sex***, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance . . . ." 28 U.S.C. § 1681 (emphasis added). Again, "on the basis of ***sex***," not "on the basis of sex ***or gender identity***."

Legislative history confirms that Title IX covers just what it says – "sex," not "gender identity." Nowhere in the Congressional debates over Title IX does the phrase "gender identity" or "transgender" appear. Moreover, Congress has refused to amend Title IX to cover "gender identity."[1] Congress clearly would not have tried to add superfluous new protections for "gender identity" if Title IX already provided them.

Case law affirms Title IX's plain language and legislative history, holding that its protections do not extend to "gender identity." One well-reasoned opinion

[1] *See* H.R. 1652, 113th Cong. (2013); S.439, 114th Cong. (2015).

held, after carefully analyzing Title IX's plain language and its legislative history, that "Title IX's language does not provide a basis for a transgender status claim." *Johnston v. Univ. of Pittsburgh of Com. Sys. of Higher Educ.*, 97 F. Supp. 3d 657, 676 (W.D. Pa. 2015). And *Johnston* is supported by many other cases that reach the same result under Title VII, Title IX's sister anti-discrimination statute in the employment context.

Moreover, the State of Wisconsin has joined 12 other states in challenging another unlawful federal government mandate that rests on an identical misreading of Title IX. *See State of Texas, et al. v. United States, et al.*, No. 16-cv-00054 (N.D. Tex.). There, the federal government improperly demanded, again citing Title IX, that public schools allow students to use the bathrooms, locker rooms, and showers of the students' choosing, regardless of their biological sex. But that overreach must fail for the same reason as here – federal agencies cannot impose their policy preferences on the States by expanding Title IX to cover "gender identity" without Congressional action.

The United States Constitution also restrains HHS from imposing its view of the Affordable Care Act and Title IX on the State of Wisconsin and ETF. Although the federal government can contribute money to the States to be spent on various programs, that power cannot be used to "undermine the status of the States as independent sovereigns in our federal system." *See* U.S. CONST. art. I, § 8, cl. 1; *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2602 (2012) ("*NFIB*"). Indeed, when federal funding conditions "take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the states to accept policy changes." *Id.* at 2604.

HHS now threatens to withhold federal financial assistance if ETF refuses to implement the federal government's novel interpretation of Title IX. Specifically, HHS's new rules condition federal aid on ETF's "assurances" that its health programs comply with those rules. *See* 45 C.F.R. §§ 92.5-6 (requiring "assurances"); 42 U.S.C. § 18116 (applying Title IX's enforcement mechanisms to the Affordable Care Act); 20 U.S.C. § 1682 (compliance can be enforced by terminating federal assistance). Since ETF partly depends on federal financial assistance in the form of Medicare Part D subsidies, HHS improperly threatens to withhold those subsidies if ETF fails to comply with its novel reading of Title IX. *NFIB*, 132 S. Ct. at 2604. This likely amounts to unconstitutional coercion.

HHS also cannot find authority for its new rules in the Fourteenth Amendment. That Amendment allows Congress to "enforce, by appropriate legislation" its guarantee to "the equal protection of the laws." U.S. CONST. amend.

XIV, §§ 1, 5. But HHS can only issue rules that target a recognized equal protection violation. *See Kimel v. Florida Bd. of Regents*, 528 U.S. 62 (2000). Since many courts have concluded that transgender individuals are not a "suspect class" that triggers heightened constitutional scrutiny, coverage exclusions like ETF's here "need only be rationally related to a legitimate governmental purpose" to be valid under the Fourteenth Amendment.[2]

ETF can easily clear that low bar. For instance, it can point to the high costs the State must bear for covering services and procedures related to gender transition, or to medical research suggesting that such procedures (especially sex transformation surgeries) may in fact harm patients. Even if a heightened level of scrutiny did apply here, these coverage exclusions could for the same reasons pass muster as "substantially related to a sufficiently important governmental interest."[3] Since ETF's coverage provisions at issue here do not violate the Fourteenth Amendment, HHS may not bar them by citing the Fourteenth Amendment.

II. Even If HHS's Rules are Lawful, the Board Need Not Revise the Uniform Benefits As ETF Has Recommended.

Leaving aside the validity of HHS's new rules, ETF's recommended revisions to the Uniform Benefits go beyond what those rules require. Again, ETF has recommended striking entirely two policy exclusions from the Uniform Benefits:

- "Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment." Uniform Benefits § IV.1.a.

- "Sexual counseling services related to . . . sexual transformation." Uniform Benefits § IV.11.ah.

These revisions would arguably mandate that ETF cover ***all*** such procedures, whether medically necessary or not. But HHS expressly noted that its rules "do not . . . affirmatively require covered entities to cover any particular procedure or treatment for transition-related care." 81 Fed. Reg. 31376 at 31429 (May 18, 2016). Likewise, the rules "do not affirmatively require covered entities to cover any

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[2] *Claussen v. Pence*, - F.3d - , 2016 WL 3213036, at *4 (7th Cir. June 10, 2016) (outlining "rational basis" standard).

[3] *See City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985) (establishing "intermediate scrutiny" standard); *Craig v. Boren*, 429 U.S. 190, 199–200 (1976) ("Clearly, the protection of public health and safety represents an important function of state and local governments.").

particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory." *Id.* at 31435. And HHS's rules expressly note that they are not "intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case." 45 C.F.R. § 92.207(d).

STATE OF WISCONSIN
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Correspondence Memorandum

Date: August 11, 2016

To: Group Insurance Board

From: David H. Nispel, General Counsel
Diana M. Felsmann, Attorney

Subject: Uniform Benefits Provisions Related to Sex Discrimination

Information for GIB Consideration
After reviewing the Department of Justice (DOJ) August 10, 2016, memo requesting that the Group Insurance Board (GIB) reconsider its adoption of the Department of Employee Trust Funds' (ETF) recommended changes to the State of Wisconsin Group Health Insurance Program's Uniform Benefits, ETF offers additional information for the GIB's consideration:

- As fiduciaries,[1] GIB Board members must ensure that the Group Health Insurance Program complies with state and federal law. Basic fiduciary principles found in common law include the three "core" fiduciary duties: (1) the duty of loyalty, (2) the duty of impartiality, and (3) the duty of prudence. A fiduciary may rely on the advice and reports of experts (i.e., attorneys, accountants, financial advisors), provided the subject matter is within the expert's area or expertise and the expert is fully informed. Ensuring compliance with state and federal law falls under the duty of prudence.

- The United States Department of Health and Human Services (HHS) final rule implementing the Affordable Care Act's (ACA) nondiscrimination requirements provides that health insurance issuers may not contract away their own nondiscrimination obligations under the rule.[2] As a result, a decision not to comply with the HHS rule would jeopardize ETF's ability to contract with its health insurance issuers as of January 1, 2017.

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[1] Wis. Stat. §40.03(6)(d).

[2] Moreover, nothing in the rule authorizes qualified health plan issuers or other issuers that are covered entities to contract away their own nondiscrimination obligations. Issuers must ensure that enrollees have equal access to health services provided by their coverage without discrimination on the basis of a prohibited criterion.

81 Federal Register 31376 (May 18, 2016), 31383.

- The cost of removing the Uniform Benefits exclusion related to benefits and services in connection with gender reassignment or sexual transformation is anticipated to be low. Based on a 2014 study Segal Consulting did for the state of Maryland, the highest estimated cost was .01% of the annual cost of Maryland's health insurance program. That study reflected that the annual costs associated with Maryland's health insurance program were approximately $1.3B. The largest estimated cost, $100,000 represents less than a 0.01% increase in annual costs for the cost of the initial procedure(s) and related drug therapy and counseling.

- The Group Health Insurance Program's Uniform Benefits continues to require that services be medically necessary,[3] as determined by the health plan and/or PBM.[4]

Background

The changes to the Group Health Insurance Program recommended in ETF's June 22, 2016, memo entitled *Guidelines Contract and Uniform Benefits Changes for 2017*, and adopted unanimously by the GIB on July 12, 2016, were made after careful research on the application of federal law, specifically the ACA nondiscrimination rule published by HHS on May 18, 2016. ETF's role in relation to the GIB is to make recommendations to assist the GIB in the performance of its fiduciary duties to the insurance programs administered by ETF, including the Group Health Insurance Program, and to provide information so that the Program is properly administered.

The recommended changes to the Program's Uniform Benefits in connection with the HHS rule, and as adopted by the GIB at the July 12, 2016 meeting were as follows:

1. Removing the current exclusion related to benefits and services related to gender reassignment or sexual transformation. Required effective date is January 1, 2017.

2. Including the federally required nondiscrimination notification language on all significant communications related to ETF's health programs. Required effective date is October 16, 2016 (90 days from July 18, 2016).

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[3] Defined in ETF's Uniform Benefits as a service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM:

1. consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; and
2. appropriate under the standards of acceptable medical practice to treat that Illness or Injury; and
3. not solely for the convenience of the Participant, physician, Hospital or other health care Provider; and
4. the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner. http://etf.wi.gov/members/IYC2016/IYC_Cert_of_Cov2107.pdf

[4] State of Wisconsin Group Health Insurance Program Uniform Benefits, Section III, Page 4-23.

Summary of August 10, 2016 Department of Justice Memo
In its August 10, 2016, memo to the GIB entitled *ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services*, the Department of Justice (DOJ), offers two reasons for the GIB to reconsider the changes to ETF's Uniform Benefits adopted at the July 12, 2016, GIB meeting.

The first reason DOJ provides is that the new HHS rule is unlawful, "at least as applied to coverage provisions that classify health services based on 'gender identity'." Included under that heading, DOJ writes that even if the new HHS rule is not based on a misreading of Title IX, which protects against sex discrimination, the rule "improperly intrude[s] on powers reserved to the State of Wisconsin to administer its own health policy."

The second reason offered by DOJ was that the HHS nondiscrimination rule does not mandate coverage for any particular procedure.

Benefits Coverage
Specific to the HHS rule and benefits coverage, as noted in ETF's June 22, 2016 memo to the GIB, ETF agrees with DOJ that the rule does not require coverage of specific benefits. However, of note:

- The rule specifies that categorical exclusions in coverage for all health services related to gender transition are facially discriminatory.

- The rule does not explicitly require the coverage of any particular service to treat gender dysphoria, and allows plans to deny services that are not medically necessary. HHS' Office for Civil Rights (OCR) will determine whether certain benefits designs are discriminatory on a fact-specific, case-by-case basis. 81 Fed. Reg. at 31434 & fn. 258.

- Denying coverage for transition-related services on the basis of those services not being medically necessary is anticipated to be subject to careful scrutiny. (Proposed HHS Nondiscrimination Rule) 80 Fed. Reg. 54172, 54190 (Sept. 8, 2015).

- The regulations allow covered entities to use reasonable medical management techniques and apply neutral, nondiscriminatory standards to health-related coverage. Specifically, OCR will consider whether an entity used "a neutral rule or principle when deciding to adopt the design feature or take the challenged action or whether the reason for its coverage decision is pretext for discrimination." 81 Fed. Reg. at 31433.

Penalties for Noncompliance with the HHS Rule

The HHS rule applies the same enforcement mechanisms under Title VI of the Civil Rights Act of 1964 (discrimination on the basis of race, color, and national origin), Title IX of the Education Amendments of 1972 (discrimination on the basis of sex), Section 504 of the Rehabilitation Act of 1973 (discrimination on the basis of disability), or the Age Discrimination Act of 1975. Penalties under Title IX include the termination of federal financial assistance.[5] Thus, one potential impact of a GIB decision to reconsider its adoption of the Uniform Benefits changes would be the Group Health Insurance Program's loss of Medicare Part D subsidies.[6] The Program received approximately $36 million in Medicare Part D subsidies in 2015.

In addition, the HHS rule allows for compensatory damages to be granted if an individual were to successfully litigate a claim that the Group Health Insurance Program was not in compliance with the law.[7]

Current EEOC Complaints Filed Against the GIB

It is important to note that two individual health plan participants have filed complaints with the Equal Employment Opportunity Commission (EEOC) against the GIB on the denial of benefits in relation to transgender services:

- EEOC Charge No. 443-2016-00291—Amended [redacted], Charging Party vs. University of Wisconsin, Respondent, and Department of Employee Trust Funds and Group Insurance Board, Additional Respondents.[8]

- EEOC Charge No. 443-2016-01428—Amended [redacted], Charging Party vs. Department of Employee Trust Funds, Respondent and Group Insurance Board, Additional Respondent.[9]

The EEOC takes the position that Title IX's prohibition against sex discrimination includes discrimination on the basis of gender identity. Compensatory and punitive damages may be awarded in cases involving intentional discrimination based on gender identity.[10]

The HHS Rule references the EEOC's position, and indicates that HHS' Office for Civil Rights (OCR) intends to refer any cases that fall outside of OCR's jurisdiction to the EEOC for investigation.[11] As a result, if the GIB were to reconsider the changes it

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[5] 45 C.F.R. §92.301(a).
[6] *See* 20 U.S.C. §1682.
[7] 45 C.F.R. §92.301(b).
[8] *See* April 5, 2016, memo to the GIB from ETF General Counsel David H. Nispel.
[9] As of the writing of this memo, ETF has not yet received any details about this EEOC complaint. When ETF receives additional information, ETF will pass that information on to the GIB.
[10] The United States Department of Justice *Title VI Legal Manual*: https://www.justice.gov/crt/title-vi-legal-manual#XII (visited August 11, 2016).

[11] 81 Federal Register at 31432.

adopted to the Uniform Benefits on July 12, ETF anticipates an increase in complaints filed against the GIB.

GIB Authority to Modify Uniform Benefits

State law provides the GIB the authority to modify or expand insurance coverage when that modification or expansion is required by law.[12] The law further provides the GIB the authority to modify or expand benefits as it deems advisable unless the modification or expansion would increase premiums.[13]

The authority to make decisions on insurance coverage is necessary for the GIB, as trustees, to fulfill their fiduciary duties. Based on information provided by Segal Consulting, ETF anticipates the costs of providing the changes to the Uniform Benefits adopted by the GIB in relation to the HHS rule would be extremely low,[14] and would not increase premiums. As a result, whether the HHS rule is found to be invalid, the GIB would still have had the authority under state law to make these changes to the Uniform Benefits.

Recommendations Going Forward

1. ETF does not recommend the GIB reconsider its July 12, 2016, adoption of the changes made to the Group Health Insurance Program's Uniform Benefits in connection with the HHS rule. ETF recommended those changes after careful review of the HHS rule and in consideration of the GIB's fiduciary duties to the Group Health Insurance Program. In particular, the GIB's duty of prudence requires the GIB to ensure the Program is compliant with state and federal law.

   To address DOJ's questions with respect to the validity of the HHS rule, ETF recommends continuing with the changes as adopted at the July 12 GIB meeting, and revisiting that decision in one year. Such a reevaluation could be made in light of any court decisions interpreting the rule. In addition, reevaluation after one year would allow for ETF to present claims data to the GIB, which would provide the Board with insight into the cost of providing these benefits.

2. Important to note is the failure to meet fiduciary obligations may result in severe penalties, including personal liability. The August 10 DOJ memo does not address how the reconsideration of the GIB's adoption of the Uniform Benefits changes on July 12 comports with the GIB's fiduciary duties. As a result, if the GIB were to consider reversing its adoption of the changes to the Uniform Benefits, ETF first recommends the GIB obtain a legal opinion analyzing the Board's fiduciary duties under these specific circumstances.

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[12] Wis. Stat. §40.03(6)(c).
[13] Wis. Stat. §40.03(6)(c) & (d).
[14] Segal Consulting drafted a report for the State of Maryland in 2014 concluding that the cost of providing initial procedures, drug therapy and counseling would be approximately .01% of the state's total health insurance costs; *See also* page 2.

Exhibit Q

From: Brockman, Sara - ETF <Sara.Brockman@etf.wi.gov>
Sent: Tuesday, January 31, 2017 12:01 PM
To: Brockman, Sara - ETF
Cc: Ellinger, Lisa - ETF
Subject: [ETFnoPII] 2/8 GIB Meeting Materials & Information (Confidential Information)
Attachments: Item 0_GIB 2 8 17_Agenda.pdf; Item 1_GIB 12 13 16_OPEN Minutes.pdf; Item 1_GIB 12 30 16_OPEN Minutes.pdf; CONFIDENTIAL_Item 1_GIB 12 13 16_CLOSED Minutes.pdf; CONFIDENTIAL_Item 1_GIB 12 30 16_CLOSED Minutes.pdf; Item 3_GIB 02 08 17 _Election of Officers.pdf; Item 4_GIB 02 08 17_UB Gender Assignment.pdf; Item 5A_GIB 01 18 17_SIR Evaluation Results Analysis.pdf; Item 8A_GIB 02 08 17_IYC Dates.pdf; Item 8B_GIB 02 08 17_2018 UB Changes.pdf; Item 8C_GIB 02 08 17_2018 WPE LAHP Program Changes.pdf; Item 8D_GIB 02 08 17_Medicare Options.pdf; Item 9A_GIB 02 08 17_LTDI Closure.pdf; Item 9C_GIB 02 08 17_Aetna Contract Extension.pdf; Item 9D_GIB 02 08 17_ICI Oversight.pdf; Item 10B_GIB 02 08 17_Leg Update.pdf; Item 10C_GIB 02 08 17_Legal Case Update.pdf; Item 10D_GIB 02 08 17_Admin Rule Update.pdf; Item 10E_GIB 02 08 17_Ombuds Service Report.pdf; Item 10G_GIB 02 08 17_WPE ICI Participation.pdf; Item 10H_GIB 02 08 17_ERA HSA Program Updates.pdf; Item 10I_GIB 02 08 17_Life Insurance Audit.pdf; Item 10J_GIB 02 08 017_2018 Meeting Dates.pdf; Item 10K_GIB 02 08 17_Board Manual Updates.pdf; Item 10L_GIB 02 08 17_2015-2017 Audit Plan Status.pdf

Good afternoon Group Insurance Board member,

Your materials for the February 8 GIB meeting are attached in PDF format. If you have issues accessing the attached materials, please call or email me. Your Board packet will be mailed later today, and materials will be available on the ETF website later this afternoon.

Please note that the Closed minutes from the December 13 and December 30 meetings contain confidential information. As such, these materials should not be distributed, nor will they be posted online.

NOTE 1 – The following items are not yet ready for distribution. They will be e-mailed to you when available and hardcopies will either be mailed to you later this week or provided at the meeting. I will provide additional information as these items are finalized.

- Item 5B – State of Wisconsin Health Benefit Program: Assessment and Deliberation
- Item 9B – Disability Program Redesign: ICI Program
- Item 10A – GIB Correspondence
- Item 10F – 2017 It's Your Choice Enrollment Results

NOTE 2 – The meeting will be held on **Wednesday, February 8 from 8:30 a.m. to 3:30 p.m.** at the **Sheraton Madison Hotel – Destination South Ballroom** (706 John Nolen Dr, Madison). The meeting will be held in the Destination South Ballroom. Boxed lunches will be provided, as well as a selection of soft drinks. Water and coffee will also be available throughout the meeting.

Please let me know if you have any questions. Thanks and have a great day!

Sara C. Brockman | Health Policy Advisor

Office of Strategic Health Policy
Department of Employee Trust Funds
Phone: (608) 261-8920
http://etf.wi.gov

DRAFT

MINUTES

December 13, 2016

Group Insurance Board

State of Wisconsin

Location:

Clarion Suites at the Alliant Energy Center – Michigan Room
2110 Rimrock Rd, Madison, WI 53713

BOARD MEMBERS PRESENT:

Michael Farrell, Chair
Bonnie Cyganek, Vice Chair
Herschel Day, Secretary
Terri Carlson
Chuck Grapentine
Michael Heifetz
Nancy Thompson
Ted Neitzke
Stacey Rolston
JP Wieske
Bob Ziegelbauer

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Bob Conlin, Secretary
John Voelker, Deputy Secretary
Office of Strategic Health Policy:
Lisa Ellinger, Director
Sara Brockman, Board Liaison
Eileen Mallow, Deputy Director
Arlene Larson, Tara Pray, Renee Walk

OTHERS PRESENT:

ETF Budget & Procurement:
Jason Barrett, Dana Perry, Joe Schneider
ETF Information Technology Services:
Ryan Perkins
ETF Legal Services:
Diana Felsmann, Daniel Hayes, David Nispel
ETF Office of Communications:
Mark Lamkins
Martin Schreiber & Associates
Annie Early, Jeremey Shepherd
MercyCare:
Sherrie Sargent, DuWayne Severson
Michael Best Strategies:
Andrew Hitt
Momentum Insurance:
Stephanie Steel
Navitus Health Solutions:
Tara Argall, Pam Olson

Board	Mtg Date	Item #
GIB	2.8.17	1

ETF Office of the Secretary:
Liz Doss-Anderson, Pam Henning, Tarna Hunter, James Kates, Mary Richardson, Cheryllynn Wilkins
ETF Office of Strategic Health Policy:
Sarah Bradley, Rachel Carabell, Sherry Etes, Jessica Rossner, Joan Steele, Wade Whitmus
American Federation of State, County and Municipal Employers (AFSCME):
Susan McMurray
Anthem Blue Cross and Blue Shield:
Brian Martin, Ted Osthelder
Association of Career Employees:
Sally Drew, Jack Lawton
Aurora Health Care:
Andrew Hanus
Baraboo Ambulance:
Troy Snow
Dean Health Plan:
Angie Dalton, Brant Sonzogni, Michael Weber
Department of Administration:
Jennifer Kraus
Department of Justice:
Kevin Potter, Colin Roth
Division of Personnel Management:
Paul Ostrowski
General Public:
Hickory Hurie, Sharon Hutchinson
Group Health Cooperative – South Central Wisconsin:
Emily Halter
Grand Rounds:
Eric Weiner
Grunke Group:
David Grunke
Health Choice:
Bob Pearson
Humana:
David Ehrenfried, Mary Haffenbredl, Elisabeth Wright
Legislative Audit Bureau:
Emily Pape
Office of the Commissioner of Insurance:
Jennifer Stegall
Office of Representative Chris Taylor:
Maggie Gay
Office of Representative John Nygren:
Caroline Krause
Office of Senator Alberta Darling:
Rachel Keith
Physicians Plus:
Tom Luddy, Ron Sebranek
Protect Our Wisconsin Retirement Security (POWRS):
Roger Springman
Rural Wisconsin Health Co-Op:
Jeremy Levin
Segal Consulting:
Kirsten Schatten, Ken Vieira
State Engineering Association:
Bob Schaefer
United Healthcare:
Kurt Rich
Unity Health Insurance:
Cari Alexander, Terry Bolz, Rob Plesha
UW Madison:
Diane Blaskowski
UW System Administration:
LaDonna Steinert
WEA Trust:
Greg Cieslewicz
Wisconsin Academy of Physician Assistants:
Reid Bowers
Wisconsin Association of Health Plans:
Phil Dougherty, Tim Lundquist, Nancy Wenzel
Wisconsin Health News:
Sean Kirkby
Wisconsin Hospital Association:
Joanne Alig
Wisconsin Medical Society:
Chris Rasch
Wisconsin Public Radio:
Shamane Mills

Legislative Fiscal Bureau: Jere Bauer, Rachel Janke	Wisconsin State Journal: David Walhberg
M3 Insurance: Nathan Janke, Brad Niebuhr	WisPolitics.com: Polo Rocha
MacIver Institute: Chris Rochester	WPS Arise: Matt Harty

Michael Farrell, chair, called the meeting of the Group Insurance Board (Board) to order at 8:30 a.m.

