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Correspondence Memorandum

Date: June 22, 2016

To: Group Insurance Board

From: Tara Pray, Alternate Health Plans Manager
Office of Strategic Health Policy

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 Guidelines and Uniform Benefit change 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 special 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 Regulations and Recommended Changes
On May 18, 2016, the federal Department of Health and Human Services (HHS) issued final regulations pertaining to Section 1557 of the Affordable Care Act (ACA). The regulations apply 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.[1]

[1] 81 Federal Register 31376 (May 18, 2016).

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy
Lisa Ellinger Electronically Signed 7/5/16

Board	Mtg Date	Item #
GIB	7.12.16	3A

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.[2]

Covered entities may still use reasonable medical management techniques, and are not required to cover any particular treatment or procedure. However, entities will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination.

For purposes of these regulations, ETF's Office of Legal Services has concluded that ETF is a covered entity. As a result, there are two areas in which staff are recommending changes to bring ETF into compliance with these requirements:

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).

Further analysis is provided below for the Board's reference.

Analysis of ETF as a Covered Entity and Rationale for Recommendations
ETF's Office of Legal Services conducted an analysis of ETF's status under these regulations and determined that ETF is a covered entity. A covered entity is defined as follows:

- 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.[3]

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[2] 81 Fed. Reg. at 31471-72.
[3] 81 Fed. Reg. at 31466.

The definition of "health program or activity" includes the provision or administration of health-related services or health insurance coverage.[4] Federal financial assistance is characterized, in part, as the acceptance of Medicare Parts A, C and D, Medicaid payments, and premium tax credits or cost-sharing reduction payments for enrollees (Medicare Part B is not included).[5]

With respect to ETF's self-insured plans, ETF meets the definition of covered entity because ETF administers health insurance coverage, which comes under the definition of a health program or activity, and ETF accepts Medicare Part D subsidies, which constitute federal financial assistance through HHS. Regarding the insured plans, the regulations provide that for an entity principally engaged in providing or administering health insurance coverage, all of its operations are considered part of the health program or activity.[6] As a result, ETF is also a covered entity in connection with the insured plans because ETF is principally engaged in administering health insurance coverage.

If ETF did not meet the definition of covered entity, ETF staff would be recommending the same changes to the Uniform Benefits for two reasons. First, health insurance plans are covered entities, and those plans are prohibited from contracting away nondiscrimination obligations. Therefore, beginning with plan year 2017, the health insurance plans could not enter into a contract with ETF that failed to comply with these regulations.

Second, the HHS Office of Civil Rights (OCR) has specifically indicated its intent to refer discrimination complaints made against entities not covered by these new regulations to other federal agencies.[7] Separate and apart from these new HHS regulations, the Equal Employment Opportunity Commission (EEOC), which has enforcement authority over general nondiscrimination laws related to race, age, disability, and sex, also interprets sex discrimination to include gender discrimination. Thus, employers that are not covered entities would remain at risk by maintaining benefit designs that would be considered discriminatory on the basis of sex and gender identity under Title VII of the Civil Rights Act of 1964 and EEOC regulations.

As noted above, ETF recommends removing the current exclusion related to benefits and services related to gender reassignment or sexual transformation, with an effective date of January, 1, 2017. This recommendation is based on language in the regulations reflecting that blanket benefits exclusions in this regard are discriminatory on the basis of sex.[8]

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[4] *Id.* at 31467.
[5] *Id.* at 31385.
[6] *Id.* at 31386 & 31467.
[7] *Id.* at 31432.
[8] *Id.* at 31429 & 31472.

Recommended Changes to Meet Notice Requirements
ETF's second recommendation is to include the required nondiscrimination notification language on all significant communications and significant publications related to ETF's health programs, effective October 16, 2016. The purpose of these requirements is to provide notice that a covered entity does not discriminate in connection with its health programs and activities on the basis of race, color, national origin, age, disability, or sex. Further required are statements that the covered entity will provide free language assistance services to individuals with limited English proficiency (LEP), and that the covered entity provides free services and aids to individuals with disabilities. Finally, the notice must contain a statement identifying an employee responsible for compliance, and how an individual may file a grievance.