CONSIDERATION OF NOVEMBER 30, 2016 OPEN AND CLOSED MEETING MINUTES

MOTION: Mr. Wieske moved to approve the open session meeting minutes of the November 30, 2016, meeting as submitted by the Board Liaison. Mr. Heifetz seconded the motion, which passed on a voice vote. Ms. Thompson abstained from voting.

MOTION: Mr. Wieske moved to approve the closed session meeting minutes of the November 30, 2016, meeting as submitted by the Board Liaison. Mr. Heifetz seconded the motion, which passed on a voice vote. Ms. Thompson abstained from voting.

ANNOUNCEMENTS

Ms. Ellinger made the following announcements:

- The Pharmacy Benefit Manager Request for Proposal (RFP) was released on November 18, 2016. The first round of vendor questions were due December 9, 2016.
- The contract negotiation process with Truven Health Analytics began on December 12, 2016.
- WisconsinEye was not present to record the meeting.

Ms. Ellinger provided a brief overview of the meeting structure, stating that it would largely be held in closed session for the assessment and deliberation of proposals for the State of Wisconsin Health Benefit Program (RFP#ETG0003). The purpose of the closed session was to protect confidential and proprietary information obtained as part of the RFP process.

OPERATIONAL UPDATES

Mr. Farrell referred the Board to the Operational Updates in the Board Packets (Ref. GIB | 12.13.16 | 3) and offered that staff were available if the Board had questions. Of

note, several letters were submitted for the Board's consideration from legislators and members, including a letter from the chairs of the Joint Committee on Finance.

ASSESMENT AND DELIBERATION OF PROPOSALS FOR THE STATE OF WISCONSIN GROUP HEALTH BENEFIT PROGRAM (ETG0003)

Request for Proposals for the State of Wisconsin Health Benefit Program: Results and Analysis

Ms. Ellinger referred the Board to the memo, Request for Proposals for the State of Wisconsin Health Benefit Program: Results and Analysis (Ref. GIB | 12.13.16 | 4A). The memo presented a variety of options for the State of Wisconsin Group Health Insurance Program (GHIP). These options aimed to maintain benefits, contain costs and improve quality.

A total of nine proposing vendors submitted responses to the RFP, including two statewide/regional vendors and nine regional vendors. Ms. Ellinger stated that not all currently participating plans responded to the RFP.

Ms. Ellinger provided an overview of the RFP scoring process and evaluation categories. She emphasized that the RFP was focused on a balance between cost and quality performance.

The November 30 Board meeting was the first opportunity for the Board to review the results of the RFP in detail. Feedback and guidance provided by the Board was used by ETF to develop potential scenarios. Primary objectives identified by the Board included reducing long-term costs, ensuring member access to providers, vendor proposal scores, improving quality and maintaining benefit levels.

Ms. Ellinger presented seven program scenarios developed by ETF based on Board priorities and RFP results. The seven scenarios produced equivalent future costs, allowing the Board to focus on the non-financial merits of each scenario. Ms. Ellinger stated the scenarios were ordered from the least change (Option 1) to the largest degree of change (Option 7).

Ms. Ellinger stated the status quo for the GHIP was not presented as an option; and that the program is in transition. The Board previously approved several initiatives that will ultimately change the program, regardless of any decisions the Board may make about self-insurance. These initiatives included the implementation of the StayWell contract for the Third Party Administration of Wellness and Disease Management programs (RFP#ETG0005), and the decision to issue an intent to award the contract for a Data Warehouse / Visual Business Intelligence Solution (RFP#ETG0004/ETG006) to Truven Health Analytics on November 30, 2016.

All options presented were summarized in Table 12 of the memo (Ref. GIB | 12.13.16 | 4A), which is included below for reference.

Table 12. All Scenarios

Scenario	Self-Insured	Fully-Insured
Scenario 1: Current Program Structure Up to 16 Vendors	• *Statewide:* 1 plan	• *Maintain current structure* • *Up to 16 plans* • *Plans define service area*
Scenario 2: Regionalized 7-11 Total Vendors	• *Statewide:* 1 plan	• *East:* Multiple plans • *West:* Multiple plans • *North:* Multiple plans • *South:* Current plans that define service area
Scenario 3: Regionalized 6-10 Total Vendors	• *Statewide:* 2 plans	• *East:* Fewer plans • *West:* Fewer plans • *North:* Fewer plans • *South:* Current plans that define service area
Scenario 4: Regionalized 6-8 Total Vendors	• *Statewide:* 2 plans • *Regions determined by Board*	• *Regions selected by Board* • *South:* Current plans that define service area
Scenario 5: Regionalized 6 Total Vendors	• *Statewide:* 2 plans • *Regions determined by Board*	• *Regions determined by Board* • *South:* 2 plans
Scenario 6: Regionalized 6 Total Vendors	• *Statewide:* 2 plans • *Regions determined by the Board*	• *None*
Scenario 7: Statewide 1-2 Total Vendors	• *Statewide:* 1-2 plans	• *None*

Health Insurance: 2018 Program and Operational Considerations

Ms. Larson, Ms. Pray and Ms. Walk presented the memo, Group Health Insurance Program and Wisconsin Public Employers Program: 2018 Program and Operational Considerations (Ref. GIB | 12.13.16 | 4B). Program structure changes currently under consideration by the Board require and/or create the opportunity to revamp the following aspects of the health insurance program:

- Reduce the number of options available in the Wisconsin Public Employers (WPE) Program,
- Combine the WPE with the Local Annuitant Health Program (LAHP),
- Consolidate the It's Your Choice (IYC) Access Plan (Standard Plan) into statewide/nationwide contracts, and
- Make new Medicare Advantage options available to for 2019.

Ms. Walk provided an overview of the WPE Program recommendations. In 2015 Segal Consulting recommended offering only Program Options (PO) that mirror state benefits. These two plans are PO 16 – IYC Local Health Plan and PO 17 – IYC Local High Deductible Health Plan (HDHP). Staff stated that most local government employers offer employees plan options that do not mirror the state employee plans, PO 12 – IYC Local Traditional Plan and PO 14 – IYC Local Deductible Plan.

ETF surveyed WPE employers in late 2016 to ask whether they would consider terminating participation in the program if ETF limited options to PO 16 and PO 17. Most responded that they would prefer to offer benefits to their employees that are more generous than the state plans, and they would prefer not to be forced to change their benefits. These employers were also undecided about remaining in the program if the Board changes program options.

ETF recommended reducing the available options to three POs for 2018 – PO 12, PO 16 and PO 17. New deductibles for the state plans (POs 16 and 17) provide options comparable to PO 14 that were not previously available. Maintaining the inclusion of PO 12 provides the richer benefit option local governments can use as a competitive recruitment tool, while bringing local government offerings into closer alignment with state plans.

Ms. Larson provided an overview of the LAHP recommendations. She stated the LAHP is required by Wis. Stat. § 40.51 (10), is fully insured, offers different benefit levels than other ETF-administered programs, and is administered by WPS. The program serves a small population of annuitants from municipalities who are not otherwise eligible for program participation and who may not have an insurance offering through their former employer. LAHP offers a Medicare Supplement to retirees over age 65 and a Preferred Provider Organization (PPO) for retirees under age 65.

Combining the LAHP with the WPE would simplify administration and could also stabilize volatile rates in the LAHP. Previous analysis indicated no adverse program impact on the WPE.

ETF recommended administering the LAHP within the WPE program structure, with additional changes to implement limited enrollment periods and eliminate individual medical underwriting of late applications.

Ms. Larson provided an overview of the IYC Access Plan recommendations. The IYC Access Plan is statutorily required. The program is currently a self-insured, Tier 3 PPO that is administered by WPS and available nationwide.

The program is attractive to out-of-state members and those who desire freedom of choice for providers. However, the program has low and decreasing membership.

The IYC Access Plan also has slight benefit variations from Uniform Benefits.

ETF recommended pursuing a strategy that would establish a Tier 1 statewide/nationwide plan to replace the IYC Access Plan to ensure that it is a competitive offering. In order to achieve this objective, ETF also recommended adjusting benefit offerings to align with Uniform Benefits, implementing a meaningful differential between in-network and out-of-network costs in order to steer care in-network, and investigating any statutory changes necessary to implement this program change.

Ms. Pray provided an overview of the Medicare options recommendations. Currently, Medicare-eligible annuitants have several options available for coverage under the GHIPL the IYC Health Plan; the IYC Medicare Advantage (MA) plan; and the IYC Medicare Plus supplement.

With structural changes to the GHIP, there is an opportunity to improve offerings for Medicare retirees. In addition, Segal has recommended that the Board consider offering more Medicare Advantage plan choices to state and WPE annuitants, noting that Medicare-eligible annuitants could see reductions in premiums if more Medicare Advantage plans were available.

ETF recommended minimal Medicare changes for 2018, with the intent to expand Medicare Advantage options for 2019. This will allow time to determine the most cost effective and highest quality program structure, as well as the necessary amount of time for a communications campaign, and better alignment with the timing of other Board initiatives.

ETF agreed to provide more information on the recommended program changes at the next Board meeting.

The chair announced the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (e) for the purpose of deliberating the potential investment of public funds and to review proposals for services for which

competitive and bargaining reasons required a closed session. Staff from the Department of Employee Trust Funds (ETF), Office of the Commissioner of Insurance (OCI), the Department of Administration (DOA), and actuarial advisors from Segal Consulting were invited to remain during the closed session.

> ***MOTION: Mr. Wieske moved to convene in closed session, pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (e) to deliberate or negotiate the investing of public funds or conduct other specified public business. Mr. Ziegelbauer seconded the motion, which passed on the following roll call vote:***
>
> ***Members Voting Aye: Carlson, Cyganek, Day, Farrell, Grapentine, Heifetz, Neitzke, Rolston, Thompson, Wieske, Ziegelbauer***

The Board took a break from 9:39 a.m. to 9:47 a.m.

The Board convened in closed session at 9:47 a.m. and reconvened in open session at 2:34 p.m.

The Board took a break from 2:34 p.m. to 2:40 p.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Mr. Farrell announced the Board met in closed session to assess and deliberate the many options for the State of Wisconsin Health Benefit Program presented by ETF staff and Segal Consulting. The Board asked ETF and Segal to gather more data in order to continue deliberations. Mr. Farrell stated that there is much complexity and large volumes of information related to these considerations, and the Board does not take these decisions lightly.

No action was taken during closed session. The Board will reconvene in January.

DISCUSSION AND CONSIDERATION OF 2017 UNIFORM BENEFITS – HHS NONDISCRIMINATION RULE

Ms. Ellinger referred the Board to the memo, Discussion and Consideration of 2017 Uniform Benefits – HHS Nondiscrimination Rule (Ref. GIB | 12.13.16 | 6), which included memoranda previously submitted for Board consideration. The item was added to the December 13 meeting agenda at the request of a Board member, as the Wisconsin Department of Justice (DOJ) indicated the intent to send representation to the Board meeting to discuss the issue.

The DOJ previously submitted a memorandum in regard to the July 12, 2016, Board action to approve changes to the Guidelines Contract and Uniform Benefits for 2017

(Ref. GIB | 7.12.16 | 3A). Mr. Potter stated that the August 10, 2016, memorandum was authored by the DOJ at the request of the governor's office for the benefit of the Board.

Mr. Potter noted the State of Wisconsin has joined a federal lawsuit in Texas challenging the federal Department of Health and Human Services (HHS) final regulations pertaining to Section 1557 of the Affordable Care Act (ACA) issued on May 18, 2016. The lawsuit requests a preliminary injunction be issued to preclude the enforcement of the HHS regulations. A hearing is scheduled for December 20, 2016.

Mr. Potter stated that the DOJ recommends the Board follow the law as it currently stands. The changes approved by the Board on July 12 are in compliance with the HHS regulations.

ETF was directed to proceed with the implementation of the language previously adopted. Should the court order a preliminary injunction, the Board will reassess the language at a future Board meeting.

ADJOURNMENT

MOTION: Mr. Grapentine moved to adjourn the meeting. Mr. Neitzke seconded the motion, which passed unanimously on a voice vote.

The meeting adjourned at 2:53 p.m.

Date Approved: _____

Signed: _____
Herschel Day, Secretary
Group Insurance Board

Exhibit R

From: Bogardus, Jeff E - ETF
Sent: Thursday, December 29, 2016 4:46 PM
To: Steven Alexander; Shannon B. Tischer; Olson; Pam
Subject: FW: ETF Update -- Group Insurance Board, Agenda Revised

FYI: below is info about the special GIB meeting that has been scheduled for tomorrow. No need to attend but wanted you to be aware of it. This came up at 5pm last night.

Meeting will be a discussion with Dept of Justice and their recommendation to the GIB to not implement the uniform benefit changes for 2017 surrounding gender identity. This is being pushed by the Governor's office and attorney general. It is based solely on the AG's opinion that the HHS non-discrimination rule is illegal – which I think the courts would have to determine – not the AG.

The link below (revised agenda/notice) takes you to the agenda where you can then link to the documents they will be discussing. The DOJ memo is an interesting read but doesn't account for all the facts – which isn't a surprise and which our Legal Counsel points out in his recommendations memo from August 2016 (also included in that package of info).

While you never know what will happen these days we don't expect the GIB to change from what they were doing previously. Nonetheless, just a heads up that the gender edits may have to be put back on if the politics outweighs the BIB's consideration of their fiduciary duty and the facts.

Let me know if you have any questions.

Jeff Bogardus
Manager, Pharmacy Benefit Programs
Office Of Strategic Health Policy
Department of Employee Trust Funds
Phone: (608) 266-3099
FAX: (608) 267-0633
Email: jeff.bogardus@etf.wi.gov
Web: http://etf.wi.gov/

From: WI Department Employee Trust Funds (ETF) [mailto:etfwi@public.govdelivery.com]
Sent: Thursday, December 29, 2016 2:52 PM
To: Bogardus, Jeff E - ETF <Jeff.Bogardus@etf.wi.gov>
Subject: ETF Update -- Group Insurance Board, Agenda Revised

You are subscribed to Current News/Press Releases and/or Group Insurance Board for the Wisconsin Department of Employee Trust Funds. This information has recently been updated and is now available.

Group Insurance Board
The revised agenda/notice for the Board's scheduled meeting on December 30, 2016, is now available for viewing. This agenda/notice contains links to board meeting memos and other materials.

The Board is meeting to discuss and consider the 2017 uniform benefits and services related to gender reassignment or sexual transformation and the federal Department of Health and Human Services (HHS) nondiscrimination rule.

The Board may meet in closed session pursuant to Wis. Stats. § 19.85(1)(g).

Please note: The December 30 meeting will take place at the Department of Revenue - Events Room, 2135 Rimrock Rd, Madison, WI 53713 - View map of this location.

Exhibit S

DRAFT

MINUTES

December 30, 2016

Group Insurance Board
State of Wisconsin

Location:
State Revenue Building – Events Room
2135 Rimrock Rd, Madison, WI 53713

BOARD MEMBERS PRESENT:

Michael Farrell, Chair
Herschel Day, Secretary (via telephone)
Terri Carlson (via telephone)
Chuck Grapentine
Waylon Hurlburt
Ted Neitzke (via telephone)
Stacey Rolston (via telephone)
Nancy Thompson (via telephone)
JP Wieske (via telephone)
Bob Ziegelbauer (via telephone)

BOARD MEMBERS ABSENT:

Bonnie Cyganek, Vice Chair

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Bob Conlin, Secretary
John Voelker, Deputy Secretary
Office of Strategic Health Policy:
Lisa Ellinger, Director
Eileen Mallow, Deputy Director
Office of the Secretary:
Cheryllynn Wilkins, Board Liaison

OTHERS PRESENT:

ETF Information Technology Services:
Kadimma Mbanefo
ETF Legal Services:
Diana Felsmann, David Nispel
ETF Office of Communications:
Mark Lamkins
Department of Justice:
Kevin Potter
Department of Transportation:
Richard Way
Fair Wisconsin:
Megin McDonell
General Public:
Caitlyn Allen, Cora Allen-Coleman, Luella Allen-Waller, Kyle Bittorf, DJ Bruce, Brittyn Calyx, Rowan Calyx, Fred Day, Alex Fleagle, Jordan Foley, Alex Frye, Laura Gutknecht, Michele Hatchell, Ronni Hayon, Tracey Janke, Gabriel Javier, Caleb Johnson, Corrine Jutz, Owen Karcher, Autumn Kent, Lex Lancaster, Darla Lannert, Ray McMahon, Jaymee Meier, Jaime Neidermeier, Pamela Oliver,

Board	Mtg Date	Item #
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General Public (continued):
Kathy Oriel, David Patton, Rachel Perry, Jennifer Pressman, Emily Ptak-Pressman, Melanee Ratman, Dan Ross, Erica Rotondo, Betsy Stovall, Steph Tai, Nick Telson, Jo Tent, Mitchell Turine, Sara Whitworth, CV Vitolo-Haddad

GSAFE:
Sawyer Johnson

Human Rights Campaign (HRC):
Joanne Lee

Madison Area Transgender Association (MATA):
Violet Byrns

Our Lives Magazine:
Patrick Farabaugh, Emily Mills

OutReach:
Ginger Baier

Physicians Plus:
Ron Sebranek

Michael Farrell, chair, called the meeting of the Group Insurance Board (Board) to order at 3:00 p.m. Waylon Hurlburt is attending today's meeting as the Department of Administration designee.

Mr. Potter from the Department of Justice (DOJ) attended the meeting in order to discuss the July 12, 2016, Board action to approve changes to the Guidelines Contract and Uniform Benefits for 2017 (Ref. GIB | 7.12.16 | 3A). These changes are in compliance with the federal Department of Health and Human Services (HHS) final regulations pertaining to Section 1557 of the Affordable Care Act (ACA) issued on May 18, 2016.

The state of Wisconsin has joined a federal lawsuit in Texas challenging the legality of the HHS regulations. The lawsuit requested a preliminary injunction be issued to preclude the enforcement of the HHS regulations, and a decision was expected soon. The request was heard on December 20, 2016, but no decision was issued by the time of the December 30 Board meeting.

The Chair announced the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat § 19.85 (1) (g) to confer with legal counsel concerning advice about strategy to be adopted with respect to litigation in which the Board is or is likely to become involved. Mr. Nispel, Mr. Potter, Ms. Wilkins and Mr. Mbanefo were invited to remain during the closed session.

MOTION: Mr. Grapentine moved to convene in closed session, pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (g) to confer with legal counsel concerning advice about strategy to be adopted with respect to litigation in which the Board is or is likely to become involved. Mr. Hurlburt seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Carlson, Day, Farrell, Grapentine, Hurlburt, Neitzke, Rolston, Thompson, Wieske, Ziegelbauer

Members Absent: Cyganek

The Board convened in closed session at 3:13 p.m. Mr. Neitzke departed at 5:00 p.m. Other ETF staff were invited into closed session at 6:15 p.m. The Board reconvened in open session at 6:24 p.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Mr. Farrell announced the Board met in closed session to consult with DOJ and ETF Legal Counsel regarding the final HHS rule. The Board will receive an update on this matter at the January 18, 2017, Board meeting. The Board also reserves the right to revisit the benefit in the future as necessitated by legal action, statutory compliance, potential financial impact, or in keeping with the Board's fiduciary responsibilities.

DISCUSSION AND CONSIDERATION OF 2017 UNIFORM BENEFITS – BENEFITS AND SERVICES RELATED TO GENDER REASSIGNMENT OR SEXUAL TRANSFORMATION - HHS NONDISCRIMINATION RULE

The Board's discussion of the gender reassignment language proposed was based on the legality of the final HHS rule.

MOTION: Mr. Hurlburt moved to reinstate the current exclusion related to benefits and services related to gender reassignment or sexual transformation contingent on all of the following:

- ***Subject to a court ruling or an administrative action that enjoins, rescinds or invalidates the HHS Rule;***
- ***Subject to compliance with Wis. Stat. section 40.03 (6)(c);***
- ***Subject to renegotiation of contacts that maintain or reduce premium costs for the state; and finally***
- ***Subject to the opinion of the DOJ that the action taken does not constitute a breach of board members' fiduciary duties.***

Mr. Wieske seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Carlson, Farrell, Grapentine, Hurlburt, Rolston, Wieske, Ziegelbauer

Members Voting Nay: Day, Thompson

Members Absent: Cyganek, Neitzke

ADJOURNMENT

MOTION: Mr. Grapentine moved to adjourn the meeting. Mr. Hurlburt seconded the motion, which passed unanimously on a voice vote.

The meeting adjourned at 6:32 p.m.

Date Approved: _____

Signed: _____
Herschel Day, Secretary
Group Insurance Board

Exhibit T

RE: Request to review 60 day material modification notice (ACA rule)

From:

"Pray, Tara - ETF" <tara.pray@etf.wi.gov>

To:

ellinger, "lisa - etf", nispel, "david - etf", felsmann, "diana m - etf"

Cc:

Mallow <mallow>, Eileen K - ETF <"eileen k - etf">, Steele <steele>, Joan M - ETF <"joan m - etf">

Date:

Mon, 06 Feb 2017 15:19:07 -0600

Hi again –

[redacted]

Thanks,
Tara

From: Ellinger, Lisa - ETF
Sent: Monday, February 06, 2017 8:44 AM
To: Nispel, David - ETF <David.Nispel@etf.wi.gov>; Pray, Tara - ETF <Tara.Pray@etf.wi.gov>; Felsmann, Diana M - ETF <Diana.Felsmann@etf.wi.gov>
Cc: Mallow, Eileen K - ETF <Eileen.Mallow@etf.wi.gov>; Steele, Joan M - ETF <Joan.Steele@etf.wi.gov>
Subject: RE: Request to review 60 day material modification notice (ACA rule)

Thank you for the speedy analysis!

From: Nispel, David - ETF
Sent: Monday, February 06, 2017 8:28 AM
To: Pray, Tara - ETF <Tara.Pray@etf.wi.gov>; Felsmann, Diana M - ETF <Diana.Felsmann@etf.wi.gov>
Cc: Ellinger, Lisa - ETF <Lisa.Ellinger@etf.wi.gov>; Mallow, Eileen K - ETF <Eileen.Mallow@etf.wi.gov>; Steele, Joan M - ETF <Joan.Steele@etf.wi.gov>
Subject: RE: Request to review 60 day material modification notice (ACA rule)

Tara,

[redacted]

[redacted]

Thank you.

David

David H. Nispel
General Counsel
Wisconsin Department of Employee Trust Funds
Telephone: (608) 264-6936
Fax: (608) 267-0633
Email: david.nispel@etf.wi.gov

From: Pray, Tara - ETF
Sent: Friday, February 03, 2017 4:18 PM
To: Nispel, David - ETF <David.Nispel@etf.wi.gov>; Felsmann, Diana M - ETF <Diana.Felsmann@etf.wi.gov>
Cc: Ellinger, Lisa - ETF <Lisa.Ellinger@etf.wi.gov>; Mallow, Eileen K - ETF <Eileen.Mallow@etf.wi.gov>; Steele, Joan M - ETF <Joan.Steele@etf.wi.gov>
Subject: Request to review 60 day material modification notice (ACA rule)
Importance: High

Good afternoon David and Dianna,

[redacted]

Tara

p.s. Our SBCs are housed here on our website. Under Resources.

From: Steele, Joan M - ETF
Sent: Friday, February 03, 2017 12:01 PM
To: Pray, Tara - ETF <Tara.Pray@etf.wi.gov>; Mallow, Eileen K - ETF <Eileen.Mallow@etf.wi.gov>

Cc: Ellinger, Lisa - ETF <Lisa.Ellinger@etf.wi.gov>; Larson, Arlene - ETF <Arlene.Larson@etf.wi.gov>
Subject: RE: 60 day material modification notice (ACA rule)

If you are wondering, below are WEA's comments noted on the addendum below the signature:

**WEA Insurance Corporation (WEA) takes no position on whether the reinstatement of this exclusion is permitted under applicable state and/or federal law. WEA also does not accept legal liability for adverse claim determinations made pursuant to the reinstatement of this exclusion. Further, WEA has no information to determine if the State of Wisconsin, as the plan sponsor, has complied with applicable federal law to provide timely notice of the change to its plan participants. In fact, WEA accepts no legal liability for any failure on the part of the State of Wisconsin to comply with its notification requirements as the plan sponsor related to this change.*

From: Pray, Tara - ETF
Sent: Friday, February 3, 2017 11:53 AM
To: Steele, Joan M - ETF <Joan.Steele@etf.wi.gov>; Mallow, Eileen K - ETF <Eileen.Mallow@etf.wi.gov>
Cc: Ellinger, Lisa - ETF <Lisa.Ellinger@etf.wi.gov>; Larson, Arlene - ETF <Arlene.Larson@etf.wi.gov>
Subject: 60 day material modification notice (ACA rule)

Hi Joan,
Following up based on the feedback you received from a plan (WEA I think). I looked into this rule yesterday to see if it would apply to the exclusion change.

I found this article to be helpful. I added my notes in blue after the parts that apply. I initially thought we were ok because we do not need to revise the SBC (my opinion), but we could be challenged by this. After further review I think we need a review by legal to see if we are violating ACA. There are some things that are not clear to me. After looking into DOL's definition of "material reduction" (see end of this email) it is not clear to me if both provisions must be met for a reduction to be considered "material." Also, I am not sure how ERISA and the fact that we do not have to follow fits into this equation.

Here are six key things to know about the 60-day notice of material modification:

1. The requirement took effect for health plan years beginning on or after September 23, 2012.
2. The requirement only applies to changes made *during* the plan year. It does not apply to renewals of coverage or any modifications made as part of the renewal.
3. The requirement can be met by providing an updated Summary of Benefits and Coverage (SBC) if the change is reflected on the SBC, or by sending a separate written notice describing the material modification. While our SBC lists some services that are not covered,

we stated that it is not a complete list and point to Uniform Benefits (or the Certificate of Coverage). I do not think our SBCs need revision.

4. Before a material change can be effective, all impacted participants must receive at least 60 days advance written notice of the change. The rule's definition of "material modification" is listed below.

5. Plan issuers or sponsors that intentionally fail to provide the notice of material modification are subject to a fine of up to $1,000 for each failure. Each covered individual equates to a separate offense.

6. According to section 102 of the Employee Retirement Income Security Act of 1974 (ERISA), a material modification includes:

    - * Any coverage modification that alone or combined with other changes made at the same time would be considered by "an average participant" to be "an important change in covered benefits or other terms of coverage under the plan or policy." I do not think this change impacts the "average participant."
    - * An enhancement of covered benefits, services or other more general, plan or policy terms. Such as, coverage of previously excluded benefits or reduced cost-sharing.
    - * A "material reduction in covered services or benefits," including: While it is a benefit reduction, based on the actuarial evaluation it is not material to the program. After looking at the DOL rule, I realize they are not interpreting "material" to have anything to do with financial terms. I went there first because, well, I was an accountant.

        - * Changes or modifications that reduce or eliminate benefits
        - * Increases in cost-sharing

I looked at the federal register, and while I only skimmed it, everything seems to point to the SBC. See section 6. B.

Here's is the applicable excerpt.

A material modification, within the meaning of section 102 of ERISA, includes any modification to the coverage offered under a plan or policy that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant (or in the case of individual market coverage, an average individual covered under a policy) to be an important change in covered benefits or other terms of coverage under the plan or policy.[25] A material modification could be an enhancement of covered benefits or services or other more generous plan or policy terms. It includes, for example, coverage of previously excluded benefits or reduced cost-sharing. A material modification could also be a material reduction in covered services or benefits, as defined

in 29 CFR 2520.104b-3(d)(3) of the Department of Labor' regulations, or more stringent requirements for receipt of benefits. As a result, it also includes changes or modifications that reduce or eliminate benefits, increase cost-sharing, or impose a new referral requirement.[26] (However, changes to the information in the SBC resulting from changes in the regulatory requirements for an SBC are not changes to the plan or policy requiring the mid-year provision of a notice of modification, unless specified in such new requirements.)

Here's the definition of "material reduction" as outlined in 29 CFR 2520.104b-3(d)(3) of the Department of Labor' regulations:

(3)*"Material reduction".*

(i) For purposes of this paragraph (d), a "material reduction in covered services or benefits" means any modification to the plan or change in the information required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the plan.

(ii) A "reduction in covered services or benefits" generally would include any plan modification or change that: eliminates benefits payable under the plan; reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, deductibles, coinsurance, copayments, or other amounts to be paid by a participant or beneficiary; reduces the service area covered by a health maintenance organization; establishes new conditions or requirements (e.g., preauthorization requirements) to obtaining services or benefits under the plan.

What is not clear is if i and ii need to both be met.

Tara Pray | Health Plans Manager
Office of Strategic Health Policy
State of Wisconsin - Department of Employee Trust Funds
p: 608.266.1423

Exhibit U

DRAFT

MINUTES

February 8, 2017

Group Insurance Board

State of Wisconsin

Location:

Sheraton Hotel Madison – Destination South Ballroom
760 John Nolen Dr, Madison, WI 53713

BOARD MEMBERS PRESENT:

Michael Farrell, Chair
Bonnie Cyganek, Vice Chair
Herschel Day, Secretary
Terri Carlson
Chuck Grapentine
Michael Heifetz
Nancy Thompson
Ted Neitzke
Stacey Rolston
JP Wieske
Bob Ziegelbauer

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Bob Conlin, Secretary
John Voelker, Deputy Secretary
Office of Strategic Health Policy:
Lisa Ellinger, Director
Sara Brockman, Board Liaison
Eileen Mallow, Deputy Director
Rachel Carabell, Arlene Larson, Tara Pray, Joan Steel, Renee Walk
Division of Retirement Services:
Gina Fischer, Jim Guidry, Deb Roemer, Matt Stohr

OTHERS PRESENT:

ETF Budget & Procurement:
Dana Perry, Jason Barrett, Joe Schneider
ETF Division of Retirement Services:
Anne Boudreau
ETF Information Technology Services:
Kadimma Mbanefo
ETF Legal Services:
Diana Felsmann, Daniel Hayes, David Nispel
Legislative Audit Bureau:
Emily Pape
Legislative Fiscal Bureau:
Jere Bauer, Rachel Janke
M3 Insurance:
Nathan Janke, Sean LaBorde, Brad Niebuhr, Jeremy Shepherd
MacIver Institute:
Chris Rochester

Board	Mtg Date	Item #
GIB	5.24.17	1

ETF Office of Communications:
Nancy Ketterhagen, Mark Lamkins
ETF Office of Internal Audit:
Yikchau Sze
ETF Office of the Secretary:
Jennie Baurenhuber, Liz Doss-Anderson, Pam Henning, Tarna Hunter, James Kates, Mary Richardson, Cheryllynn Wilkins
ETF Office of Strategic Health Policy:
James Cooper, Jeff Bogardus, Jessica Rossner, Shayna Schomber
Anthem Blue Cross and Blue Shield:
Brian Martin, Ted Osthelder
Association of Career Employees:
Sally Drew, Jack Lawton
Aurora Health Care:
Andrew Hanus
Baraboo Ambulance:
Troy Snow
City Employees Local 236:
Michael O'Brien
City of Madison:
Emaan Abdel-Halim, Gregg Gotzion, Victoria Larson, Lara Mainella, Denise Nettum, Eric Pederson, Lisa Van Buskirk, William Wick
City of Madison – Metro Transit:
Robin Jahn, Katie McGrath, Kelly Odegaard, Katie Sellner, Nancy Ull
Dean Health Plan:
Kate Beals, Penny Bound, Michael Weber
Delta Dental of Wisconsin:
Sunshine Mikulak
Department of Administration:
Derek Sherwin
Division of Personnel Management:
Paul Ostrowski
EPIC:
Wendy Hougan
Flaherty & Associates:
Mike Flaherty
Marshfield Clinic Health System:
Ryan Natzke
Martin Schreiber & Associates
Annie Early, Jeremey Shepherd
Medical Associates Health Plan:
Karen Brunton
MercyCare:
Sherrie Sargent, DuWayne Severson
Michael Best Strategies:
Andrew Hitt
Milliman, Inc.:
Paul Correia, Dan Skwire
Momentum Insurance:
Stephanie Steel
Navitus Health Solutions:
Tara Argall, Ryan Olson
Network Health:
John Braden, Cara Techlin
Office of the Commissioner of Insurance:
Jennifer Stegall
Physicians Plus:
Tom Luddy, Ron Sebranek
Quartz:
Cari Alexander, Terry Bolz, Brian Collien, Rob Plesha
Securian:
Kjirsten Elnser
Segal Consulting:
Kirsten Schatten, Ken Vieira
UW Madison:
Diane Blaskowski, Deann DeSlover
UW System Administration:
Erin Schoonmaker, LaDonna Steinert
WEA Trust:
Greg Cieslewicz
Wisconsin Association of Health Plans:
Phil Dougherty, Tim Lundquist, Nancy Wenzel
Wisconsin Health News:
Sean Kirkby
Wisconsin Hospital Association:
Joanne Alig, Phil Dougherty

General Public:
Jim Cerro, Wendi Kent, Glenn Unger
Group Health Cooperative – South Central Wisconsin:
Paul Perkins, Al Wearing
Health Tradition:
Chris Massa
Humana:
Rain Buck, David Ehrenfried, Elisabeth Wright, Mary Haffenbredl
Johnson & Johnson:
Dennis Majeskie
Johnson Insurance Services:
Dan Higgins
Wisconsin Medical Society:
Chris Rasch
Wisconsin Public Radio:
Shamane Mills
Wisconsin State Journal:
David Walhberg
WisPolitics.com:
Polo Rocha
WiscTV:
Doug Wahl
WPS Arise:
Matt Harty, Greg Nelson

Michael Farrell, chair, called the meeting of the Group Insurance Board (Board) to order at 8:30 a.m. Mr. Neitzke arrived at 8:33 a.m.

CONSIDERATION OF DECEMBER 13, 2016 AND DECEMBER 30, 2016 OPEN AND CLOSED MEETING MINUTES

MOTION: Mr. Wieske moved to approve the open session meeting minutes of the December 13, 2016, meeting as submitted by the Board Liaison. Ms. Thompson seconded the motion, which passed on a voice vote. Ms. Cyganek abstained from voting.

MOTION: Mr. Wieske moved to approve the closed session meeting minutes of the December 13, 2016, meeting as submitted by the Board Liaison. Ms. Thompson seconded the motion, which passed on a voice vote. Ms. Cyganek abstained from voting.

MOTION: Mr. Wieske moved to approve the open session meeting minutes of the December 30, 2016, meeting as submitted by the Board Liaison. Ms. Thompson seconded the motion, which passed on a voice vote. Ms. Cyganek abstained from voting.

MOTION: Mr. Wieske moved to approve the closed session meeting minutes of the December 30, 2016, meeting as submitted by the Board Liaison. Ms. Thompson seconded the motion, which passed on a voice vote. Ms. Cyganek abstained from voting.

ANNOUNCEMENTS

Ms. Ellinger made the following announcements:

- Mary Richardson has accepted a position with the Ombudsperson Services staff in the Office of Legal Services.
- WisconsinEye was not present to record the meeting.
- Responses for the Request for Proposal (RFP) for the Administrative Services for the State of Wisconsin Pharmacy Benefits Program (RFP#ETG0013) were due January 30, 2017. Vendor selection will take place at the May Board meeting.
- Negotiations with Truven, the selected vendor for the Data Warehouse and Visual Business solution (RFP#ETG0004/ETF0006), have gone well and were nearing the final stages.

Ms. Ellinger provided a brief overview of the meeting structure, stating that it would largely be held in closed session for the assessment and deliberation of proposals for the State of Wisconsin Health Benefit Program (RFP#ETG0003). The purpose of the closed session was to protect confidential and proprietary information obtained as part of the RFP process.

ELECTION OF OFFICERS

MOTION: Mr. Wieske moved to nominate Michael Farrell as Chair of the Group Insurance Board. Mr. Grapentine seconded the motion, which passed unanimously on a voice vote, with Mr. Farrell abstaining.

MOTION: Mr. Day moved to nominate Bonnie Cyganek as Vice Chair of the Group Insurance Board. Ms. Carlson seconded the motion, which passed unanimously on a voice vote, with Ms. Cyganek abstaining.

MOTION: Ms. Cyganek moved to nominate Herschel Day as Secretary of the Group Insurance Board. Ms. Thompson seconded the motion, which passed unanimously on a voice vote, with Mr. Day abstaining.

2017 UNIFORM BENEFITS AND SERVICES RELATED TO GENDER REASSIGNMENT OR SEXUAL TRANSFORMATION – HHS NONDISCRIMINATION RULE

Ms. Ellinger directed the Board to the memo, 2017 Uniform Benefits and Services Related to Gender Reassignment (Ref. GIB | 2.8.17 | 4). At the December 30, 2016 Board meeting, the Board approved reinstating the exclusion of health benefits and services based on gender identity after certain contingencies were met.

ETF issued a 2017 health plan contract amendment (Ref. GIB | 2.8.17 | 4 - Attachment B) to all participating health plans on January 31, 2017, to reinstate the benefit

exclusion effective February 1, 2017. The amendment completed the final contingency set forth by the Board.

Ms. Ellinger also referred the Board to Item 10A – Group Insurance Board Correspondence (Ref. GIB | 2.8.17 | 10A), which included the numerous letters received regarding this topic.

Mr. Day inquired as to possible next legal steps regarding the December 31, 2016, preliminary federal injunction. Mr. Nispel advised that the preliminary injunction is required to be made a permanent injunction through a final court decision. Additional hearings are anticipated, but Mr. Nispel was not aware of any future court dates.

Mr. Day stated that in his opinion, reinstating the exclusion could potentially increase the Board's risk of liability for breach of fiduciary duty should the December 31, 2016, injunction eventually be lifted.

Mr. Nispel noted that one of the requirements for obtaining a preliminary injunction is to show a likelihood of success in receiving a permanent injunction. The Texas federal judge that issued the preliminary injunction found that the plaintiffs met the threshold to indicate they would be likely to obtain a permanent injunction.

Mr. Nispel also noted that the Board, as part of the contingencies set forth at the December 30, 2016, Board meeting, sought and received a final opinion from the Wisconsin Department of Justice (DOJ), which confirmed that the action taken does not constitute a breach of the Board's fiduciary duties. The DOJ opinion was received on January 13, 2017.

Mr. Farrell noted that the Board's December 30, 2016, decision can be revisited at any date in the future as desired by the Board.

The Board took a break at 8:44 a.m. to 8:47 a.m. due to audience disruption.

The chair announced the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (e) for the purpose of deliberating the potential investment of public funds and to review proposals for services for which competitive and bargaining reasons required a closed session. Staff from the Department of Employee Trust Funds (ETF), Office of the Commissioner of Insurance (OCI), the Department of Administration (DOA), and actuarial advisors from Segal Consulting (Segal) were invited to remain during the closed session.

> ***MOTION: Mr. Ziegelbauer moved to convene in closed session, pursuant to the exemptions contained in Wis. Stats. § 19.85 (1) (e) to deliberate or negotiate the investing of public funds or to conduct other specified business, whenever competitive or bargaining reasons require a closed***

session. Ms. Cyganek seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Carlson, Cyganek, Day, Farrell, Grapentine, Heifetz, Neitzke, Rolston, Thompson, Wieske, Ziegelbauer

The Board convened in closed session at 8:58 a.m. and reconvened in open session at 12:28 p.m.

The Board took a break from 12:18 p.m. until 12:35 p.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Mr. Farrell stated that the Board meeting was not a public hearing, and that the Board would not hear comments from the public.

Mr. Farrell announced the Board met in closed session to assess and deliberate the many options for the State of Wisconsin Health Benefit Program presented by ETF and Segal. He stated that the intent of the Board was to provide as much detail as possible after the adjournment of the meeting and in keeping with the requirements of the procurement process, including press releases and frequently asked questions, as well as the language of any motions made, for the sake of transparency.

Mr. Farrell stated that the Board would make a recommendation to the Joint Committee on Finance after the conclusion of the meeting.

MOTION: In an effort to maintain employee benefits as they currently exist, and support the health of our friends and neighbors who are employed by the State of Wisconsin and local regions, and to attract and retain those great employees, Mr. Neitzke moved that;

Whereas the State of Wisconsin currently provides health insurance to state employees, retirees, continuants, and graduate assistants through the It's Your Choice State of Wisconsin Group Health Insurance Program (State Plan), and to local government employees and annuitants through the It's Your Choice local plans;

Whereas the State of Wisconsin has an interest in the good health and wellbeing of its employees, and most large employers of similar size provide employee health insurance through a self-funded plan, and the cost of the State Plan benefits have continued to rise;

Whereas the actuarial value of the State Plan at 96% is one of the highest benefit values in the country for a state employee plan;

Whereas the cost of the State Plan is higher than individual health insurance plans of similar actuarial value on the federal health insurance exchange;

Whereas the Request for Proposals (RFP) to evaluate self-insuring and regionalizing the state employee health insurance program issued by the Department of Employee Trust Funds (ETF) resulted in vendor options for the Group Insurance Board's (Board) consideration that promise significant savings to Wisconsin taxpayers to fund the State Plan;

Whereas one proposed option to self-fund and regionalize includes having one contract in place for statewide coverage, along with two administrator contracts in each of the southern and eastern regions, and one administrator contract in each of the western and northern regions, with minimal provider disruption, meaning an estimated 98% of the current health care providers participating in the State Plan will continue to be accessible;

Whereas such proposed self-funding/regionalization model does not change the benefits that the employees receive, rather it changes the financing of those benefits;

Whereas the proposed self-funding/regionalization model is estimated to save the state more than $60 million over the 2017-2019 biennium and similar amounts in subsequent years;

Whereas an additional $30 million in Affordable Care Act (ACA) taxes will be avoided by moving to a self-funded/regionalization model; and
Whereas the proposed self-funding/regionalization model will provide the state with ownership rights over the State Plan data, thereby maximizing the ability of the new data warehouse/business intelligence solution to inform state efforts related to improving employee health and lowering health care costs; now, therefore, be it resolved, that the Group Insurance Board:

Give ETF authority to enter into contract negotiations to move the state to a self-funded health plan effective January 1, 2018, with the following administrators in the following regions:

1. ***Statewide Coverage: Compcare Health Services Insurance Corporation (Anthem Blue Cross Blue Shield)***
2. ***Northern Region: Security Administrative Services***
3. ***Eastern Region: Compcare Health Services Insurance Corporation (Anthem Blue Cross Blue Shield) and Network Health Administrative Services, LLC***

4. ***Southern Region: Dean Health Plan, Inc. and SPWI TPA, Inc. (Quartz)***
5. ***Western Region: HealthPartners Administrators, Inc.***

Contracts shall be for a period of three years. If contract negotiations stall with any of the administrators, ETF shall schedule a Board meeting to update the Board on outstanding issues and the Board shall determine next steps. ETF shall not move to the next highest scoring vendor if contract negotiations fail to progress with any of the administrators.

Mr. Wieske seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Carlson, Cyganek, Day, Farrell, Heifetz, Neitzke, Rolston, Thompson, Wieske, Ziegelbauer

Members Voting Nay: Grapentine

HEALTH INSURANCE

It's Your Choice Open Enrollment Period

Ms. Ellinger referred the Board to the memo, It's Your Choice Open Enrollment Period (Ref. GIB | 2.8.17 | 8A). Ms. Ellinger stated that the Board typically approves the annual It's Your Choice Open Enrollment period at the first meeting of each year. However, given the unknown factors regarding contract negotiations and program design for plan year 2018, the decision will be delayed until the May Board meeting. While ETF anticipates the enrollment period will remain in its usual timeframe of October to November, more information is desired before making a formal recommendation.