Notice of nondiscrimination must be posted in conspicuously-visible font size in three places:

1. Significant communications and significant publications;
2. In conspicuous physical locations where the entity interacts with the public; and
3. In a conspicuous location on the homepage of the entity's website.

Therefore, to be in compliance, ETF recommends its significant communications and publications be updated to offer the required nondiscrimination notice.

ETF continues to review the potential impact of these regulations on all health-related programs.

Other Key Changes for 2017
Several Guidelines changes were noted in the memo and presentation at the May Board meeting relating to wellness, claims data submission requirements, and disease management. These changes are related to the ongoing vendor procurements in these areas. The associated draft contract language is now detailed in Attachment A.

Clarified language has also been added on the following topics:

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

2017 Guidelines Contract and Uniform Benefits Changes

Ref #	Color key:	State contract specific change = blue	Local contract specific change = green	Guidelines/Uniform Benefits = white	Text key: Bold items = new changes since the May Board meeting Red text = the new 2017 language Blue text = references that will be added at a later date
	Topic	Contract/ Uniform Benefits Reference	Description of change	Current language	Proposed language
1	Wellness	Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 6.	Removes requirement to administer the HRA and provide the $150 incentive. Clarifies that any other wellness-related offerings must be approved by the department, and also that plans still need to provide biometric screenings.	HEALTH PLANS must administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult PARTICIPANTS including PARTICIPANTS whose biometric results are obtained through the State's biometric screening vendor. Plans must provide a screening tool to participants in the annual Health Risk Assessment that includes screening for substance abuse, tobacco use, and depression. Participants who are identified as at-risk for substance abuse, depression, tobacco, diet, exercise, and obesity must be offered the opportunity for health coaching and, if appropriate, information on intervention and treatment services. Plans must provide incentives of $150.00 in value to PARTICIPANTS who complete an HRA and biometric screening to encourage participation. HEALTH PLANS must provide information as specified by the DEPARTMENT for payroll tax purposes. Biometric screenings shall at a minimum test: 1) glucose level; body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings shall be administered as non-fasting in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines. PARTICIPANTS may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes verification of results for the four tests listed above and the results were obtained within the timeframe allowed by current USPSTF guidelines. The BOARD may reward HEALTH PLANS that administer HRAs and biometric screenings to more than 50% of the PARTICIPANTS described above by crediting the plan's composite score during annual negotiation. Plans must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the results to improve the health of PARTICIPANTS of the State of Wisconsin Group Health Benefit Program.	