Health Benefit Program Agreement & Uniform Benefits for the 2018 Plan Year

Ms. Walk referred the Board to the memo, Health Benefit Program Agreement & Uniform Benefits for the 2018 Plan Year (Ref. GIB | 2.8.17 | 8B). The Board typically considers and approves health insurance benefit and contract changes at its May meeting. Staff presented 2018 recommendations at the February meeting in order to:

- Enable staff to incorporate 2018 contractual changes in the negotiation process;
- Allow early implementation and promotion of changes to the wellness incentive; and
- Minimize changes for 2018, as directed by the Board, affording an expedited process for analysis.

Ms. Walk provided an overview of recommendations for 2018, including technical and administrative changes, as well as benefit parameters and programmatic changes designed to position the Group Health Insurance Program (GHIP) for a more member-centric, Total Health Management approach. The key recommendations included changes to:

- Wellness incentive design,

- Data reporting requirements,
- Performance standards and quality measurements,
- Technical changes/clarifications, and
- Additional changes to discuss at the May Board meeting.

MOTION: Ms. Thompson moved to approve the changes to the Health Benefit Program Agreement as detailed in the memo and grant ETF staff the authority to make additional changes as necessary. Mr. Grapentine seconded the motion, which passed unanimously on a voice vote.

2018 Program and Operational Recommendations

Ms. Ellinger referred the Board to the memo, 2018 Program and Operations Recommendations for the Group Health Insurance Program (GHIP) and Wisconsin Public Employers (WPE) Program (Ref. GIB | 2.8.17 | 8C).

Ms. Ellinger noted that one of the items in the memo was the proposed elimination of the WPE Deductible Plan Program Option (PO) 4/14. The Board received a significant amount of correspondence regarding the proposal. Ms. Ellinger stated that it is ETF staff opinion that many of the critiques received were legitimate and that a 2018 elimination timeframe was premature. ETF staff requested altering the recommendation to delay potential implantation to 2019, in order to allow staff time for additional discussion with impacted employers and to complete additional analysis to present to the Board.

Mr. Farrell noted that there was an error with the reported number of employees enrolled in PO 4/14. Ms. Ellinger clarified that in December 2016, ETF staff initially reported only 1,238 employees enrolled. However, upon further review of the date, it was discovered that 9,283 employees are enrolled. Ms. Ellinger stated that despite the increase in enrolled employees, ETF staff's original recommendation to eliminate PO 4/14 remained the same.

Ms. Walk requested the Board disregard the proposed elimination of PO 4/14. Ms. Walk and Ms. Larson provided an overview the other two recommendations in the memo regarding 2018 program and operational changes.

ETF recommends administering the IYC Access Plan through the statewide/nationwide vendor contract(s) for the 2018 plan year, as the current contract ends December 31, 2017. The IYC Access Plan is statutorily required and currently self-insured. In addition, ETF recommended aligning benefits coverage for the IYC Access Plan with Uniform Benefits.

Ms. Larson noted that the IYC Access Plan is currently a Tier 3 program. Offering the IYC Access Plan through the statewide/nationwide vendor would allow the plan to become a Tier 1 program, which would be less expensive and more appealing to

members, while the alignment with Uniform Benefits would make the plan more consistent to administer and simplify contracting with a new vendor.

ETF also recommends consolidating the Local Annuitant Health Program (LAHP) be consolidated into the WPE program, and that LAHP members be offered PO 16, The LAHP is a fully insured retiree program that offers benefits different from any other plan administered by ETF. The enrollment group size is small, with 178 total subscribers, and the rates are highly volatile. Consolidation would help to stabilize rates over time and reduce administrative complexity.

MOTION: Ms. Cyganek moved to approve the pursuit of the following program changes for 2018:

1. ***It's Your Choice (IYC) Access Plan (formerly the Standard Plan) – Offer through statewide/nationwide vendor(s) and match Uniform Benefits***
2. ***Local Annuitant Health Program (LAHP) – combine with WPE Program***

Mr. Grapentine seconded the motion, which passed unanimously on a voice vote.

Medicare Member Options Strategy

Ms. Carabell and Ms. Pray referred the Board to the memo, Medicare Member Options Strategy (Ref. GIB | 2.8.17 | 8C). Ms. Carabell provided an overview of current offerings, which include IYC Medicare Plus (Supplement), IYC Medicare, and IYC Health Plan – Medicare.

Ms. Walk provided a brief overview of Medicare Advantage plan administration. In its November 2015 report, Segal suggested the Board explore offering additional Medicare Advantage plans in order to offer Medicare Advantage plans with significantly lower premiums than the current Medicare offerings and to provide enhanced offerings to Medicare-eligible participants with federal oversight and focus on quality.

Ms. Pray provided a brief overview of current Medicare offerings. IYC Medicare Plus is the only Medicare Supplement plan currently offered through the program. The current administrative contract with WPS expires at the end of 2017. Humana administers the program's only Medicare Advantage offering, and the contract also expires at the end of 2017.

ETF recommends incorporating negotiations on the Medicare Supplement and Medicare Advantage plans into the contract negotiations with the new statewide vendor for the program's non-Medicare population, and requests Board approval to explore options to offer additional Medicare offerings beginning in 2019. If the statewide vendor is unable to administer the Medicare Advantage Plan, ETF requests the Board approve extending the contract with the current vendor for 2018.

ETF is currently researching multiple issues and plan design considerations for 2019 and will bring more information and preliminary recommendations to the Board at its May 2017 meeting.

The Board discussed whether it was in the best interest of the program to negotiate with the new statewide vendor to administer the IYC Medicare Advantage Plan, given that the Medicare Advantage plan is fully insured. Ms. Ellinger made an alternate recommendation to negotiate a one year extension of the IYC Medicare Advantage Plan contract with Humana for one year, with the ability to negotiate with the new statewide vendor in the event of unsuccessful negotiations. The Board agreed to the alternate recommendation.

MOTION: Mr. Wieske moved to approve the pursuit of the following program changes related to Medicare member options for 2018 and 2019:

1. ***Negotiate with the new statewide vendor to administer the It's Your Choice Medicare Plus Plan (Medicare Supplement) for 2018, and negotiate with the current vendor to extend the contract for the It's Your Choice Medicare Advantage Plan (Medicare Advantage plan) with the current vendor for one year;***
2. ***If ETF is unable to complete a one year contract extension with the current Medicare Advantage plan vendor, negotiate with the new statewide vendor to administer the Medicare Advantage plan for 2018; and***
3. ***Explore options to offer additional Medicare offerings starting in 2019 approve the pursuit of the following program changes related to Medicare member options for 2018 and 2019.***

ETF will incorporate negotiations of the Medicare Supplement plan into the contract negotiations with the new statewide vendor for the program's non-Medicare population. ETF will bring options for additional Medicare offerings to the Board at its May 2017 meeting. Ms. Rolston seconded the motion, which passed unanimously on a voice vote.

DISABILITY PROGRAM UPDATE

Mr. Conlin provided a brief history of disability program oversight. He stated that ETF has made several efforts to become more proactive in the management of these programs, with the ultimate goal of streamlining and stabilizing the disability programs. The ETF Board has already made several decisions regarding disability program changes, and it was now appropriate for the Board to do the same.

Closure of the Long-Term Disability Insurance Program

Ms. Roemer referred the Board to the memo, Closure of the Long-Term Disability Insurance (LTDI) Program (Ref. GIB | 2.8.17 | 9A). Pursuant to their authority under Wis. Stat. § 40.03 (1) (i), the ETF Board adopted a recommendation to close the LTDI programs to new claims effective January 1, 2018 and reopen the 40.63 Disability

Annuity program (40.63), effective on the same date. The Board took this action at its meeting on September 29, 2016. Ms. Roemer cited several reasons for this action. LTDI was implemented in 1992 to address potential age discrimination issues raised by changes to the Age Discrimination in Employment Act (ADEA); however, a later Supreme Court decision diminished these concerns. The need for both the LTDI and 40.63 programs was questioned, as they are very similar.

Secondly, after analyzing various factors related to both programs, the ETF Board determined that closing the LTDI program and reopening the 40.63 program to new claims would be the most efficient and economical choice for the agency. Staff have begun the necessary administrative rules changes to facilitate the ETF Board's actions, as well as the internal processes for the run-out of the current LTDI claims.

Disability Program Redesign – Income Continuation Insurance

Ms. Roemer referred the Board to the memo, Disability Program Redesign – Income Continuation Insurance (ICI) (Ref. GIB | 2.8.17 | 9B). The state ICI program has had to increase premiums for the past several years because the program is not fully funded. The proposed changes to the state ICI program are intended to help with the long-term sustainability of the program as well as make it easier to understand and administer.

Ms. Roemer and Mr. Guidry presented an overview of the redesign proposal, including historical background, program status, plan enrollment statistics, disability redesign goals, ICI redesign specific goals, feedback from employers, and next steps. Mr. Skwire and Mr. Correia from Milliman presented the results of several experience studies and further analysis.

> ***MOTION: Mr. Ziegelbauer moved to take action on the proposal to redesign the ICI program. Ms. Cyganek seconded the motion, which passed unanimously on a voice vote.***

Aetna Contract Amendment and Extension

Ms. Roemer presented the memo, Aetna Contract Amendment and Extension (Ref. GIB | 2.8.17 | 9C). Aetna currently provides administrative services for the ICI and LTDI programs. Aetna was awarded the contract in December 2008 with a five-year term from January 1, 2009, through December 31, 2013, with options for two two-year extensions. The Board elected to exercise each of the two-year extensions; the final extension is scheduled to end December 31, 2017.

Aetna has been a strong partner with ETF in the administration of the ICI and LTDI programs. ETF believes the Board would be best served by having Aetna run out the LTDI claims process instead of contracting with a new vendor. No changes to Aetna's fee structure will result from this proposal.

> ***MOTION: Mr. Ziegelbauer moved to amend the current administrative services contract with Aetna Life Insurance Company (Aetna) to add two***

additional one-year contract extensions and exercise one of those options to extend the contract with Aetna for an additional one-year period. This action would extend the contract from January 1, 2018 through December 31, 2018. Ms. Cyganek seconded the motion, which passed unanimously on a voice vote.

Transfer Oversight of Income Continuation Insurance Program and Long-Term Disability Insurance Program from the Group Insurance Board to Employee Trust Funds Board

Mr. Stohr presented the memo, Transfer Oversight of Income Continuation Insurance Program and Long-Term Disability Insurance Program from the Group Insurance Board to Employee Trust Funds Board (Ref. GIB | 2.8.17 | 9D). ETF administers multiple disability programs: state and local ICI, LTDI, 40.63 Disability (also known as disability retirement), and Duty Disability.

Under current state statute, the Board oversees both the state and local ICI plans. The ETF Board oversees the 40.63 Program and the Duty Disability Program. The ETF Board delegated oversight of the LTDI Program to the Board, although staff presents LTDI Program information, such as annual valuations, to both Boards because the LTDI program is so closely tied to the 40.63 Program.

Mr. Stohr stated that the current disability program structure is confusing to employers, members, and ETF staff. The same holds true to the Board oversight structure. Consolidating oversight of the disability programs to the ETF Board is anticipated to reduce time and expense for both ETF staff and actuaries by eliminating duplicative meetings and actuary expenses. Such a change to ICI would require statutory changes. ETF will work with the Legislature and the Governor's Office on the changes, and the shift from the Board to the ETF Board will be effective upon potential enactment of the statutory changes.

MOTION: Mr. Ziegelbauer moved to approve the transfer of oversight of the Income Continuation Program and Long-Term Disability programs from the Group Insurance Board to the Employee Trust Funds Board. Ms. Cyganek seconded the motion, which passed unanimously on a voice vote.

Mr. Neitzke departed at 2:20 p.m.

OPERATIONAL UPDATES

Mr. Farrell referred the Board to the Operational Updates in the Board Packets (Ref. GIB | 2.8.17 | 10) and offered that staff were available if the Board had questions.

The chair announced the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat § 19.85 (1) (a) for quasi-judicial deliberations on an

appeal. Ms. Gibson and Ms. Brockman were invited to remain during the closed session.

MOTION: Mr. Wieske moved to convene in closed session, pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (a) for the purpose of quasi-judicial deliberations on an appeal. Ms. Thompson seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Carlson, Cyganek, Day, Farrell, Grapentine, Heifetz, Rolston, Thompson, Wieske, Ziegelbauer

Members Absent: Neitzke

The Board convened in closed session at 2:44 p.m. and reconvened in open session at 2:59 p.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

During closed session, the Board moved to adopt the hearing examiner's proposed decision with amendments as recommended by counsel in regard to Appeal No. 2016-006-GIB.

FUTURE ITEMS FOR DISCUSSSION

The Board meeting originally scheduled for February 22, 2017 was cancelled. The Board will reconvene in May.

ADJOURNMENT

MOTION: Mr. Wieske moved to adjourn the meeting. Ms. Carlson seconded the motion, which passed unanimously on a voice vote.

The meeting adjourned at 3:00 p.m.

Date Approved: _____

Signed: _____
Herschel Day, Secretary
Group Insurance Board

Exhibit V

DRAFT

MINUTES

May 24, 2017

Group Insurance Board
State of Wisconsin

Location:
Lussier Family Heritage Center
3101 Lake Farm Road, Madison, WI 53711

BOARD MEMBERS PRESENT:

Michael Farrell, Chair
Herschel Day, Secretary
Chuck Grapentine
Michael Heifetz
Nancy Thompson
Ted Neitzke
Stacey Rolston
JP Wieske
Bob Ziegelbauer

PARTICIPATING EMPLOYEE TRUST FUNDS (ETF) STAFF:

Bob Conlin, Secretary
John Voelker, Deputy Secretary
Office of Strategic Health Policy:
Lisa Ellinger, Director
Eileen Mallow, Deputy Director
Sara Brockman, Board Liaison
Sarah Bradley, Rachel Carabell, James Cooper, Arlene Larson, Tara Pray, Shayna Schomber, Joan Steele, Renee Walk
Division of Retirement Services:
Deb Roemer

OTHERS PRESENT:

ETF Budget & Procurement:
Dana Perry, Jason Barrett
ETF Division of Retirement Services:
Gina Fischer, Jim Guidry, Megan Jeffers
ETF Information Technology Services:
Ryan Perkins
ETF Legal Services:
Diana Felsmann, Daniel Hayes, David Nispel, Amanda Postel
ETF Office of Communications:
Nancy Ketterhagen, Mark Lamkins
Legislative Fiscal Bureau:
Rachel Janke
LTCI Partners:
Tom Long
M3 Insurance:
Nathan Janke, Brad Niebuhr
Milliman, Inc.:
Paul Correia
Navitus Health Solutions:
Tara Argall, Brent Eberle, Ryan Olson, Tom Radloff

Board	Mtg Date	Item #
GIB	8.30.17	1

ETF Office of Internal Audit:
Yikchau Sze
ETF Office of the Secretary:
Jennie Bauernhuber, Liz Doss-Anderson, Pam Henning, Tarna Hunter, James Kates, Mary Richardson
ETF Office of Strategic Health Policy:
Jeff Bogardus, Sherry Etes, Jessica Rossner
Anthem Blue Cross and Blue Shield:
Ted Osthelder
Association of Career Employees:
Jack Lawton
Baraboo Ambulance:
Troy Snow
City of Madison:
William Wick
Dean Health Plan:
Katie Beals, Penny Bound
Department of Administration:
Jennifer Kraus, Derek Sherwin, Nicole Zimm
Division of Personnel Management:
Rachel Martin, Paul Ostrowski
EPIC:
Karen Browne, Daniel Rodriguez
General Public:
Ted Collins, Hickory Hurie, Sharon Hutchinson
Group Health Cooperative – South Central Wisconsin:
Emily Halter, Mark Huth, Al Wearing
Health Choice:
Bob Pearson
HealthPartners:
Amy Mahan, Sue Tobias
Humana:
Rain Buck, Christa Klein, Shari Stoltmann
Legislative Audit Bureau:
Emily Pape
Network Health:
Kerry Arnold, Cara Techlin, Hannah Zillmer
Office of the Commissioner of Insurance:
Jennifer Stegall
Physicians Plus:
Ron Sebranek
Protect Our Wisconsin Retirement Security (POWRS):
Roger Springman
Quartz:
Cari Alexander
Securian:
Kjirsten Elnser
Segal Consulting:
Kirsten Schatten, Ken Vieira
SeniorCare Insurance Services:
Kevin Kumpf
StayWell:
David Gregg, Emily Rathjen
UW Health:
Anthony Dix
UW Madison:
Diane Blaskowski
UW System Administration:
Beth Ritchie, Erin Schoonmaker, Zoua Vang
Walgreens:
Matt Wessels
WEA Trust:
Greg Cieslewicz
Wisconsin Association of Health Plans:
Phil Dougherty, Tim Lundquist, Nancy Wenzel
Wisconsin Hospital Association:
Joanne Alig
Wisconsin Public Radio:
Shamane Mills
WisPolitics.com:
Polo Rocha
WPS Arise:
Greg Nelson

Michael Farrell, chair, called the meeting of the Group Insurance Board (Board) to order at 8:31 a.m.

CONSIDERATION OF FEBRUARY 8, 2017 OPEN AND CLOSED MEETING MINUTES

MOTION: Mr. Wieske moved to approve the open session meeting minutes of the February 8, 2017, meeting as submitted by the Board Liaison. Mr. Heifetz seconded the motion, which passed on a voice vote.

MOTION: Ms. Thompson moved to approve the closed session meeting minutes of the February 8, 2017, meeting as submitted by the Board Liaison. Mr. Wieske seconded the motion, which passed on a voice vote.

ANNOUNCEMENTS

Ms. Ellinger made the following announcements:

- Mr. Grapentine, Mr. Neitzke, and Mr. Ziegelbauer were expected to join the meeting late.
- Terri Carlson has announced her departure from the Board.
- Bonnie Cyganek, vice chair, has also departed the Board. Ms. Cyganek has accepted a new position with the Department of Employee Trust Funds (ETF). The Wisconsin Department of Justice will replace Ms. Cyganek for the August Board meeting. An election of officers will also take place in August.
- WisconsinEye was not present to record the meeting.

Ms. Ellinger provided a brief overview of the meeting structure, stating the morning portion would be held in open session and the afternoon would be held in closed session for the assessment and deliberation of proposals for the State of Wisconsin Health Pharmacy Benefit Program (RFP#ETG0013). The purpose of the closed session was to protect confidential and proprietary information obtained as part of the request for proposals (RFP) process.

HEALTH INSURANCE

Self-Insurance/Regionalization Status and Next Steps

Ms. Ellinger referred the Board to the memo, Self-Insurance/Regionalization Status and Next Steps (Ref. GIB | 5.24.17 | 3A). Ms. Ellinger stated the purpose of the memo was to provide an update to the Board regarding self-insuring contract negotiations, discuss alternative structures for the State of Wisconsin Group Health Insurance Program (GHIP), and review preliminary fully insured program structure premiums for plan year 2018 with the Board's actuary, Segal Consulting (Segal). Guidance from the Board was also requested regarding a preferred program structure for plan year 2018 in the event the self-insurance contracts were rejected by the legislature's Joint Committee on Finance (JCF).

ETF negotiated contracts to self-insure and regionalize the GHIP for 2018, as directed by the Board at its February 8, 2017, meeting. These contracts were delivered to the JCF for passive review on May 8, 2017, as required under Wis. Stat. § 40.03(6) (L).

An objection to the contracts was filed by the JCF on May 16, 2017. Ms. Ellinger noted that the JCF would schedule a vote on the contracts in the near future, as part of the legislative budget process.

Ms. Ellinger stated that ETF has impressed upon the JCF members the importance of a timely decision regarding the self-insurance contracts. She also noted that there has been substantial public discussion regarding alternative program changes to achieve $60 million GPR savings in the next biennium.

Furthermore, Ms. Ellinger stated that in order to be fully prepared for the 2018 plan year, ETF staff have initiated the standard renewal process and have begun collecting data from health plans currently participating in the program.

Ms. Ellinger provided a brief overview of possible cost shifting alternatives that would be required for plan year 2018 to achieve the budget-required savings in the current fully-insured program structure. The estimates, provided by Segal, included:

- Employee premium contributions: 50% increase
  - 82% employer and 18% employee share of premium (replacing 88% to 12% ratio)
- Deductible/out-of-pocket maximums (OOPM):
  - Increase of $1,000 single / $2,000 family
    - Current deductible: $250 / $500
    - New deductible: $1,250 / $2,500
    - Current OOPM: $1,250 / $2,500
    - New OOPM: $2,250 / $4,500
- Minimal allowable premium increase

Ms. Ellinger noted that the last significant premium contribution increase occurred in 2011, when the employee premium contribution increased from 6% to 12%. She also noted that deductibles were introduced to the GHIP in 2016.

Segal was also asked to explore a potential coinsurance increase, but found that a coinsurance increase would not produce significant cost savings for the program.

Ms. Ellinger also provided a brief overview of the reserve fund. At the close of calendar year 2016, the reserve net fund balance was approximately $160 million (state only). The Board reviews the reserve fund balance on an annual basis during the August Board meeting as part of the rate-setting and tiering process, and determines at that time whether to utilize the reserve fund to offset premium increases. The Board also compares the reserve fund balance to the Board policy, with actuarial input from Segal, to determine an appropriate reserve fund balance based on a percentage of total annual claims.

Over the past decade, the reserve fund has remained fairly stable. Ms. Ellinger noted that fluctuations in the reserve balance are the result of the Board opting to draw from the reserves, as well as the accrual of interest over time. The Board has drawn from the reserve fund eight out of the past ten years. The reserve fund was not utilized for plan years 2011 or 2017. In the past six years, over $100 million in reserve funds have been utilized in keeping with the Board policy and to provide premium relief for members.

Mr. Ziegelbauer arrived at 8:39 a.m.

Mr. Vieira and Ms. Schatten from Segal provided an early analysis of fully-insured program premium increases for plan year 2018. Mr. Vieira noted the 5% rate cap for plan year 2017 renewals pushed the projected loss ratio to 96%, stating that this puts pressure on renewals for 2018.

Based on the initial data provided by participating health plans, Segal is projecting a potential average premium increase of 10.4% for state employees and 5.1% for local employees under the current fully-insured model for 2018.

Mr. Grapentine arrived at 9:09 a.m. Mr. Neitzke arrived at 9:42 a.m.

The Board discussed possible cost shifting alternatives and potential program structure changes at length, including the possible utilization of regionalization and multi-year contracts as potential cost-saving measures.

Given the fully-insured program premium estimates provided by Segal, the Board requested that ETF help prepare a communication to the JCF to inform the committee of the potential premium increases for 2018 and reaffirm the potential cost savings associated with the self-funded program structure.

The Board requested that ETF continue to explore all program options available: self-insured regionalization, fully-insured regionalization, and the current fully-insured structure. ETF was also instructed to bring 2018 program structure options to the Board for final consideration at the August Board meeting.

The Board did not take any action related to this item.

Establish It's Your Choice Open Enrollment Dates

Ms. Steele referred the Board to the memo, Establish It's Your Choice (IYC) Open Enrollment Dates (Ref. GIB | 5.24.17 | 3B). The proposed four-week timeframe of October 2 – October 27, 2017, occurs two weeks earlier than the 2016 IYC open enrollment period. The recommended two-week shift is driven by potential changes to the GHIP for 2018, as well as the January 2018 rollout of the new Benefits Administration System (BAS).

Ms. Steele noted the earlier IYC open enrollment period cuts into IYC communication plans, but ETF is making adjustments to ensure that quality information is provided to members.

Ms. Rolston expressed concerns with the proposed timeline, questioning whether it was too aggressive, considering annual enrollment logistics, coordination with employers, and the uncertainty regarding the program design for plan year 2018. Ms. Mallow stated the proposed enrollment timeline was developed with input from employers and provides sufficient time for enrollment finalization before January 1, 2018.

MOTION: Ms. Thompson moved to approve October 2 – 27, 2017, as the It's Your Choice open enrollment period for 2018. Mr. Day seconded the motion, which passed on a voice vote with Ms. Rolston opposed.

Health Plan Quality Measurement

Ms. Ellinger referred the Board to the memo, Health Plan Quality Measurement (Ref. GIB | 5.24.17 | 3C). No presentation was made regarding this informational memo in the interest of time. The memo describes the process undertaken by ETF to improve the existing ETF health plan report card and the healthcare performance metrics in the Health Plan Agreement (Agreement).

Board approval of the proposed quality measure set was presented under the memo, 2018 Group Health Benefit Program Changes (Ref. GIB | 5.24.17 | 3D).

2018 Group Health Benefit Program Changes

Ms. Walk referred the Board to the memo, 2018 Group Health Benefit Program Changes (Ref. GIB | 5.24.17 | 3D). Ms. Walk provided an overview of proposed program changes, including:

- Wellness premium differential for 2019
- Medication Therapy Management (MTM) expansion for the pharmacy benefit
- Addition of comprehensive audit reporting requirements
- Contract changes resulting from the self-insuring/regionalization procurement and negotiation process

ETF staff indicated that work would continue on the wellness incentive redesign, which was approved by the Board in February 2017. The monthly premium differential would replace the current Well Wisconsin $150 cash incentive. Staff also noted the current incentive is taxable at a 40% rate as a gift card; providing that same incentive as a premium reduction would not be taxable. Ms. Walk noted the current tax rate acts as a disincentive for members to engage in wellness, and was the driving reason behind the wellness incentive redesign.

ETF would like to begin promotion of the premium differential in the fall of 2017 during the annual IYC open enrollment period. Activities completed by members in 2018 would count toward premium differential eligibility in plan year 2019.

ETF has held discussions with both Department of Administration (DOA) and University of Wisconsin System Administration (UWSA) payroll managers to assess payroll center needs. DOA and UWSA indicated the wellness incentive redesign is a positive change. They are also in agreement with the 2019 implementation timeline, as it will take considerable time and effort to accurately build premium differential capabilities into all affected systems.

Ms. Walk cited the need for additional discussions with local employers to determine the impact of this change on their payroll systems. Internally, ETF is working on policy and promotion concepts, and to determine the impact of this change on BAS.

ETF also recommended expanding access to MTM services to the entire participant population. MTM is a type of medication counseling provided by pharmacists to help members better understand their medications, as well as understand what interactions might occur between medications.

Currently, MTM is only available to participants who are enrolled in Medicare as a part of the Employer Group Waiver Plan (EGWP). Ms. Walk noted that expanding MTM services would be of benefit to members with chronic conditions, such as diabetes, and help the Board to deliver the most effective drug coverage program. MTM is available from all Pharmacy Benefit Manager (PBM) request for proposals (RFP) proposers, with costs to be determined through contract negotiations.

Regarding audit reporting requirements, ETF audit staff recommended adding a requirement for Service Organization Controls (SOC) 1, Type 2 reporting to all future vendor contracts. Type 2 reporting is done over a specific audit period, and demonstrates the design of an organization's financial controls, as well as the effectiveness of those controls.

Next, Ms. Walk provided an overview of additional changes to the GHIP contract (Agreement) resulting from self-insured contract negotiations. Several changes presented were required regardless of program design, while some would only apply to a self-insured program.

Ms. Walk stated that ETF intends to use the revised Agreement for plan year 2018, regardless of program design.

Key recommendations that would apply to both a fully-insured and self-insured program model include:

- Plan qualification status
- Primary care provider (PCP) requirement
- Biometric screenings
- Definition of dependent for legal wards
- Definition of subscriber

- Re-enrollment rights due to member fraud
- Provider guarantee language
- Clinical performance guarantees

Changes that would only apply to a self-insured program include:

- Organ re-transplantation
- Rate-making process
- Proposal process
- Independent/external review
- Mid-year plan transfers

Ms. Walk also provided an update on the possible removal of the dual-enrollment requirement for the High Deductible Health Plan (HDHP) and Health Savings Account (HSA). Following further research by ETF legal counsel, a statutory change is necessary to remove the HDHP and HSA dual-enrollment requirement. ETF did not recommend pursuing this change for plan year 2018.

MOTION: Ms. Rolston moved to approve the following health benefit program changes:

1. ***Wellness premium differential for 2019;***
2. ***Medication Therapy Management (MTM) expansion for the pharmacy benefit;***
3. ***Addition of comprehensive audit reporting requirements; and***
4. ***Contract changes resulting from the self-insuring/regionalization procurement and negotiation process.***

Mr. Wieske seconded the motion.

Mr. Day indicated he wanted to amend the motion by adding an item to reinstate coverage for transgender health services and transgender reassignment surgery. Mr. Day cited the direct positive impact on the affected members' lives and a desire to return the determination of medical necessity to medical professionals as justification for this proposed amendment.

Amendment: Mr. Day moved to amend the motion with the following language:

5. ***Withdraw the exclusion of health benefits and services based on gender identity for plan year 2018.***

Ms. Thompson seconded the amendment motion.

The Board engaged in further discussion regarding the proposed amendment, including how it could affect the pending litigation against the Board.

The question was called and the motion to amend failed to pass on the following roll call vote:

Members Voting Aye: Day, Thompson

Members Voting Nay: Farrell, Grapentine, Neitzke, Wieske, Ziegelbauer

Members Abstaining: Heifetz, Rolston

Mr. Neitzke provided his reasoning for his vote, stating he voted no on the motion because of uncertainty in relation to court rulings, and that he did not want to create legal liability for the Board.

Ms. Rolston stated that legal advice from the DOJ is required before reconsidering the gender identity benefit exclusion. She also stated that she appreciated the sentiment of the amendment.

The question was called on Ms. Rolston's motion, which passed unanimously on a voice vote.

Medicare Advantage – Request for Proposals

Ms. Carabell and Ms. Pray referred the Board to the memo, Medicare Advantage – Request for Proposals (Ref. GIB | 5.24.17 | 3E). ETF staff requested approval to develop and release an RFP for plan year 2019 with the intention to contract with one or more vendors that meet the following previously communicated goals:

- Expand Medicare offerings that have lower monthly premium costs
- Deliver high quality, high value services
- Offer excellent benefit packages
- Provide participant choice

Currently, national carriers dominate the group Medicare Advantage market in Wisconsin. Ms. Carabell noted that numerous regional carriers offer individual Medicare Advantage plans, and they may be interested in pursuing CMS approval to offer a group Medicare Advantage product to state employees.

ETF will recommend the optimal vendor mix to achieve the desired goals. Ms. Pray noted this could include awarding a contract to a vendor with a nationwide network as well as regional vendor(s) with more limited provider networks.

Later in 2017, ETF plans to survey Medicare-eligible members about benefit design and desired features. Based on RFP and survey responses, ETF will then evaluate the following:

- Whether the current IYC Uniform Benefits package is appropriate for the Medicare population and if there should be additional or different benefit offerings;
- Determine the optimal number of benefit choices for members;
- Find out what other benefit designs Medicare members value and the likely premium; and

- The effect of offering a pharmacy benefit combined with the medical benefit specifically for Medicare Advantage.

ETF will present the Board with a comprehensive proposal for Medicare options for 2019 and beyond after the RFP results have been evaluated. ETF plans to issue the RFP in the fall of 2017 and bring vendor proposals to the Board in February 2018.

MOTION: Mr. Day moved to approve the development and issuance of a Request for Proposals (RFP) to select an administrator(s) for Medicare Advantage options to be effective for the 2019 plan year. Mr. Neitzke seconded the motion, which passed unanimously on a voice vote.

DENTAL INSURANCE

Uniform Dental Benefit Changes

Ms. Schomber referred the Board to the memo, Uniform Dental Benefit Changes (Ref. GIB | 5.24.17 | 4A). Ms. Schomber provided a brief overview of proposed benefit changes for plan year 2018, which included:

- Reduced bitewing x-ray coverage
- Enhanced sealant benefit
- Adding medicament coverage
- Adding Evidence-Based Integrated Care Plan (EBICP) benefits

The changes aligned with industry standards and best practice recommendations from the Wisconsin Dental Association (WDA) and the American Dental Association (ADA).

The estimated annual claims cost increase for all recommended changes was approximately $362,000, or 0.67% of total claims costs. These changes were not expected to effect overall premiums for 2018.

ETF committed to tracking and evaluating the costs and outcomes of these programs and providing results to the Board in future years. Mr. Grapentine requested the ability to review dental costs on an annual basis, and Ms. Ellinger confirmed that updates would be provided at subsequent May Board meetings.

MOTION: Ms. Thompson moved to approve the following benefit changes for the Uniform Dental Benefit Plan, effective January 1, 2018:

- ***Reduce bitewing x-ray coverage***
- ***Enhance sealant benefit***
- ***Add medicament coverage***
- ***Add Evidence-Based Integrated Care Plan (EPICP) benefits***

Mr. Day seconded the motion, which passed on a voice vote with Mr. Wieske abstaining.

DISABILITY PROGRAM UPDATE

Acceptance of State and Local Income Continuation Insurance and Actuarial Valuations

Mr. Correia of Milliman, Inc., presented an actuarial valuation overview of the State and Local Income Continuation Insurance (ICI) plans (Ref. GIB | 5.24.17 | 5A) as of December 31, 2016.

State ICI Plan

At its May 19, 2015, meeting, the Board approved a motion to increase State ICI premiums 20% each year from 2016 through 2020. ETF recommended the Board's 2015 premium rate decision remain in effect. Maintaining this decision did not require a new vote of the Board.

On February 8, 2017, the Board approved recommended State ICI program design changes to address the deficit position of the program. ETF indicated that staff is developing the necessary statute changes to institute the design changes effective January 1, 2020. Once the statutory changes are in place, a new premium rate schedule will be developed for the 2020 plan year and brought to the appropriate Board for approval.

> ***MOTION: Mr. Grapentine moved to approve the State ICI Actuarial Review as of December 31, 2016. Mr. Wieske seconded the motion, which passed unanimously on a voice vote.***

Local ICI Plan

According to Milliman, the Local ICI plan had a surplus as of December 31, 2016. ETF therefore recommended a continuation of the premium holiday for the Local ICI plan.

> ***MOTION: Ms. Thompson moved to approve the Local ICI Actuarial Review as of December 31, 2016. Mr. Neitzke seconded the motion, which passed unanimously on a voice vote.***

Acceptance of Long-Term Care Disability Actuarial Valuation

Mr. Correia presented an actuarial valuation overview of the Long-Term Disability Insurance (LTDI) plan (Ref. GIB | 5.24.17| 5B) as of December 31, 2016. The overview included a discussion of funding analyses.

In 2016, the Employee Trust Funds Board approved closing the LTDI program to new open claims effective January 1, 2018. According to Milliman's financial projections, which were consistent with LTDI valuation assumptions, the plan would remain in a deficit position when it closes to new claims in 2018 if contributions are not made beyond 2017.

Mr. Correia provided an overview of two contribution scenarios. ETF staff recommended Scenario 1, which is a reduced contribution rate of 0.06% effective January 2018 and no additional contributions required for 2019 and beyond.

MOTION: Mr. Wieske moved to approve the Long-Term Disability Insurance Actuarial Review as of December 31, 2016, and the implementation of Scenario 1. Mr. Day seconded the motion, which passed unanimously on a voice vote.

Acceptance of Local Income Continuation Insurance Plan Language Revisions

Ms. Roemer referred the Board to the memo, Acceptance of Local Income Continuation Insurance (ICI) Plan Language Revisions (Ref. GIB | 5.24.17| 5C). Clearinghouse Rule CR 16-034 became effective on May 1, 2017. This rule modified the eligibility requirements in Administrative Rule ETF 50.10 for ICI for employees of local units of government, to make the requirements consistent with changes made in 2015 Wisconsin Act 55 for state employees. Ms. Roemer noted these changes better aligned the state and local ICI programs.

MOTION: Mr. Neitzke moved to approve revisions to the Local ICI plan effective May 1, 2017. Ms. Thompson seconded the motion, which passed unanimously on a voice vote.

OPTIONAL PLANS

Optional Insurance Program Annual Update

Mr. Farrell referred the Board to the memo, Optional Insurance Program Annual Update (Ref. GIB | 5.24.17 | 7A). No presentation was made regarding this informational memo in the interest of time.

Optional Insurance Program Proposals

Ms. Schomber referred the Board to the memo, Optional Insurance Program Proposals (Ref. GIB | 5.24.17 | 7B). She provided an overview of plan proposals received by ETF for plan year 2018 and ETF's recommendation for minimal plan changes due to the recently initiated optional insurance program alignment initiative.

Existing Plan Proposals

ETF received proposals for rate and benefit changes from EPIC for the Dental Wisconsin and Benefits+ plans. These proposals were still under review. ETF staff will present the EPIC proposals at the August 2017 Board meeting.

ETF received a proposal for benefit enhancements to the current Vision Service Plan (VSP) with no rate changes. The proposed enhancements for 2018 were:

- Premium rate guarantee for 3 years, through 2020
- Increase contact lens and frame allowances from $130 to $150
- Add full coverage for UV protection coating

- Decrease the contact lens exam copay from $60 to $40
- Add Primary EyeCare Supplemental Coverage, which includes additional benefits at a $20 copay
- Treatment for eye pain or infection
- Testing for sudden vision changes
- Cataract monitoring exams
- Retinal screenings

Anthem DentalBlue and Zurich North America proposed no rate or benefit changes for plan year 2018.

New Proposals Review

Nationwide submitted a Voluntary Pet Insurance plan proposal for consideration. Staff indicated that pet insurance is considered Property and Casualty (P&C) insurance, and is different from the Accident and Health insurance plans offered by the Optional Insurance Program. Nationwide would not provide data regarding loss ratios or agree to 75% minimum loss ratio required to participate in the program. ETF staff recommended not approving Nationwide's proposal.

ETF received three proposals from Securian: Accidental Death and Dismemberment (AD&D), Critical Illness, and Hospital Indemnity. Based on the progress of the alignment initiative, ETF recommended not approving Securian's proposals for 2018, but instead considering them for 2019.

SeniorCare submitted a proposal for Long Term Care insurance (LTC) on behalf of LifeCare and National Guardian Life (NGL). SeniorCare was unable to provide the required employer references in accordance with the Board-approved Standards for Proposing and Offering Long Term Care Insurance to State Employees (Standards).

Ms. Schomber noted that ETF previously experienced prolonged difficult contract negotiations with SeniorCare regarding a previously proposed LTC plan from TransAmerica. Based on past experiences and the lack of adequate employer references, ETF recommended not approving SeniorCare's proposal for LTC insurance for 2018.

Optional Insurance Program Alignment Initiative

Ms. Schomber provided an overview of the current Optional Insurance Program structure. Nine plans are currently offered, and most duplicate benefits already offered under Uniform Benefits or other plans within the Optional Insurance Program.

ETF has initiated a review of the Optional Insurance Program in order to address concerns raised by payroll centers in 2016 regarding the complexity of the supplemental benefit options. The goals of this initiative:

- Limit plan offerings based on overall value to members
- Reduce benefit overlap

- Reduce member confusion
- Standardize available benefits
- Maximize administrative efficiency

Staff will bring analysis and a recommendation to the Board at the November 2017 meeting.

MOTION: Mr. Ziegelbauer moved to approve the following Optional Insurance Program offerings, effective January 1, 2018:

- ***Pend discussion of EPIC plan changes and rates until August 2017 meeting***
- ***Approve benefit changes for Vision Service Plan (VSP)***
- ***Approve continued participation with no changes***
  - ***Anthem DentalBlue***
  - ***Zurich North America***
- ***Deny proposals for newly proposed plans***
  - ***Nationwide Mutual***
  - ***Securian Life Insurance Company***
  - ***SeniorCare***

Ms. Thompson seconded the motion, which passed unanimously on a voice vote.

WISCONSIN PUBLIC RECORDS TRAINING

Mr. Nispel referred the Board to the presentation, Wisconsin Public Records Law Basics for State Employees (Ref. GIB | 5.24.17 | 8). This Board-focused training presentation included an overview of public records responsibilities for Board members, as well as an overview of what does and does not constitute a public record.

WELLNESS AND DISEASE MANAGEMENT

StayWell Implementation & General Overview

Ms. Bradley referred the Board to the memo, 2016 Well Wisconsin Program Participation (Ref. GIB | 5.24.17 | 9A). Ms. Bradley provided an overview of participation in the Well Wisconsin Program and an update on the transition to StayWell, the third party administrator for the wellness program.

Participation rates for the Well Wisconsin Program have remained consistent over the three-year program history. The overall participation rate increased from 13.5% in 2016 to 15.5% in 2016. Ms. Bradley noted this increase is likely due to the decrease in eligible participants resulting from the 2015 ruling by the U.S. Equal Employment Opportunity Commission that restricted the participation of adult dependents in wellness programs. The implementation of this federal guideline reduced the total number of members eligible to participate from 204,610 in 2015 to 185,089 in 2016.

There was a significant increase in employer on-site health screenings from 187 in 2015 to 227 in 2016. Ms. Bradley noted StayWell is on target to provide a similar number of on-site health screenings in 2017, if not more.

Future Disease Management Capabilities

Ms. Rathjen and Dr. Gregg with StayWell presented an overview of the 2017 launch of StayWell services and future program components, including disease management capabilities.

StayWell's contract began in August 2016, with implementation and development through December 2016. StayWell's first on-site screening event was held on February 1, 2017. There were 228 events scheduled to date with the potential to screen over 19,000 participants. For plan year 2017, StayWell was targeting is a total of 36,000 to 50,000 members completing a health assessment and a health screening.

The Wellness Portal launched on January 5, 2017. The portal had 20,000 users to date, with approximately 1,000 new users joining each week. Ms. Rathjen provided a brief overview of the Wellness Portal. Through the portal, members can access the online health assessment and additional tools and resources, including self-directed coaching. Employer engagement toolkits are also available online.

StayWell's overall program goals included increasing awareness and engagement in the Well Wisconsin Program, integrating with and supporting state and local employers' wellness indicatives, and implementing on-site health behavior change programs.

Additional goals for 2017 included launching the Mindfulness Collection and piloting the Ignite Group Coaching Program. The Mindfulness Collection promotes resiliency and stress management. Offerings include three digital workshops on the benefits of mindfulness and stress management and a 21-day meditation experience. The Ignite Group Coaching Program is a 12-week coaching program that targets those with metabolic syndrome or a body mass index (BMI) of 30 or more.

For 2018, StayWell noted it is exploring points-based incentive options and the addition of engagement activities. Possible additional engagement programs include the million steps challenge, destination challenges and partner programs.

Dr. Gregg provided an overview of disease management (DM) services offered by StayWell, including information on identifying participants with a disease management condition and possible interventions. Dr. Gregg also answered questions from the Board regarding future capabilities.

OPERATIONAL UPDATES

Mr. Farrell referred the Board to the Operational Updates in the Board Packets (Ref. GIB | 5.24.17 | 10) and offered that staff were available if the Board had questions.

ASSESSMENT AND DELIBERATION ON PROPOSALS FOR THE STATE OF WISCONSIN PHARMACY BENEFIT PROGRAM (ETG0013)

The chair announced the Board would convene in closed session pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (e) for the purpose of deliberating the potential investment of public funds and to review proposals for services for which competitive and bargaining reasons required a closed session. Staff from ETF, Office of the Commissioner of Insurance (OCI), the Department of Administration (DOA), and actuarial advisors from Segal Consulting (Segal) were invited to remain during the closed session.

> ***MOTION: Mr. Neitzke moved to convene in closed session, pursuant to the exemptions contained in Wis. Stats. § 19.85 (1) (e) to deliberate or negotiate the investing of public funds or to conduct other specified business, whenever competitive or bargaining reasons require a closed session. Mr. Wieske seconded the motion, which passed on the following roll call vote:***
>
> ***Members Voting Aye: Day, Farrell, Grapentine, Heifetz, Neitzke, Rolston, Thompson, Wieske, Ziegelbauer***

The Board convened in closed session at 12:05 p.m.

The Board took a break from 12:05 p.m. until 12:30 p.m.

The Board reconvened in open session at 3:43 p.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Mr. Farrell announced the Board met in closed session to assess and deliberate proposals for the State of Wisconsin Health Pharmacy Benefit Program.

> ***MOTION: Mr. Neitzke moved to grant authority to the Secretary of ETF to issue a letter of intent to award the contract for Third Party Administrative Services for the State of Wisconsin Pharmacy Benefit Programs (RFP#ETG0013) to Navitus Health Solutions, LLC for the period of July 1, 2017, through December 31, 2018, with the potential for three, two-year extensions, subject to successful contract and cost reduction negotiations.***
>
> ***In addition, if the contract negotiations fail or extend beyond a reasonable period of time, the Secretary has the authority to issue an intent to award the contract for the State of Wisconsin Benefit Programs to Optum Rx with the same contingencies.***

Mr. Ziegelbauer seconded the motion, which passed on the following roll call vote:

Members Voting Aye: Day, Farrell, Grapentine, Heifetz, Neitzke, Rolston, Thompson, Wieske, Ziegelbauer

ADJOURNMENT

MOTION: Mr. Neitzke moved to adjourn the meeting. Ms. Thompson seconded the motion, which passed unanimously on a voice vote.

The meeting adjourned at 3:48 p.m.