~~HEALTH PLANS must administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult PARTICIPANTS including PARTICIPANTS whose biometric results are obtained through the State's biometric screening vendor. Plans must provide a screening tool to participants in the annual Health Risk Assessment that includes screening for substance abuse, tobacco use, and depression. Participants who are identified as at-risk for substance abuse, depression, tobacco, diet, exercise, and obesity must be offered the opportunity for health coaching and, if appropriate, information on intervention and treatment services. Plans must provide incentives of $150.00 in value to PARTICIPANTS who complete an HRA and biometric screening to encourage participation.~~ HEALTH PLANS must receive written approval from the DEPARTMENT prior to offering any financial incentive or discount programs to PARTICIPANTS. HEALTH PLANS must participate in collaboration efforts between the DEPARTMENT, its wellness and disease management vendor and the HEALTH PLANS. HEALTH PLANS must accept PARTICIPANT level data transfers from the DEPARTMENT'S wellness and disease management vendor. HEALTH PLAN must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the PARTICIPANT level data from DEPARTMENT'S wellness and disease management vendor to identify PARTICIPANTS appropriate for complex/chronic case management and enroll PARTICIPANTS in such HEALTH PLAN programs. HEALTH PLANS must provide incentive payment information as specified by the DEPARTMENT for payroll tax purposes. Provider obtained biometric ~~Biometric~~ screenings as required by the DEPARTMENT'S wellness program shall still be provided by the HEALTH PLANplan at the PARTICIPANT'S request, for no cost to the PARTICIPANT, and at a minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings may ~~shall~~ be administered as non-fasting and in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines. ~~PARTICIPANTS may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes verification of results for the four tests listed above and the results were obtained within the timeframe allowed by current USPSTF guidelines. The BOARD may reward HEALTH PLANS that administer HRAs and biometric screenings to more than 50% of the PARTICIPANTS described above by crediting the plan's composite score during annual negotiation. Plans must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the results to improve the health of PARTICIPANTS of the State of Wisconsin Group Health Benefit Program.~~
2	Claims data submission requirements	Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 11.	New: Add requirement regarding claims submittal.	N/A	HEALTH PLANS must submit claims data for all PARTICIPANTS, for all claims processed for dates of service from January 1, 2014 through December 31, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the Claims Data Specifications document (Appendix X). HEALTH PLANS must also submit provider data for providers under contract anytime from January, 2014 through December, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the Provider Data Specifications document (Appendix Y).
3	Disease management	Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 11, bullet 8. [Note: Item will become #12 after renumbering due to new #11, above.]	New: Adds requirement to coordinate with the new wellness and disease management vendor.	If PARTICIPANTS are identified as having a disease and/or condition that would place them into a moderate or high risk category as determined by the plan, have a process to enroll the participants into the appropriate wellness and/or disease management programs.	If PARTICIPANTS are identified as having a disease and/or condition that would place them into a moderate or high risk category as determined by the HEALTH PLAN, have a process to enroll the PARTICIPANTS ~~participants~~ into the appropriate wellness, ~~and/or~~ disease management, or chronic care management programs. The HEALTH PLAN must coordinate this effort with the program(s) offered by the DEPARTMENT'S wellness and disease management vendor.

2017 Guidelines Contract and Uniform Benefits Changes

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4	Remove conversion policy requirement	Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 16.	No longer necessary due to the Marketplace.	Plans must permit enrolled employees the opportunity to convert coverage in the event of termination of employment. Such conversion right shall pertain to those employees who terminate employment and move out of the service area, and to those employees who remain in the service area but are unable to continue under the State of Wisconsin Group Health Benefit Program as a result of such termination of employment. Marketplace plans meet the requirements of a conversion policy set forth in Wis. Stat. §632.897.	Plans must provide SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. §632.897 and/or Marketplace plan in the event of termination of employment. ~~Plans must permit enrolled employees the opportunity to convert coverage in the event of termination of employment. Such conversion right shall pertain to those employees who terminate employment and move out of the service area, and to those employees who remain in the service area but are unable to continue under the State of Wisconsin Group Health Benefit Program as a result of such termination of employment. Marketplace plans meet the requirements of a conversion policy set forth in Wis. Stat. §632.897.~~
5	Addendum 1: Transitional Care description	Addendums: Addendum 1, Table 3A, B. Hospital Outpatient, 8. Other Facility, b. Transitional Care	Add clarification that services are not limited to substance abuse due to mental health parity	Transitional Care -This benefit includes substance abuse rehabilitation services provided in a transitional care program. Services may be outpatient or day care setting and charges would include professional and facility charges.	Transitional Care -This benefit includes substance abuse rehabilitation services, or other mental health services as required by the Federal Mental Health Parity Act, provided in a transitional care program. Services may be outpatient or day care setting and charges would include professional and facility charges.
6	**Benefits Definition**	**State and Local Contracts: ARTICLE 1 DEFINITIONS, 1.2 BENEFITS**	**Update reference to Uniform Benefits, from Attachment A**	**BENEFITS means those items and services as listed in Attachment A.**	**BENEFITS means those items and services as listed in Uniform Benefits ~~Attachment A.~~**
7	Disabled adult dependent when subscriber deceases	State and Local Contracts: ARTICLE 1 DEFINITIONS, 1.7 DEPENDENT, (3) (a) Uniform Benefits: II. DEFINITIONS: DEPENDENT	Revise "support test" language for situations where adult disabled dependent's parent, the subscriber, is deceased.	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.	An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is dependent on the SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER should decease, the disabled adult DEPENDENT must still meet the remaining disabled criteria and be incapable of self-support. The 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.
8	**Privacy breaches**	**State Contract and Local Contracts: ARTICLE 2 ADMINISTRATION, 2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW, (5)**	**Add specific requirements related to known or suspected privacy breaches**	**The HEALTH PLAN shall comply with all state and federal laws regarding patient privacy. The HEALTH PLAN shall notify the DEPARTMENT within two business days of discovering that the protected health information (PHI) or personal information of one or more PARTICIPANTS has been breached, as defined by state and federal law, including Wis. Stat. § 134.98 and the federal Health Insurance Portability and Accountability Act of 1996. This notification requirement shall apply only to PHI or personal information received or maintained by the HEALTH PLAN pursuant to this agreement. The HEALTH PLAN shall make good faith efforts to communicate with the DEPARMENT about breaches by major provider groups if the HEALTH PLAN knows those breaches affect PARTICIPANTS.**	**The HEALTH PLAN shall comply with all state and federal laws regarding patient privacy. The HEALTH PLAN shall notify the DEPARTMENT within ~~two~~ one business days of discovering that the protected health information (PHI) and/or personal identifiable information (PII) of one or more PARTICIPANTS may have been breached, or has been breached, as defined by state and federal law, including Wis. Stat. § 134.98 and the federal Health Insurance Portability and Accountability Act of 1996. The HEALTH PLAN is required to report using the form provided by the DEPARTMENT. Even if the full details are not known, the HEALTH PLAN must report the known information to the DEPARTMENT and then follow up to provide additional information as details are known, and as requested by the DEPARTMENT. The following categories of information shall be reported:** **• Description of incident** **• Root cause** **• Actual or estimated number of participants impacted** **• Impact list (as soon as known)** **• A copy of any correspondence sent to affected participants (this must be approved by the DEPARTMENT prior to disseminating)** **• Steps taken to ensure a similar incident will not be repeated** **This notification requirement shall apply only to PHI or ~~personal information~~ PII received or maintained by the HEALTH PLAN pursuant to this agreement. The HEALTH PLAN shall make good faith efforts to communicate with the DEPARTMENT about breaches by major provider groups if the HEALTH PLAN knows those breaches affect PARTICIPANTS.**