Date Approved: _____

Signed: _____
Herschel Day, Secretary
Group Insurance Board

Exhibit W

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs,

v. Case No. 17-CV-264

STATE OF WISCONSIN DEPARTMENT
OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

STATE DEFENDANTS' RESPONSES AND OBJECTIONS TO PLAINTIFFS' FIRST SET OF REQUESTS FOR ADMISSION, INTERROGATORIES, AND REQUESTS FOR PRODUCTION OF DOCUMENTS AND THINGS

Pursuant to Federal Rules of Civil Procedure 26, 33, 34, and 36, Defendants State of Wisconsin Department of Employee Trust Funds, State of Wisconsin Group Insurance Board, Robert J. Conlin, Secretary of the Department of Employee Trust Funds (ETF), Board of Regents of the University of Wisconsin System, Raymond W. Cross, President of the University of Wisconsin System, Rebecca M. Blank, Chancellor of the University of Wisconsin-Madison, University of Wisconsin School of Medicine and Public Health, and Robert N. Golden, M.D., Dean of the University of Wisconsin School of Medicine and Public Health (the "State Defendants"), by their counsel, hereby object and respond to Plaintiffs First Set of Requests for Admission, Interrogatories and Requests for Production of Documents and Things.

GENERAL OBJECTIONS

The State Defendants assert the following objections as to each of the Plaintiffs' First Set of Requests for Admission, Interrogatories and Requests for Production of Documents and Things to State Defendants ("Plaintiffs' First Requests"):

1. The State Defendants object to the Plaintiffs' First Requests to the extent that they purport to impose burdens other than or beyond those imposed by Rules 26, 33, 34 and 36 of the Federal Rules of Civil Procedure.

2. The State Defendants object to Instruction No. 1, to the extent that it includes individual members of the Board of Regents of the University of Wisconsin System and individual members of the Group Insurance Board on the grounds that it requires these State Defendants to seek discovery from individuals that are not defendants in this case that is not in the possession, custody, or control of the State Defendants.

3. The State Defendants further object to Instruction No. 1 as it relates to requests for electronically produced or stored documents on the grounds that it is overbroad, unduly burdensome, and disproportionate to the needs of the case. Notwithstanding and without waiving these objections, electronically produced or stored documents for the following State Defendant custodians were searched using the following search terms:

Custodian	**Search Terms**
ETF custodians	
Bob Conlin (ETF Secretary) John Voelker (ETF Deputy Secretary) Pam Henning (ETF Assistant Deputy Secretary) Liz Doss-Anderson (Ombudsperson) James Kates (Ombudsperson) Mary Richardson (Ombudsperson) Lisa Ellinger (Director of the Office of Strategic Health Policy) Eileen Mallow (Deputy Director of the Office of Strategic Health Policy) Arlene Larson (Manager of Federal Health Programs & Policy) Tara Pray (Member Engagement and Communication Leadworker) Sara Brockman (GIB liaison) Joan Steele (Health Policy Advisor) Shayna Schomber (formerly Gobel) (Manager of Self-Insured Health, Dental, and Supplemental Benefits) Renee Walk (Strategic Health Policy Advisor) Jeff Bogardus (Manager of Pharmacy Benefits) Steve Hurley (Director of the Office of Policy, Privacy and Compliance) Mary Alice McGreevy (Privacy Officer) Lucas Strelow (Policy Advisor) Laura Patterson (Policy Advisor) Tarna Hunter (Director of Government Relations)	transgender* "sex discrimination" "sexual transformation*" "gender identity" "gender transition*" "gender identity disorder" "gender dysphoria" transsexual* "gender transition*" "gender reassignment*" "gender confirmation*" "sex hormone*" "hormone therap*" Segal "reinstatement of the benefit exclusion" Boyden Andrews "breast augmentation*" "augmentation mammoplasty" "vaginoplasty" penectomy bilateral orchiectomy clitoroplasty urethroplasty labiaplasty perineoplasty subcutaneous mastectomy hysterectomy ovariectomy metoidioplasty phalloplasty vaginectomy scrotoplasty "arbitrary discrimination"

Other custodians (same search terms)	
Rebecca Blank (Chancellor, University of Wisconsin – Madison)	
Robert Golden (Dean, School of Medicine and Public Health)	
Raymond Cross (President, University of Wisconsin System)	

Responsive non-privileged emails that resulted from this search will be provided in response to the Plaintiffs' Requests for the Production of Documents. Responsive emails were also collected from the relevant email accounts of GIB members who served at the time the coverage exclusion at issue was under consideration.

4. The State Defendants object to second paragraph in Instruction No. 5 on the grounds that it is overbroad, unduly burdensome, and disproportionate to the needs of the case. This instruction has a multiplier effect of making a separate interrogatory with discrete subparts for each document produced, creating an impermissible attempt to require answers to interrogatories in excess of the number permitted by Fed. R. Civ. P. 33.

5. The State Defendants object to Instruction No. 11 to the extent it applies to responsive documents that are privileged in their entirety and protected from disclosure. These documents will be included on a compliant privilege log, but will not be otherwise produced because they are privileged and protected from disclosure.

6. The State Defendants object to Instruction No. 13 because it requests that they provide information that is not within their personal knowledge. Under Fed. R. Civ. P. 33, answers to interrogatories must be made "under oath," which compels signatories to only provide responses they know to be truthful.

7. The State Defendants object to Instruction Nos. 16 and 17 as applied to the Requests for Admissions on the grounds that such requests would be vague and ambiguous under these instructions, and may require different responses or objections for each verb tense. Requests for Admissions will be responded to as written with no change in verb tense.

8. The State Defendants object to the Plaintiffs' First Requests to the extent they seek to require the State Defendants to disclose information prepared in anticipation of litigation or protected from disclosure by the attorney-client privilege, work-product doctrine, or any other applicable privileges on the ground that such discovery is impermissible under Rule 26(b) of the Federal Rules of Civil Procedure. The State Defendants do not waive, and expressly reserve, the protection for materials prepared in anticipation of litigation, the attorney-client privilege, the work-product doctrine, and every other privilege and doctrine with respect to each and every document protected by such privilege or doctrine. Inadvertent production of any such protected information shall not constitute a waiver of

any privilege or protection or of any other ground for objection to discovery with respect to the information contained therein. Nor shall such inadvertent production waive the right of the State Defendants to object to the use of any such document or the information contained therein in this action or during any subsequent proceeding. Upon notification that such disclosure was inadvertent, the information and any copies thereof shall be returned immediately.

9. The State Defendants object to any discovery directed at Defendant University of Wisconsin School of Medicine and Public Health (SMPH). In Plaintiffs' response to the State Defendants' motion to dismiss, they concede that "SMPH may be dismissed as a defendant." (Dkt. 39:20 (n.11).)

SPECIFIC OBJECTIONS AND RESPONSES TO REQUESTS FOR ADMISSION

The State Defendants hereby incorporate the General Objections described above into each response below, as if fully restated therein.

REQUEST FOR ADMISSION NO. 1: Admit that the Defendant, Board of Regents, employs Plaintiff, Alina Boyden.

RESPONSE TO REQUEST FOR ADMISSION NO. 1: Admit.

REQUEST FOR ADMISSION NO. 2: Admit that the Board of Regents is responsible for paying Alina Boyden's salary and providing her with the benefits of employment provided to her as a state employee, including health insurance coverage.

RESPONSE TO REQUEST FOR ADMISSION NO. 2: The Board of Regents objects that the phrase "responsible for . . . providing her with the benefits of employment provided to her as a state employee" is vague and ambiguous. Subject to and without waiving that objection, the Board of Regents responds as follows:

Admit that the Board of Regents is responsible for paying Alina Boyden's salary. Deny the remainder of Request for Admission No. 2.

REQUEST FOR ADMISSION NO. 3: Admit that Defendant, Board of Regents, employs Plaintiff, Shannon Andrews.

RESPONSE TO REQUEST FOR ADMISSION NO. 3: Admit.

REQUEST FOR ADMISSION NO. 4: Admit that the Board of Regents is responsible for paying Shannon Andrews' salary and providing her with the benefits of employment provided to her as a state employee, including health insurance coverage.

RESPONSE TO REQUEST FOR ADMISSION NO. 4: The Board of Regents objects that the phrase "responsible for . . . providing her with the benefits of employment provided to her as a state employee" is vague and ambiguous. Subject to and without waiving that objection, the Board of Regents responds as follows:

Admit that the Board of Regents is responsible for paying Shannon Andrews' salary. Deny the remainder of Request for Admission No. 4.

REQUEST FOR ADMISSION NO. 5: Admit that the Board of Regents is responsible under Wisconsin law to offer GIB-approved health insurance plans to their eligible employees, including Boyden and Andrews.

RESPONSE TO REQUEST FOR ADMISSION NO. 5: The Board of Regents objects that the phrase "responsible under Wisconsin law to offer GIB-approved health insurance plans to their eligible employees" is vague and ambiguous. Subject to and without waiving that objection, the Board of Regents responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 6: Admit that Raymond W. Cross ("Cross"), is responsible under Wisconsin law to offer GIB-approved health insurance plans to University employees, including Boyden and Andrews.

RESPONSE TO REQUEST FOR ADMISSION NO. 6: Raymond W. Cross objects that the phrase "responsible under Wisconsin law to offer GIB-approved health insurance plans to University employees" is vague and ambiguous. Subject to and without waiving that objection, Raymond W. Cross responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 7: Admit that Rebecca M. Blank ("Blank"), is responsible under Wisconsin law to offer GIB-approved health insurance plans to University of Wisconsin employees, including Boyden and Andrews.

RESPONSE TO REQUEST FOR ADMISSION NO. 7: Rebecca M. Blank objects that the phrase "responsible under Wisconsin law to offer GIB-approved health insurance plans to University of Wisconsin employees" is

vague and ambiguous. Subject to and without waiving that objection, Rebecca M. Blank responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 8: Admit that the School of Medicine is responsible under Wisconsin law to offer GIB-approved health insurance plans to their employees, including Andrews.

RESPONSE TO REQUEST FOR ADMISSION NO. 8: The Board of Regents objects that the School of Medicine is not a separate, suable legal entity under state law. The Board of Regents further objects that the phrase "responsible under Wisconsin law to offer GIB-approved health insurance plans to their employees" is vague and ambiguous. Subject to and without waiving those objections, the Board of Regents responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 9: Admit that Robert N. Golden, M.D. ("Golden"), is responsible under Wisconsin law to offer GIB-approved health insurance plans to their employees, including Andrews.

RESPONSE TO REQUEST FOR ADMISSION NO. 9: Robert N. Golden objects that the phrase "responsible under Wisconsin law to offer GIB-approved health insurance plans to their employees" is vague and ambiguous. Subject to and without waiving that objection, Robert N. Golden responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 10: Admit that the University is engaged in an industry affecting commerce and has more than fifteen (15) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year.

RESPONSE TO REQUEST FOR ADMISSION NO. 10: Deny.

REQUEST FOR ADMISSION NO. 11: Admit that the School of Medicine is engaged in an industry affecting commerce and has more than fifteen (15) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year.

RESPONSE TO REQUEST FOR ADMISSION NO. 11: Deny.

REQUEST FOR ADMISSION NO. 12: Admit that GIB is part of ETF.

RESPONSE TO REQUEST FOR ADMISSION NO. 12: GIB and ETF object that the phrase "part of ETF" is vague and ambiguous. Subject to and without waiving that objection, GIB and ETF respond as follows:

Deny.

REQUEST FOR ADMISSION NO. 13: Admit that ETF is "a person engaged in an industry affecting commerce who has fifteen (15) or more employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year" or is an "agent of such a person."

RESPONSE TO REQUEST FOR ADMISSION NO. 13: Admit.

REQUEST FOR ADMISSION NO. 14: Admit that GIB is "a person engaged in an industry affecting commerce who has fifteen (15) or more employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year" or is an "agent of such a person."

RESPONSE TO REQUEST FOR ADMISSION NO. 14: Deny.

REQUEST FOR ADMISSION NO. 15: Admit that ETF staff concluded in or about June, 2016 that ETF was a "covered entity" under the Affordable Care Act (ACA), with respect to the self-insured health insurance plans it offers state employees.

RESPONSE TO REQUEST FOR ADMISSION NO. 15: Admit.

REQUEST FOR ADMISSION NO. 16: Admit that ETF staff concluded that ETF could be held liable under the ACA for denying health insurance coverage for gender transition.

RESPONSE TO REQUEST FOR ADMISSION NO. 16: Deny.

REQUEST FOR ADMISSION NO. 17: Admit that ETF receives federal funds.

RESPONSE TO REQUEST FOR ADMISSION NO. 17: Admit.

REQUEST FOR ADMISSION NO. 18: Admit that GIB sets the guidelines for eligibility and specifies the contractual terms for group health insurance plans for state employees.

RESPONSE TO REQUEST FOR ADMISSION NO. 18: GIB objects that the phrase "sets the guidelines for eligibility and specifies the contractual terms" is vague and ambiguous. Subject to and without waiving that object, GIB responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 19: Admit that GIB establishes the health insurance coverage benefits available for Alina Boyden and Shannon Andrews.

RESPONSE TO REQUEST FOR ADMISSION NO. 19: GIB objects that the phrase "establishes the health insurance coverage benefits" is vague and ambiguous. Subject to and without waiving this objection, GIB responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 20: Admit that ETF and Robert J. Conlin ("Conlin"), as Secretary of ETF, execute the decisions of GIB with respect to health insurance coverage.

RESPONSE TO REQUEST FOR ADMISSION NO. 20: ETF and Secretary Conlin object that the phrase "execute the decisions of GIB with respect to health insurance coverage" is vague and ambiguous. Subject to and without waiving this objection, ETF and Secretary Conlin respond as follows:

Deny.

REQUEST FOR ADMISSION NO. 21: Admit that Defendant Conlin, as Secretary of ETF, promulgates, with the approval of GIB, all rules required for the administration of group health insurance plans for state employees, including Boyden and Andrews.

RESPONSE TO REQUEST FOR ADMISSION NO. 21: Deny.

REQUEST FOR ADMISSION NO. 22: Admit that Defendant Conlin, as Secretary of ETF, provides executive leadership for the policy development and administration of group health insurance for state employees.

RESPONSE TO REQUEST FOR ADMISSION NO. 22: Secretary Conlin objects that the phrase "provides executive leadership for the policy development and administration of group health insurance for state

employees" is vague and ambiguous. Subject to and without waiving this objection, Secretary Conlin responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 23: Admit that Defendant Conlin, as Secretary of ETF, develops and recommends policy to the GIB relating to changes in the design of employee benefit plans.

RESPONSE TO REQUEST FOR ADMISSION NO. 23: Secretary Conlin objects that the phrase "develops and recommends policy to the GIB relating to changes in the design of employee benefit plans" is vague and ambiguous. Subject to and without waiving this objection, Secretary Conlin responds as follows:

Deny.

REQUEST FOR ADMISSION NO. 24: Admit that ETF creates and distributes a document describing Uniform Benefits for State Employees, which includes descriptions of health benefits and exclusions from those benefits.

RESPONSE TO REQUEST FOR ADMISSION NO. 24: Admit.

REQUEST FOR ADMISSION NO. 25: Admit that Defendant Conlin, as Secretary of ETF, enters into contracts with group health insurance providers, such as Dean and WPS, that specify the health benefits and exclusions to be covered under plans offered to state employees.

RESPONSE TO REQUEST FOR ADMISSION NO. 25: Deny.

REQUEST FOR ADMISSION NO. 26: Admit that Defendant Conlin issued a memorandum on January 30, 2017, in which he concluded, in consultation with the GIB chair, that the criteria for reinstating the exclusion of gender confirmation treatment had been met and stated that "ETF issued a 2017 health plan contract amendment to all participating health plans to reinstate the benefit exclusion, effective February 1, 2017."

RESPONSE TO REQUEST FOR ADMISSION NO. 26: Admit that Defendant Conlin issued a memorandum on January 30, 2017 that contains the quoted language; otherwise deny.

REQUEST FOR ADMISSION NO. 27: Admit that only transgender persons seek "surgery and sex hormones associated with gender reassignment."

RESPONSE TO REQUEST FOR ADMISSION NO. 27: The State Defendants lack the information needed to admit or deny this Request for Admission.

REQUEST FOR ADMISSION NO. 28: Admit that the exclusion of health insurance coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment" adversely affects only transgender persons, since only they seek such procedures, services and supplies for "gender reassignment."

RESPONSE TO REQUEST FOR ADMISSION NO. 28: The State Defendants lack the information needed to admit or deny this Request for Admission.

REQUEST FOR ADMISSION NO. 29: Admit that the document titled "The Secretary's Role" (revised: April 2012), attached as **Exhibit A**, is a true and correct copy of an authentic document created by ETF.

RESPONSE TO REQUEST FOR ADMISSION NO. 29: Admit.

REQUEST FOR ADMISSION NO. 30: Admit that the document titled "Correspondence Memorandum" (dated June 22, 2016) (includes one internal Attachment: A), attached as **Exhibit B**, is a true and correct copy of an authentic document created by ETF.

RESPONSE TO REQUEST FOR ADMISSION NO. 30: Admit.

REQUEST FOR ADMISSION NO. 31: Admit that the document titled "Correspondence Memorandum" (dated August 12, 2016) (includes two (2) internal Attachments: A and B), attached as **Exhibit C**, is a true and correct copy of an authentic document created by ETF.

RESPONSE TO REQUEST FOR ADMISSION NO. 31: Admit.

REQUEST FOR ADMISSION NO. 32: Admit that the document titled "Correspondence Memorandum" (dated January 30, 2017) (includes two (2) internal Attachments: A and B), attached as **Exhibit D**, is a true and correct copy of an authentic document created by ETF.

RESPONSE TO REQUEST FOR ADMISSION NO. 32: Admit.

SPECIFIC OBJECTIONS AND RESPONSES TO INTERROGATORIES

The State Defendants hereby incorporate the General Objections described above into each response below, as if fully restated therein.

INTERROGATORY NO. 1: Identify and describe all reasons why the State of Wisconsin provides insurance coverage for state employees.

RESPONSE TO INTERROGATORY NO. 1: The State Defendants object that the phrase "provides insurance coverage for state employees" is vague and ambiguous. The State Defendants further object to the extent that this Interrogatory seeks information from non-parties to this litigation. Subject to and without waiving that objection, the State Defendants respond as follows:

Wisconsin Stat. § 40.01(1) provides that "a 'public employee trust fund' is created to aid public employees in protecting themselves and their

beneficiaries against the financial hardships of old age, disability, death, illness and accident, thereby promoting economy and efficiency in public service by facilitating the attraction and retention of competent employees, by enhancing employee morale, by providing for the orderly and humane departure from service of employees no longer able to perform their duties effectively, by establishing equitable benefit standards throughout public employment, by achieving administrative expense savings and by facilitating transfer of personnel between public employers."

INTERROGATORY NO. 2: Identify and describe all reasons why the State of Wisconsin has the Gender Confirmation Treatment Exclusion, including, but not limited to, each and every state or governmental interest that you contend is advanced by the Gender Confirmation Treatment Exclusion, and a detailed explanation for why you contend that the Exclusion furthers that state interest, and all facts in support of your explanation.

RESPONSE TO INTERROGATORY NO. 2: Defendants ETF, Robert J. Conlin, the Board of Regents, Raymond W. Cross, Rebecca M. Blank, the School of Medicine, and Robert N. Golden, lack knowledge regarding the information sought by this Interrogatory. GIB objects that this Interrogatory is premature given that discovery is still ongoing in this matter and because expert disclosure deadlines have not yet arrived. GIB expects that the information requested by this Interrogatory will be addressed by expert testimony and thus it incorporates into this Response any future relevant expert testimony. Subject to and without waiving these objections, GIB responds as follows:

The coverage exclusion contained in the Uniform Benefits section IV.A.1.c. furthers the state interests contained in Wis. Stat. § 40.01(1), among others.

INTERROGATORY NO. 3: To the extent that any state interest that you identified in response to the preceding interrogatory is related to protection of the State of Wisconsin and/or its taxpayers from adverse economic or financial consequences, describe with particularity how the State and/or its taxpayers would suffer adverse economic consequences if transgender state employees were provided health insurance coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment."

RESPONSE TO INTERROGATORY NO. 3: See the response to Interrogatory No. 2.

INTERROGATORY NO. 4: Identify and describe all the responsibilities of ETF and the ETF Secretary with respect to GIB, including, but not limited to, its responsibilities related to budgeting, program coordination and related management functions.

RESPONSE TO INTERROGATORY NO. 4: ETF and Secretary Conlin object that the phrase "responsibilities related to budgeting, program coordination and related management functions" is vague and ambiguous. Subject to and without waiving that objection, ETF and Secretary Conlin respond as follows:

The statutory authority and responsibilities of ETF and its Secretary with respect to GIB are set forth in Wis. Stat. ch. 40, including in Wis. Stat. §§ 40.03(1)–(2), (6) as well as in Wis. Stat. §§ 15.03, 15.04, and 15.165(2). In particular, ETF staff administer the programs under the purview of the GIB.

This includes analysis of benefit and contract changes, vendor contract administration, and management of day-to-day program operations. ETF staff also facilitate GIB meetings.

INTERROGATORY NO. 5: Identify and describe all the responsibilities of ETF and the ETF Secretary with respect to health insurance coverage for state employees.

RESPONSE TO INTERROGATORY NO. 5: ETF and Secretary Conlin object that the phrase "all the responsibilities of ETF and the ETF Secretary with respect to health insurance coverage for state employees" is vague and ambiguous. Subject to and without waiving that objection, ETF and Secretary Conlin respond as follows:

The statutory authority and responsibilities of ETF and its Secretary with respect to health insurance coverage for state employees are set forth in Wis. Stat. ch. 40, including in Wis. Stat. §§ 40.02(25)(b), 40.03(1)–(2), and 40.51, as well as in Wis. Admin. Code § ETF 10.20 and Wis. Admin. Code ETF ch. 40. More detail on the Group Health Insurance Program can be found in an ETF publication available at http://etf.wi.gov/publications/et8902.pdf.

INTERROGATORY NO. 6: For the period from January 2012 to the present, identify the number of state employees provided individual health insurance coverage annually and the number of state employees provided family health insurance coverage annually.

RESPONSE TO INTERROGATORY NO. 6: To the best of ETF's knowledge, the yearly statistics that follow reflect subscriber or contract counts (including Graduate Assistants) and thus depict the number of state

employees provided individual and family health insurance coverage annually:

- 2017 individual: 26,463; family: 42,767
- 2016 individual: 26,168; family: 43,054
- 2015 individual: 26,430; family: 44,339
- 2014 individual: 25,981; family: 44,441
- 2013 individual: 25,450; family: 44,378
- 2012 individual: 25,325; family: 44,830

INTERROGATORY NO. 7: For the period from January 2012 to the present, identify the total amount of state funds spent on health insurance coverage for state employees annually and specify the figures, calculations or statistics the State maintains regarding those expenditures.

RESPONSE TO INTERROGATORY NO. 7: ETF objects that the phrases "total amount of state funds" and "specify the figures, calculations or statistics the State maintains regarding those expenditures" are vague and ambiguous. Subject to and without waiving that objection, ETF responds as follows:

Year	Employer (estimate)	Employee (estimate)	Total
2012	$905,265,208.30	$127,941,944.50	$1,033,207,152.80
2013	$946,162,383.20	$134,209,071.00	$1,080,371,454.20
2014	$987,394,303.90	$139,909,389.50	$1,127,303,693.40
2015	$1,026,746,076.20	$145,053,934.00	$1,171,800,010.20

2016	$979,741,313.30	$131,984,136.50	$1,111,725,449.80
2017	$998,003,809.42	$132,613,004.50	$1,130,616,813.92
Total	$5,843,313,094.32	$811,711,480.00	$6,655,024,574.32

INTERROGATORY NO. 8: Identify and explain the reasons for the denials of the Plaintiff, Alina Boyden's, requests for coverage of gender confirmation surgery and/or rejection of any appeals of those denials of coverage.

RESPONSE TO INTERROGATORY NO. 8: Defendants Board of Regents, Raymond W. Cross, Rebecca M. Blank, the School of Medicine, and Robert N. Golden had no authority over any of Alina Boyden's requests for health insurance coverage of particular procedures.

As for ETF and GIB, Alina Boyden's request for coverage was denied based on the State of Wisconsin Group Health Insurance Uniform Benefits. Specifically, Section IV.A.1.a. of the 2016 Uniform Benefits, Exclusions and Limitations, excludes coverage for "[p]rocedures, services, and supplies related to surgery and sex hormones associated with gender reassignment." Dean Health Plan affirmed its denial of coverage in a grievance decision dated July 8, 2016. ETF's ombudsperson services affirmed Dean's denial in a letter dated September 20, 2016. ETF did not receive a request for an appeal through ETF's administrative appeals process.

INTERROGATORY NO. 9: Identify and explain the reasons for the denials of the Plaintiff, Shannon Andrews', requests for payment for gender confirmation surgery under her employee health insurance plan and/or rejection of any appeals of those denials.

RESPONSE TO INTERROGATORY NO. 9: Defendants Board of Regents, Raymond W. Cross, Rebecca M. Blank, the School of Medicine, and Robert N. Golden had no authority over any of Shannon Andrews' requests for health insurance coverage of particular procedures.

As for ETF and GIB, Shannon Andrews' request for coverage of services provided in October of 2015 was denied based on a coverage exclusion in her health insurance policy. Specifically, the policy excluded coverage for certain surgical services including "HEALTH CARE SERVICES for, or leading to, sex transformation surgery and sex hormones related to such TREATMENT." WPS affirmed its denial of coverage in a grievance decision dated May 5, 2016. On July 1, 2016, Ms. Andrews submitted a health insurance complaint to ETF. On July 26, 2016, before responding to her complaint, ETF learned through an online article in the Milwaukee Journal/Sentinel that the ACLU had filed an EEOC complaint against ETF on behalf of Dr. Andrews based on the denial of her request for coverage. (*See* https://www.jsonline.com/story/news/politics/2016/07/26/transgender-researcher-files-discrimination-complaint/87604452/.) ETF did not subsequently respond to Dr. Andrews' July 1, 2016, health insurance complaint.

INTERROGATORY NO. 10: Identify and describe any actions taken by Secretary Conlin to determine whether the Gender Confirmation Treatment Exclusion results in arbitrary discrimination, consistent with his obligations under Wis. Stat. § 15.04(1)(g).

RESPONSE TO INTERROGATORY NO. 10: Secretary Conlin objects that the phrase "consistent with his obligations under Wis. Stat. § 15.04(1)(g)" is vague and ambiguous. Secretary Conlin further objects to this request, to the extent that it addresses communications protected by the attorney-client privilege. Subject to and without waiving that objection, Secretary Conlin responds as follows:

Secretary Conlin is familiar with the language in Wis. Stat. § 15.04(1)(g), which requires heads of state agencies to "examine and assess the statutes under which the head has powers or regulatory responsibilities, the procedures by which those statutes are administered and the rules promulgated under those statutes."

Secretary Conlin is familiar with Wis. Stat. ch. 40, which governs ETF, and the ETF chapters of the Wisconsin Administrative Code. Under Wis. Stat. § 40.03(2)(f), ETF's Secretary may delegate to other ETF employees any power or duty of the Secretary. Secretary Conlin has delegated regular review of those statutes and administrative code provisions to ETF's Office of Legal Services (OLS), Office of Policy, Privacy and Compliance (OPPC), Division of Retirement Services (DRS), and Office of Strategic Health Policy (OSHP).

With respect to health insurance, Secretary Conlin has delegated regular review of applicable statutes and administrative code provisions to OLS, OPPC, and OSHP. Regarding the State of Wisconsin Group Health Insurance Program's Uniform Benefits and the administration of that Program, for purposes of Wis. Stat. § 15.04(1)(g), Secretary Conlin has delegated review of the Uniform Benefits primarily to OSHP.

Specific to the Uniform Benefits exclusion at issue in this case, the exclusion was a part of the first publication of the Uniform Benefits, effective January 1, 1994. It was included in the Uniform Benefits by the Group Insurance Board (GIB) because the Section IV. benefits and services were generally accepted by health insurance companies and health care providers to be experimental and not medically necessary. ETF notes that this type of exclusion remained the industry standard until the issuance of the federal Department of Health and Human Services (HHS) final rule interpreting Section 1557 of the Patient Protection and Affordable Care Act (ACA) on May 18, 2016. Also, the GIB has final authority over the Uniform Benefits' health insurance coverage provisions, under Wis. Stat. § 40.03(6) and Wis. Admin. Code § ETF 10.20.

To remain current on employee benefits law and policy and industry-wide standards, Secretary Conlin subscribes to many different publications

and email updates, which he reviews on a daily basis. He also maintains memberships in multiple professional organizations.

The following is a non-exhaustive list of specific actions taken by ETF and Secretary Conlin to review the Uniform Benefits coverage exclusion at issue in this case:

- On May 18, 2016, HHS issued the final rule on the Patient Protection and Affordable Care Act Section 1557 provision on nondiscrimination in health programs and activities. ETF's OSHP staff and ETF attorneys reviewed the final rule.
- Subject to and without waiving the attorney-client privilege, on May 26, 2016, Secretary Conlin requested a legal opinion from ETF's attorneys on the application of the HHS rule to ETF. On May 29, 2016, ETF attorneys responded to Secretary Conlin's request.
- Subject to and without waiving the attorney-client privilege, on June 1, 2016, ETF attorneys offered legal analysis to OSHP on the application of the HHS rule to ETF.
- Subject to and without waiving the attorney-client privilege, on June 8, 2016, ETF attorneys communicated to Secretary Conlin their legal analysis regarding the application of the HHS rule to ETF.
- On June 15, 2016, OSHP contacted all health plans participating in the State of Wisconsin Group Health Insurance Program to inform them

that, in order to comply with the HHS rule, ETF intended to recommend to GIB that the Uniform Benefits exclusion regarding procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment, be removed. OSHP further informed the health plans that ETF intended to recommend to GIB that procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment should be covered under the Uniform Benefits, when medically necessary.

- Prior to the July 12, 2016, Group Insurance Board (GIB) meeting, OSHP drafted a memo entitled "Guidelines Contract and Uniform Benefit Changes for 2017" and dated June 22, 2016. Secretary Conlin reviewed that memo prior to it being finalized and participated in a meeting on July 6th at which the memo was discussed.
- Secretary Conlin attended the July 12, 2016 GIB meeting.
- Subject to and without waiving the attorney-client privilege, on July 26, 2016, ETF attorneys provided Secretary Conlin an update on the status of litigation in related cases and an article that appeared that day in the Milwaukee Journal/Sentinel on the filing of an EEOC complaint by the ACLU on behalf of Shannon Andrews. (*See* https://www.jsonline.com/story/news/politics/2016/07/26/transgender-researcher-files-discrimination-complaint/87604452/)

- Subject to and without waiving the attorney-client privilege, on August 9, 2016, Secretary Conlin requested an update from ETF attorneys on the status of Dr. Andrews EEOC complaint.
- On August 10, 2016, Secretary Conlin received, reviewed and gave feedback on a memo from the Wisconsin Department of Justice (DOJ) entitled "ETF's Proposed Revisions to Uniform Benefits Provisions Regarding "Gender Identity" Health Services."
- Subject to and without waiving the attorney-client privilege, on August 10, 2016, ETF attorneys provided a legal case update to Secretary Conlin. That day, Secretary Conlin sought a legal opinion from ETF attorneys based on the update provided.
- Subject to and without waiving the attorney-client privilege, ETF's OLS drafted a memo entitled "Uniform Benefits Provisions Related to Sex Discrimination" and dated August 11, 2016. Secretary Conlin reviewed and provided feedback on that memo prior to it being finalized.
- Subject to and without waiving the attorney-client privilege, on August 11, 2016, Secretary Conlin participated in a meeting to discuss the DOJ memo and the memo from ETF's OLS.
- Secretary Conlin attended the August 16, 2016, GIB meeting.

- Subject to and without waiving the attorney-client privilege, on August 18, 2016, Secretary Conlin discussed the coverage exclusion at issue in this case with ETF attorneys.
- Subject to and without waiving the attorney-client privilege, on August 29, 2016, ETF attorneys provided Secretary Conlin with a legal case update and analysis of sex discrimination cases. That day, Secretary Conlin discussed that update with them.
- Subject to and without waiving the attorney-client privilege, on August 31, 2016, ETF attorneys gave Secretary Conlin an update on other health plan exclusions similar to the one at issue in this case.
- On December 8, 2016, Secretary Conlin prepared for the upcoming December 13, 2016, GIB meeting. On December 9, 2016, Secretary Conlin participated in a meeting at which the HHS nondiscrimination rule was discussed.
- Subject to and without waiving the attorney-client privilege, on December 12, 2016, ETF attorneys updated Secretary Conlin on the status of ACA Section 1557 litigation. That day, Secretary Conlin discussed that update with them.
- Prior to the December 13, 2016 GIB meeting, Secretary Conlin reviewed the December 8, 2016 memo entitled "Discussion and Consideration of 2017 Uniform Benefits—HHS Nondiscrimination

Rule," written by OSHP and the attachments to that memo. Secretary Conlin offered feedback on that memo before it was finalized.

- Secretary Conlin attended the December 13, 2016 GIB meeting.
- On or about December 28, 2016, Department of Administration Secretary Scott Neitzel contacted Secretary Conlin regarding scheduling a GIB meeting to reconsider the coverage exclusion at issue in this case. Either later that day, or early the following day, GIB Chair Mike Farrell contacted Secretary Conlin to schedule that meeting.
- Subject to and without waiving the attorney-client privilege, on December 28 and 29, 2016, Secretary Conlin prepared for the December 30, 2016, GIB meeting, in consultation with ETF attorneys and OSHP.
- Prior to the December 30, 2016 GIB meeting, Secretary Conlin reviewed the December 29, 2016 memo entitled "2017 Uniform Benefits and Services Related to Gender Reassignment or Sexual Transformation—HHS Nondiscrimination Rule," and offered his input.
- Secretary Conlin attended the December 30, 2016, GIB meeting, and was present when the GIB announced that the exclusion at issue in this case would be reinstated after four contingencies were met. One of those contingencies was the issuance of an injunction against enforcement of the HHS rule on nondiscrimination in health programs and activities.

- On December 31, 2016, a federal judge in Texas issued an injunction barring enforcement of the HHS rule. Subject to and without waiving the attorney-client privilege, Secretary Conlin reviewed that injunction and consulted with ETF attorneys.
- Subject to and without waiving the attorney-client privilege, between December 31, 2016 and January 29, 2017, Secretary Conlin met with ETF attorneys and OSHP leadership on multiple occasions to discuss the coverage exclusion at issue in this case.
- Subject to and without waiving the attorney-client privilege, on January 30, 2017, Secretary Conlin wrote a memo to the GIB, in consultation with ETF attorneys and OSHP, detailing the contingencies set by the GIB at the December 30, 2016 meeting, and reporting that those contingencies had been met.
- On January 31, 2017, Secretary Conlin, OLS, and OSHP, after consultation with the GIB chair, issued a 2017 health plan contract amendment to all participating health plans to reinstate the benefits exclusion, effective February 1, 2017.
- Secretary Conlin attended the February 8, 2017, GIB meeting; the health plan contract amendment was part of the GIB meeting materials.

- Subject to and without waiving the attorney-client privilege, on May 9, 2017, ETF attorneys updated Secretary Conlin on the status of litigation regarding ACA Section 1557 regulations.
- Subject to and without waiving the attorney-client privilege, on July 31, 2017, ETF attorneys provided Secretary Conlin with an update on the status of related cases.
- Subject to and without waiving the attorney-client privilege, on October 5, 2017, ETF attorneys updated Secretary Conlin on the status of ACA Section 1557 litigation.

INTERROGATORY NO. 11: Identify and describe any actions taken by Secretary Conlin to remediate any arbitrary discrimination resulting from the Gender Confirmation Treatment Exclusion, consistent with his obligations under Wis. Stat. § 15.04(1)(g).

RESPONSE TO INTERROGATORY NO. 11: Secretary Conlin objects that the phrase "consistent with his obligations under Wis. Stat. § 15.04(1)(g)" is vague and ambiguous. Secretary Conlin further objects that this Interrogatory assumes based on facts not in evidence that "arbitrary discrimination" occurred. Subject to and without waiving these objections, Secretary Conlin responds as follows:

See the response to Interrogatory No. 10. Consistent with that response, Secretary Conlin was directly involved in ETF's recommendation that the exclusion at issue in this case be removed from the Uniform Benefits.

INTERROGATORY NO. 12: Identify all persons with knowledge of the genesis, formulation and adoption of the Gender Confirmation Treatment Exclusion as it existed prior to June 2016.

RESPONSE TO INTERROGATORY NO. 12: The State Defendants object that the phrase "genesis, formulation and adoption of the Gender Confirmation Treatment Exclusion as it existed prior to June 2016" is vague and ambiguous. Subject to and without waiving that objection, the State Defendants respond as follows:

With respect to ETF, Tom Korpady (Division of Insurance Services Administrator), and Bill Kox (Health Benefits & Insurance Plans Bureau Director), are former ETF employees who may have knowledge regarding the coverage exclusion at issue in this case, as it existed prior to June 2016.

With respect to the other State Defendants, they have no relevant knowledge of the coverage exclusion at issue in this case as it existed before June 2016.

INTERROGATORY NO. 13: Identify all persons with knowledge of the genesis, formulation and adoption of the proposal to eliminate the Gender Confirmation Treatment Exclusion from state employee health benefits plans beginning in 2017.

RESPONSE TO INTERROGATORY NO. 13: The State Defendants object that the phrase "genesis, formulation and adoption of the proposal to eliminate the Gender Confirmation Treatment Exclusion from state employee health benefits plans beginning in 2017" is vague and ambiguous. Subject to and without waiving that objection, the State Defendants respond as follows:

With respect to ETF, Robert Conlin (ETF Secretary), John Voelker (ETF Deputy Secretary), Pamela Henning (ETF Assistant Deputy Secretary), Lisa Ellinger (Director of the Office of Strategic Health Policy), Arlene Larson (Manager of Federal Health Programs & Policy), Tara Pray (Member Engagement and Communication Leadworker), Sara Brockman (GIB liaison), David Nispel (General Counsel), and Diana Felsmann (Attorney) have knowledge regarding the proposal to eliminate the coverage exclusion at issue in this case. ETF is aware that Department of Administration Secretary Scott Neitzel may also have knowledge responsive to this Interrogatory.

With respect to GIB, board members Michael Farrell, Stacey Rolston, Herschel Day, Terri Carlson, Bonnie Cyganek, Charles Grapentine, Michael Heifetz, Theodore Neitzke, Daniel Schwartzer, Nancy Thompson, J.P. Wieske, and Bob Ziegelbauer have knowledge regarding the proposal to eliminate the coverage exclusion at issue in this case.

GIB is also aware that then-Deputy Attorney General Andrew Cook, in an August 10, 2016, memorandum, and Department of Justice Deputy Administrator Kevin Potter and Assistant Attorney General Colin Roth, at GIB meetings on December 13 and December 30, 2016, delivered legal analysis regarding the applicability of the Affordable Care Act and federal regulations promulgated thereunder to the coverage exclusion at issue in this case.

With respect to the other State Defendants, they have no relevant knowledge regarding the proposal to eliminate the coverage exclusion at issue in this case.

INTERROGATORY NO. 14: Identify all persons with knowledge of the genesis, formulation and adoption of the proposal to reinstate the Gender Confirmation Treatment Exclusion in state employee health benefits plans beginning in February 2017.

RESPONSE TO INTERROGATORY NO. 14: The State Defendants object that the phrase "genesis, formulation and adoption of the proposal to reinstate the Gender Confirmation Treatment Exclusion in state employee health benefits plans beginning in February 2017" is vague and ambiguous. Subject to and without waiving that objection, the State Defendants respond as follows:

With respect to ETF, Robert Conlin (ETF Secretary), John Voelker (ETF Deputy Secretary), Pamela Henning (ETF Assistant Deputy Secretary), Lisa Ellinger (Director of the Office of Strategic Health Policy), Arlene Larson (Manager of Federal Health Programs & Policy), Tara Pray (Member Engagement and Communication Leadworker), Sara Brockman (GIB liaison), David Nispel (General Counsel), and Diana Felsmann (Attorney) have knowledge regarding the proposal to eliminate the coverage exclusion at issue in this case. ETF is aware that Department of Administration Secretary Scott Neitzel may also have knowledge responsive to this Interrogatory.

With respect to GIB, board members Michael Farrell, Stacey Rolston, Herschel Day, Terri Carlson, Bonnie Cyganek, Charles Grapentine, Michael Heifetz, Theodore Neitzke, Daniel Schwartzer, Nancy Thompson, J.P. Wieske, and Bob Ziegelbauer, as well as Waylon Hurlburt, a temporary GIB member by designee, have knowledge regarding the proposal to reinstate the coverage exclusion at issue in this case.

GIB is also aware that then-Deputy Attorney General Andrew Cook, in an August 10, 2016, memorandum, and Department of Justice Deputy Administrator Kevin Potter and Assistant Attorney General Colin Roth, at GIB meetings on December 13 and December 30, 2016, delivered legal analysis regarding the applicability of the Affordable Care Act and federal regulations promulgated thereunder to the coverage exclusion at issue in this case.

With respect to the other State Defendants, they have no relevant knowledge regarding the proposal to reinstate the coverage exclusion at issue in this case.

INTERROGATORY NO. 15: To the extent that any of Plaintiffs' Requests for Admission is denied or qualified in any way such that your answer is anything other than an unqualified admission, set forth in detail for each such denial or qualification all factual bases for the denial or qualification, and identify all documents that support in any way the refusal to admit unequivocally, together with the identity of the custodian(s) of any such document(s).

RESPONSE TO INTERROGATORY NO. 15:

Request for Admission No. 2: Under Wis. Stat. ch. 40, ETF is the state entity with the authority and responsibility to administer various benefits provided to state employees, including health insurance. The University of Wisconsin's human resources departments receive benefits information from ETF and provide that information to University employees. Those human resources departments also provide information related to employee benefits elections to ETF.

Request for Admission No. 4: See response to Request for Admission No. 2.

Request for Admission No. 5: See response to Request for Admission No. 2.

Request for Admission No. 6: Wisconsin Stat. ch. 36 does not assign any personal responsibility to the President of the University Wisconsin System, in either an individual or official capacity, to offer health insurance plans to University employees. Moreover, see response to Request for Admission No. 2.

Request for Admission No. 7: Wisconsin Stat. ch. 36 does not assign any personal responsibility to the Chancellor of a University Wisconsin institution, in either an individual or official capacity, to offer health insurance plans to University employees. Moreover, see response to Request for Admission No. 2.

Request for Admission No. 8: See response to Request for Admission No. 2.

Request for Admission No. 9: Wisconsin Stat. ch. 36 does not assign any personal responsibility to the Dean of the University of Wisconsin School of Medicine and Public Health, in either an individual or official capacity, to offer health insurance plans to School of Medicine employees. Moreover, see response to Request for Admission No. 2.

Request for Admission No. 10: The University of Wisconsin is not a separate, suable entity under state law.

Request for Admission No. 11: The School of Medicine is not a separate, suable entity under state law.

Request for Admission No. 12: GIB is an "attached board" to ETF pursuant to Wis. Stat. §§ 15.03 and 15.165(2) and with the authority and responsibilities described in Wis. Stat. § 40.03(6).

Request for Admission No. 14: GIB has 11 board members, but they are not classified as employees. GIB is not an agent of ETF.

Request for Admission No. 16: The June 22, 2016, memorandum referenced in this Request for Admission speaks for itself. The characterization provided in this Request is not complete and accurate.

Request for Admission No. 18: GIB has statutory authority and responsibility with respect to state employees' group health insurance plans under Wis. Stat. ch. 40 including, for example, Wis. Stat. §§ 40.03(6), 40.51, and 40.52. Those statutes speak for themselves.

Request for Admission No. 19: See the response to Request for Admission No. 18.

Request for Admission No. 20: ETF and its Secretary's statutory authority and responsibility with respect to state employees' group health insurance plans is set forth in Wis. Stat. ch. 40 including, for example, Wis. Stat. §§ 40.03(1)–(2); those statutes speak for themselves.

Request for Admission No. 21: See the response to Request for Admission No. 20.

Request for Admission No. 22: See the response to Request for Admission No. 20.

Request for Admission No. 23: See the response to Request for Admission No. 20.

Request for Admission No. 25: Wisconsin Stat. § 40.03(6)(a)1. specifies that GIB, not ETF or its Secretary, "[m]ay, on behalf of the state, enter into a contract or contracts with one or more insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans provided for by this chapter."

Request for Admission No. 26: The January 30, 2017, memorandum referenced in this Request speaks for itself. The characterization provided in this Request is not complete and accurate.