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9	Claims data submission requirements	State and Local Contracts: ARTICLE 2 ADMINISTRATION, 2.4 REPORTING, (6)	New: Add requirement regarding claims submittal.	N/A	HEALTH PLANS must submit claims data for all PARTICIPANTS for all claims processed for dates of service from January 1, 2014 through December 31, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the most recent Claims Data Specifications document (Appendix X). HEALTH PLANS must also submit provider data for providers under contract anytime from January, 2014 through December, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the Provider Data Specifications document (Appendix Y).The DEPARTMENT will specify and communicate a schedule of deliverables and due dates once the data warehouse vendor is under contract. Plans must also submit claims for dates of service in 2017 during a six (6) month run-out period from January 1, 2018 - June 30, 2018. The DEPARTMENT will withhold 25% of the December, 2017 premium, to be paid not later than April 1, 2018, unless there are issues receiving timely run-out claims data in 2018. In the event of issues receiving run-out claims per the DEPARTMENT'S timeline, the DEPARTMENT will withhold the final 25% premium payment until all run-out claims are received.
10	Nondiscrimination notice in significant communications	State and Local Contracts: ARTICLE 2 ADMINISTRATION, 2.5 BROCHURES AND INFORMATIONAL MATERIAL, (3)	New: Revise required nondiscrimination statement to comply with section 1557 of the ACA.	Upon request, the HEALTH PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the Americans with Disabilities Act (ADA) of 1990. All brochures and informational material shall include the following statement: "[NAME OF HEALTH PLAN] does not discriminate on the basis of disability in the provision of programs, services, or activities. If you need this printed material interpreted or in an alternative format, or need assistance in using any of our services, please contact [CONTACT PERSON OR OFFICE. INCLUDE PHONE NUMBER AND TTY NUMBER IF AVAILABLE]."	All HEALTH PLANS must comply with Section 1557 of the ACA and Federal civil rights laws. Upon request, the HEALTH PLAN will provide information on programs, services, and activities in alternate formats to PARTICIPANTS with qualified disabilities as defined by the Americans with Disabilities Act (ADA) of 1990, as well as those whose primary language is not English. ~~All brochures and informational material shall include the following statement:~~ ~~"[NAME OF HEALTH PLAN] does not discriminate on the basis of disability in the provision of programs, services, or activities. If you need this printed material interpreted or in an alternative format, or need assistance in using any of our services, please contact [CONTACT PERSON OR OFFICE. INCLUDE PHONE NUMBER AND TTY NUMBER IF AVAILABLE]."~~ The notice in Appendix A of the federal section 1557 ACA regulations must be published in conspicuously-visible font size in all significant communications and significant publications, both print and web, related to the State of Wisconsin Group Health Insurance Program. The notice is as follows: [Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. [Name of covered entity]: • Provides free aids and services to people with disabilities to communicate effectively with us, such as: o Qualified sign language interpreters o Written information in other formats (large print, audio, accessible electronic formats, other formats) • Provides free language services to people whose primary language is not English, such as: o Qualified interpreters o Information written in other languages If you need these services, contact [Name of Civil Rights Coordinator] If you believe that [Name of covered entity] has failed to provide these services or discriminated in another way

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					on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: [Name and Title of Civil Rights Coordinator], [Mailing Address], [Telephone number], [TTY number—if covered entity has one], [Fax], [Email]. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). **Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.** **Wherever the above notice in Appendix A. appears, it is also required to contain the tagline in Appendix B., translated into at least the top 15 languages spoken by individuals with limited English proficiency in the State of Wisconsin. That tagline reads:** **ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).** **HHS has made available translations of the above-referenced tagline.** **Update the required non-discrimination statement as follows, to comply with the Section 1557 rule.** **"[NAME OF HEALTH PLAN] does not discriminate on the basis of race, color, national origin, sex, age, or disability in the provision of programs, services, or activities. If you need this printed material interpreted or in an alternative format, or need assistance in using any of our services, please contact [CONTACT PERSON OR OFFICE. INCLUDE PHONE NUMBER AND TTY NUMBER IF AVAILABLE]."**
11	Effective date	State and Local Contract: ARTICLE 3 COVERAGE, 3.3 SELECTION OF COVERAGE (2) (a)	Clarify effective date in relation to the receipt of the application	An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, coverage to be effective as of the first day of the month that first occurs during the 30-day period, or by electing coverage, or prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM, coverage to be effective upon becoming eligible for EMPLOYER contribution. An EMPLOYEE who enrolls for single coverage within 30 days of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for EMPLOYER contribution toward PREMIUM.	An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days **following the date** of hire, coverage to be effective as of the first day of the month that first occurs during the 30-day period, or by electing coverage, or prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM, coverage to be effective upon becoming eligible for EMPLOYER contribution. An EMPLOYEE who enrolls for single coverage within 30 days **following the date** of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for EMPLOYER contribution toward PREMIUM.