SPECIFIC OBJECTIONS AND RESPONSES TO REQUESTS FOR THE PRODUCTION OF DOCUMENTS

The State Defendants hereby incorporate the General Objections described above into each response below, as if fully restated therein.

REQUEST FOR PRODUCTION NO. 1: Any and all documents that you contend support your answers to Plaintiffs' First Interrogatories or Plaintiffs' First Requests for Admission or that concern, refer or relate to those answers, including, but not limited to, any document referred to or relied upon in any answer.

RESPONSE TO REQUEST FOR PRODUCTION NO. 1: The State Defendants will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law, (including Wis. Stat. §§ 51.30 and 146.82, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under the Family Educational Rights and Privacy Act (FERPA), or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 2: Any and all documents relating to Alina Boyden and Shannon Andrews, including, but not limited to, documents related to their employment by the University of Wisconsin, their state employee health insurance coverage, and their requests for coverage for medical treatment for gender dysphoria and gender transition.

RESPONSE TO REQUEST FOR PRODUCTION NO. 2: The State Defendants object that this request is overbroad, unduly burdensome, disproportionate to the needs of the case, and not reasonably calculated to

lead to the discovery of admissible evidence. Subject to and without waiving this objection, the State Defendants respond as follows:

The State Defendants will produce documents responsive to this Request that are also relevant to the coverage exclusion at issue in this case, and that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law, (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under the FERPA, or any other applicable privilege. Records containing private health care information and student records regarding the Plaintiffs will be produced upon receipt of an appropriate signed authorization. Further, the Board of Regents identifies the information located at https://www.wisconsin.edu/ohrwd/benefits/health/.

REQUEST FOR PRODUCTION NO. 3: Any and all documents related to the state employee health plan's coverage of procedures, services, and supplies related to "surgery and sex hormones associated with gender reassignment."

RESPONSE TO REQUEST FOR PRODUCTION NO. 3: The State Defendants object that this request is overbroad, unduly burdensome, disproportionate to the needs of the case, not reasonably calculated to lead to the discovery of admissible evidence, vague, and ambiguous. Subject to and without waiving this objection, the State Defendants respond as follows:

The State Defendants will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related

to private health care information under state and federal law, (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 4: Any and all documents related to the decision to exclude state employee health insurance coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment."

RESPONSE TO REQUEST FOR PRODUCTION NO. 4: The State Defendants object that this request is overbroad, unduly burdensome, disproportionate to the needs of the case, not reasonably calculated to lead to the discovery of admissible evidence, vague, and ambiguous. Subject to and without waiving this objection, the State Defendants respond as follows:

The State Defendants will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 5: Any and all documents related to the decisions to re-evaluate, end, and reinstate the exclusion of state employee health insurance coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment."

RESPONSE TO REQUEST FOR PRODUCTION NO. 5: The State Defendants object that this request is overbroad, unduly burdensome, disproportionate to the needs of the case, not reasonably calculated to lead to the discovery of admissible evidence, vague, and ambiguous. Subject to and without waiving this objection, the State Defendants respond as follows:

The State Defendants will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege. Further information regarding GIB's decision is available at http://etf.wi.gov/boards/agendas_gib.htm.

REQUEST FOR PRODUCTION NO. 6: Any and all documents relating to medical treatment for gender transition, gender dysphoria, gender identity disorder, and transsexualism, and the medical necessity of that treatment.

RESPONSE TO REQUEST FOR PRODUCTION NO. 6: The State Defendants object that this Request is overbroad, disproportionate to the needs of the case, and not reasonably calculated to lead to the discovery of admissible evidence. The State Defendants further object that this Request calls for the production of private health care information that is confidential and cannot be disclosed under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R.

pts. 160, 164)). Subject to and without waiving this object, the State Defendants respond as follows:

The State Defendants will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege. The defendants affiliated with the University of Wisconsin will not collect and produce documents created by University of Wisconsin professors, researchers, and other employees related to research on gender dysphoria.

REQUEST FOR PRODUCTION NO. 7: Any and all documents relating to requests for coverage by Wisconsin state employees for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment."

RESPONSE TO REQUEST FOR PRODUCTION NO. 7: The State Defendants object that this Request is overbroad, disproportionate to the needs of the case, and not reasonably calculated to lead to the discovery of admissible evidence. The State Defendants further object that this Request calls for the production of private health care information that is confidential and cannot be disclosed under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)). Subject to and without waiving this object, the State Defendants respond as follows:

Responsive records containing private health care information and student records for Plaintiffs will be produced upon receipt of an appropriate signed medical authorization.

REQUEST FOR PRODUCTION NO. 8: Any and all documents relating to state employee insurance coverage for breast augmentation (augmentation mammoplasty), vaginoplasty, penectomy, bilateral orchiectomy, clitoroplasty, urethroplasty, labiaplasty, perineoplasty, subcutaneous mastectomy, hysterectomy, ovariectomy, metoidioplasty, phalloplasty, vaginectomy, or scrotoplasty (or any medical services related to these procedures) for any medical conditions other than gender dysphoria or gender identity disorder or for a purpose other than "gender reassignment," including, but not limited to, post-oncologic reconstruction, post-traumatic reconstruction, post-infectious reconstruction, or reconstruction of congenital defects or anomalies.

RESPONSE TO REQUEST FOR PRODUCTION NO. 8: The State Defendants object that this Request is overbroad, disproportionate to the needs of the case, and not reasonably calculated to lead to the discovery of admissible evidence. The State Defendants further object that this Request calls for the production of private health care information that is confidential and cannot be disclosed under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)). Subject to and without waiving this object, the State Defendants respond as follows:

Responsive records containing private health care information and student records for Plaintiffs will be produced upon receipt of an appropriate signed medical authorization.

REQUEST FOR PRODUCTION NO. 9: Any and all documents relating to state employee insurance coverage for hormonal therapies or treatments for any medical conditions other than gender dysphoria or gender identity disorder, or for a purpose other than "gender reassignment," including, but not limited to, cancer, post-menopausal conditions, and sexual dysfunction.

RESPONSE TO REQUEST FOR PRODUCTION NO. 9: The State Defendants object that this Request is overbroad, disproportionate to the needs of the case, and not reasonably calculated to lead to the discovery of admissible evidence. The State Defendants further object that this Request calls for the production of private health care information that is confidential and cannot be disclosed under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)). Subject to and without waiving this object, the State Defendants respond as follows:

Responsive records containing private health care information and student records for Plaintiffs will be produced upon receipt of an appropriate signed medical authorization.

REQUEST FOR PRODUCTION NO. 10: Any and all documents relating to the relationship between ETF and GIB, including, but not limited to, all communications between ETF and GIB for the period between January 2012 and the present.

RESPONSE TO REQUEST FOR PRODUCTION NO. 10: ETF and GIB object that this Request is overbroad, disproportionate to the needs of the case, and not reasonably calculated to lead to the discovery of admissible

evidence. ETF and GIB further object that the phrase "the relationship between ETF and GIB" is vague and ambiguous. Subject to and without waiving these objections, the State Defendants respond as follows:

ETF and GIB will produce communications since January 1, 2016, related to the coverage exclusion at issue in this case that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 11: Any and all communications between ETF and GIB relating to insurance coverage for gender dysphoria, gender identity disorder, gender transition, and "gender reassignment."

RESPONSE TO REQUEST FOR PRODUCTION NO. 11: ETF and GIB will produce communications since January 1, 2016, responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 12: Any and all documents relating to ETF's responsibility for health insurance coverage, including, but not limited to, its responsibility to provide oversight for all of ETF and to hear appeals from denials of coverage.

RESPONSE TO REQUEST FOR PRODUCTION NO. 12: ETF objects that the phrase "ETF's responsibility for health insurance coverage" is vague and ambiguous. Subject to and without waiving that objection, ETF responds as follows:

ETF hereby identifies the statutory and administrative provisions located at Wis. Stat. §§ 40.02(25)(b), 40.03(1)–(2), and 40.51, Wis. Admin. Code § ETF 10.20 and ch. 11, and the health insurance fact sheet available at http://etf.wi.gov/publications/et8902.pdf.

REQUEST FOR PRODUCTION NO. 13: Any and all documents relating to ETF's role in studying, reviewing, administering, enforcing, facilitating, communicating, transmitting, or contracting related to the exclusion of state employee health insurance coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment"; the decision to re-evaluate and end this exclusion; and the reinstatement of the exclusion in or about December 2016 and January 2017.

RESPONSE TO REQUEST FOR PRODUCTION NO. 13: ETF will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege. Further, ETF identifies the information located at https://etfonline.wi.gov/etf/internet/RFP /HealthBeneAdminRFP1/index.html.

REQUEST FOR PRODUCTION NO. 14: Any and all documents relating to the ETF Secretary's role related to the exclusion of state employee health insurance coverage for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment"; the decision to re-evaluate and end this exclusion; and the reinstatement of the exclusion in or about December 2016 and January 2017.

RESPONSE TO REQUEST FOR PRODUCTION NO. 14: ETF and Secretary Conlin will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 15: Any and all documents relating to the relationship between the ETF Secretary and GIB, including, but not limited to, all communications between the ETF Secretary and GIB for the period between January 2012 and the present.

RESPONSE TO REQUEST FOR PRODUCTION NO. 15: Secretary Conlin and GIB object that this Request is overbroad, disproportionate to the needs of the case, and not reasonably calculated to lead to the discovery of admissible evidence. Secretary Conlin and GIB further object that the phrase "the relationship between the ETF Secretary and GIB" is vague and ambiguous. Subject to and without waiving these objections, Secretary Conlin and GIB respond as follows:

Secretary Conlin and GIB will produce communications since January 1, 2016, related to the coverage exclusion at issue in this case that are not

subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 16: Any and all communications between the ETF Secretary and GIB relating to insurance coverage for gender dysphoria, gender identity disorder, gender transition, and "gender reassignment."

RESPONSE TO REQUEST FOR PRODUCTION NO. 16: Secretary Conlin and GIB will produce communications since January 1, 2016, responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 17: Any and all documents relating to the ETF Secretary's responsibility for health insurance coverage, including, but not limited to, the ETF Secretary's responsibility to plan, direct, coordinate and execute the functions vested in the department; and to promulgate rules required for the administration of the group health insurance plans.

RESPONSE TO REQUEST FOR PRODUCTION NO. 17: Secretary Conlin objects that the phrase "responsibility for health insurance coverage" is vague and ambiguous. Subject to and without waiving that objection, Secretary Conlin responds as follows:

Secretary Conlin hereby identifies the statutory provisions located at Wis. Stat. § 40.03(2), including Wis. Stat. § 40.03(2)(f).

REQUEST FOR PRODUCTION NO. 18: Any and all documents relating to the ETF Secretary's responsibility and exercise of the ETF's responsibility to determine whether there is any arbitrary discrimination in health insurance policies and take remedial action relating to it.

RESPONSE TO REQUEST FOR PRODUCTION NO. 18: Secretary Conlin will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 19: Any and all documents relating to the role and responsibility of the Board of Regents, Cross, Blank, and Golden to provide health insurance coverage to state employees.

RESPONSE TO REQUEST FOR PRODUCTION NO. 19: The Board of Regents, Raymond Cross, Rebecca Blank, and Robert Golden are not aware of any documents in their possession responsive to this request.

REQUEST FOR PRODUCTION NO. 20: Any and all documents relating to the role and responsibility of ETF and GIB to provide health insurance to the employees of the Board of Regents.

RESPONSE TO REQUEST FOR PRODUCTION NO. 20: ETF and GIB object that the phrase **"**role and responsibility of ETF and GIB to provide health insurance to the employees of the Board of Regents" is vague and

ambiguous. Subject to and without waiving this objection, ETF and GIB respond as follows:

ETF and GIB hereby identify the statutory and administrative provisions located at Wis. Stat. §§ 40.02(25)(b), 40.03(1)–(2), and 40.51, Wis. Admin. Code § ETF 10.20 and ch. 11, and the health insurance fact sheet available at http://etf.wi.gov/publications/et8902.pdf.

REQUEST FOR PRODUCTION NO. 21: Any and all documents tending to show what, if any, financial or economic effect the State of Wisconsin and/or its taxpayers would experience, both positive and negative, if the State of Wisconsin provided health insurance coverage to state employees for "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment."

RESPONSE TO REQUEST FOR PRODUCTION NO. 21: The State Defendants will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 22: Any and all documents related to the number, or estimates of the number, of State of Wisconsin employees with gender dysphoria or gender identity disorder and the number of those employees who have sought or will seek State of Wisconsin insurance coverage for gender transition and/or for treatment of gender dysphoria or gender identity disorder.

RESPONSE TO REQUEST FOR PRODUCTION NO. 22: The State Defendants object that this Request calls for the production of private health

care information that is confidential and cannot be disclosed under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)). Subject to and without waiving this object, the State Defendants respond as follows:

Responsive records containing private health care information and student records for Plaintiffs will be produced upon receipt of an appropriate signed medical authorization.

REQUEST FOR PRODUCTION NO. 23: Any and all documents related to the number, or estimates of the number, of State of Wisconsin employees who are transgender and the number of those employees who have sought or will seek State of Wisconsin insurance coverage for treatment for gender transition, gender dysphoria or gender identity disorder.

RESPONSE TO REQUEST FOR PRODUCTION NO. 23: The State Defendants object that this Request calls for the production of private health care information that is confidential and cannot be disclosed under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)). Subject to and without waiving this object, the State Defendants respond as follows:

The State Defendants are not aware of any documents in their possession responsive to this request.

REQUEST FOR PRODUCTION NO. 24: Any and all documents related to the cost of medical treatment for gender transition, gender dysphoria, or gender identity disorder.

RESPONSE TO REQUEST FOR PRODUCTION NO. 24: The State Defendants will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

REQUEST FOR PRODUCTION NO. 25: Any and all documents concerning, referring, or relating to the State funds allocated for insurance coverage for state employees from 2012 to the present.

RESPONSE TO REQUEST FOR PRODUCTION NO. 25: The State Defendants are not aware of any documents in their possession responsive to this request.

REQUEST FOR PRODUCTION NO. 26: Any and all documents concerning, referring, or relating to projections, budgets, and estimates related to insurance coverage for state employees from 2012 to the present.

RESPONSE TO REQUEST FOR PRODUCTION NO. 26: The State Defendants are not aware of any documents in their possession responsive to this request.

REQUEST FOR PRODUCTION NO. 27: Any and all documents concerning, referring, or relating to projections, budgets, and estimates related to insurance coverage for gender transition, gender dysphoria, or gender identity disorder from 2012 to the present.

RESPONSE TO REQUEST FOR PRODUCTION NO. 27: The State Defendants will produce documents responsive to this Request that are not subject to the attorney-client privilege, privileges related to private health

care information under state and federal law (including Wis. Stat. §§ 51.30 and 146.82, HIPAA, and 65 Fed. Reg. 82, 462 (codified at 45 C.F.R. pts. 160, 164)), privileges under FERPA, or any other applicable privilege.

Dated January 16, 2018.

Respectfully submitted,

BRAD D. SCHIMEL
Wisconsin Attorney General

/s/ Colin T. Roth
COLIN T. ROTH
Assistant Attorney General
State Bar #1103985

STEVEN C. KILPATRICK
Assistant Attorney General
State Bar #1025452

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VERIFICATION OF INTERROGATORY RESPONSES

I, Robert J. Conlin, Secretary of the State of Wisconsin Department of Employee Trust Funds, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 1, 4, 5, 10, 11, 12, 13, and 14 are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 01/22/2018

ROBERT J. CONLIN
Secretary, State of Wisconsin Department of Employee Trust Funds

On his own behalf and on behalf of
Defendant State of Wisconsin Department of Employee Trust Funds

VERIFICATION OF INTERROGATORY RESPONSES

I, Lisa Ellinger, Director of the Office of Strategic Health Policy for the State of Wisconsin Department of Employee Trust Funds, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 12, 13, and 14 are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 1/18/18

Lisa Ellinger

LISA ELLINGER
Director of the Office of Strategic Health Policy, State of Wisconsin Department of Employee Trust Funds

On behalf of Defendant State of Wisconsin Department of Employee Trust Funds

VERIFICATION OF INTERROGATORY RESPONSES

I, Nanette Strennen, Financial Management Supervisor for the State of Wisconsin Department of Employee Trust Funds, believe based on reasonable inquiry that the foregoing response regarding Interrogatory No. 7 is true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on Jan. 18, 2018

NANETTE STRENNEN
Financial Management Supervisor, State of Wisconsin Department of Employee Trust Funds

On behalf of Defendant State of Wisconsin Department of Employee Trust Funds

VERIFICATION OF INTERROGATORY RESPONSES

I, Diana Felsmann, Attorney for the State of Wisconsin Department of Employee Trust Funds, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 10 and 11 are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 6/8/18

DIANA FELSMANN
Attorney, State of Wisconsin Department of Employee Trust Funds

On behalf of Defendant State of Wisconsin Department of Employee Trust Funds

VERIFICATION OF INTERROGATORY RESPONSES

I, David Nispel, General Counsel for the State of Wisconsin Department of Employee Trust Funds, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 10 and 11 are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 1/18/18

David Nispel

DAVID NISPEL
General Counsel, State of Wisconsin
Department of Employee Trust Funds

On behalf of Defendant State of Wisconsin
Department of Employee Trust Funds

VERIFICATION OF INTERROGATORY RESPONSES

I, Daniel Hayes, Attorney for the State of Wisconsin Department of Employee Trust Funds, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 8 and 9 are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on January 18, 2018

Daniel Hayes

DANIEL HAYES
Attorney, State of Wisconsin Department of Employee Trust Funds

On behalf of Defendant State of Wisconsin Department of Employee Trust Funds

VERIFICATION OF INTERROGATORY RESPONSES

I, Arlene Larson, Manager of Federal Health Programs & Policy for the State of Wisconsin Department of Employee Trust Funds, believe based on reasonable inquiry that the foregoing response regarding Interrogatory No. 6 is true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 1/18/18

Arlene Larson

ARLENE LARSON
Manager of Federal Health Programs & Policy, State of Wisconsin Department of Employee Trust Funds

On behalf of Defendant State of Wisconsin Department of Employee Trust Funds

VERIFICATION OF INTERROGATORY RESPONSES

I, Raymond W. Cross, President of the University of Wisconsin System, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 2, 3, 8, 9, 12, 13, 14, and 15 (Requests for Admission 27 and 28) are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 1-19-18

RAYMOND W. CROSS
President, University of Wisconsin System

VERIFICATION OF INTERROGATORY RESPONSES

I, Jessica Lathrop, Executive Director and Corporate Secretary for the Board of Regents of the University of Wisconsin System, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 2, 3, 8, 9, 12, 13, 14, and 15 (Requests for Admission 27 and 28) are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on January 19, 2018

JESSICA LATHROP
Executive Director and Corporate Secretary,
Board of Regents of the University of
Wisconsin System

VERIFICATION OF INTERROGATORY RESPONSES

I, Rebecca M. Blank, Chancellor of the University of Wisconsin-Madison, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 2, 3, 8, 9, 12, 13, 14, and 15 (Requests for Admission 27 and 28) are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on Jan 22, 2018

Rebecca M Blank

REBECCA M. BLANK
Chancellor of the University of Wisconsin-Madison

VERIFICATION OF INTERROGATORY RESPONSES

I, Diane S. Blaskowski, Director of Employee Services for the University of Wisconsin–Madison, believe based on reasonable inquiry that the foregoing response regarding Interrogatory No. 15 (Request for Admission No. 2, second two sentences) is true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 1/19/2018

Diane S. Blaskowski

DIANE S. BLASKOWSKI
Director of Employee Services, University of Wisconsin–Madison

On behalf of Defendant Board of Regents

VERIFICATION OF INTERROGATORY RESPONSES

I, Robert N. Golden, M.D., Dean of the University of Wisconsin School of Medicine and Public Health, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 2, 3, 8, 9, 12, 13, 14, and 15 (Requests for Admission 27 and 28) are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 1/22/18

Robt N Golden

ROBERT N. GOLDEN, M.D.
Dean, University of Wisconsin School of Medicine and Public Health

VERIFICATION OF INTERROGATORY RESPONSES

I, Michael S. Farrell, Chairperson of the State of Wisconsin Group Insurance Board, believe based on reasonable inquiry that the foregoing responses regarding Interrogatories Nos. 1, 2, 3, 8, 9, 12, 13, and 14 are true and correct to the best of my knowledge, information, and belief.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on January 23, 2018

MICHAEL S. FARRELL
Chairperson, State of Wisconsin Group Insurance Board

On behalf of Defendant State of Wisconsin Group Insurance Board

Exhibit X

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs, Case No. 17-cv-264

v.

STATE OF WISCONSIN DEPARTMENT
OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

STIPULATION

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1. The Wisconsin Department of Employee Trust Funds ("ETF") is and has been at all relevant times to this litigation a covered entity under the Affordable Care Act, 42 U.S.C. § 18116, 45 C.F.R. pt. 92, with respect to all health insurance plans offered to state employees, because it operates a health program or activity that receives Medicare Part D subsidies.

2. ETF directly receives Federal financial assistance in the form of Medicare Part D subsidies for the self-insured pharmacy benefits plan offered to state employees.

3. ETF uses the Medicare Part D subsidies it receives to pay for a portion of prescription claims and to lower the portion of the total health insurance premium associated with prescription drug benefits for state employees.

4. The Group Insurance Board ("GIB") contracts with private companies to administer the self-insured and fully-insured health insurance plans offered to state employees.

5. ETF uses Medicare Part D subsidies to offset some of the costs of prescription drug coverage for Medicare-eligible state employees and retirees who enroll in the fully-insured health insurance plans offered to state employees.

6. The Federal government receives no services from ETF in return for the Medicare Part D subsidies it provides ETF.

7. Alina Boyden is employed by the Defendant, Board of Regents, as either a teaching assistant or a fellow on at least a one-third full-time basis and has been employed on that basis since August 2013.

8. From at least 2011 to the present, the State of Wisconsin GIB has contracted with Navitus Health Solutions, Inc. to provide pharmacy benefits for state employees and retirees, including drug coverage for Medicare-eligible state employees and retirees, pursuant to the terms of the Uniform Benefits of the State of Wisconsin Group Health Insurance Program adopted by GIB. The governing contracts for 2015, 2016 and 2017 state: "This contract is entered into by and between the State of Wisconsin, Department of Employee Trust Funds (Department), the State of Wisconsin Group Insurance Board (Board) and the contractor whose name, address, and principal officer appears on page 2." The governing contract for 2018 states: "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 Navitus Health Solutions, hereinafter referred to as the 'Contractor.'"

Dated this 2nd day of May, 2018.

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