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	Topic	Contract/ Uniform Benefits Reference	Description of change	Current language	Proposed language
12	**No double coverage**	**State and Local Contract: ARTICLE 3 COVERAGE, 3.11 COVERAGE OF SPOUSE, DOMESTIC PARTNER, OR DEPENDENT (1)**	**If there is double coverage found and one parent has family coverage and one has single. Allows either SUBSCRIBER to cover the DEPENDENT(S).** **Clarification that no one can be double covered, even if they are only a subscriber on one contract.**	**(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one spouse elects family coverage, the other eligible spouse may be covered as a DEPENDENT but may not have any other coverage. If both spouses are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one spouse to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the spouses have coverage with different HEALTH PLANS at the time of marriage or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the divorce.**	**(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one spouse elects family coverage, the other eligible spouse may be covered as a DEPENDENT but may not have any other coverage. ~~If both spouses are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage.~~ PARTICIPANTS can only be covered under one State Group Health Insurance Program (including the Wisconsin Public Employers State Group Health Insurance Program) contract. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one spouse to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the spouses have coverage with different HEALTH PLANS at the time of marriage or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the divorce.**
13	No double coverage	State and Local Contract: ARTICLE 3 COVERAGE, 3.11 COVERAGE OF SPOUSE, DOMESTIC PARTNER, OR DEPENDENT (3)	If there is double coverage found and one parent has family coverage and one has single. Allows either SUBSCRIBER to cover the DEPENDENT(S). Clarification that no one can be double covered, even if they are only a subscriber on one contract.	(3) A DEPENDENT cannot be covered at the same time by two separate SUBSCRIBERS of the State Group Health Insurance Program (including the Wisconsin Public Employers State Group Health Insurance Program). In the event it is determined that a DEPENDENT is covered by two separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have 30 days to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.	(3) A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the State Group Health Insurance Program (including the Wisconsin Public Employers State Group Health Insurance Program). In the event it is determined that a DEPENDENT is covered by two separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have 30 days to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. If the DEPENDENT(S) is to be newly covered by a SUBSCRIBER that has single coverage, the contract may be converted to a family contract. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.
14	Correction	State and Local Contract: ARTICLE 3 COVERAGE, 3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE (3)	Should refer to #11 in UB, not #12	(3) Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage shall be limited in accordance with Uniform Benefits IV., A., 12., b... In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV., A., 12., b...	(3) Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage shall be limited in accordance with Uniform Benefits IV., A., ~~12~~11., b... In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV., A., ~~12~~11., b...

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15	Correction	Local Contract: ARTICLE 3 COVERAGE, 3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE (1)	Remove CONTINUANT - local only, Board approved in 2013, was not removed previously	(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, or CONTINUANT who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.	(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS~~, or CONTINUANT~~ who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.
16	Death	New: State Contract: ARTICLE 3 COVERAGE, 3.18 INDIVIDUAL TERMINATION OF COVERAGE (1) (j)	Add provision for coverage termination when subscriber dies. Same language for state and local, different contractual citation letters.	N/A	(j) Upon date of death. No refund of PREMIUM may be granted for the month in which the coverage ends. If deceased subscriber has covered dependents, see 3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS.
17	Death	New: Local Contract: ARTICLE 3 COVERAGE, 3.18 INDIVIDUAL TERMINATION OF COVERAGE (1) (l)	Add provision for coverage termination when subscriber dies. Same language for state and local, different contractual citation letters.	N/A	(l) Upon date of death. No refund of PREMIUM may be granted for the month in which the coverage ends. If deceased subscriber has covered dependents, see 3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS.
18	**Transfer of deductible and out-of-pocket limit accumulations**	**State and Local Contract: ARTICLE 3 COVERAGE, 3.20 ADMINISTRATION OF BENEFIT MAXIMUMS, DEDUCTIBLES, AND OUT-OF-POCKET LIMITS UNDER UNIFORM BENEFITS**	**Add provision for administration of deductibles and OOPLs when participants change coverage levels**	**(1) If a PARTICIPANT changes HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the EFFECTIVE DATE of coverage with the new HEALTH PLAN with the exception of the prescription annual out-of-pocket maximum.** **(2) If a PARTICIPANT changes the level of coverage (e.g., single to family), transfers to another State agency, or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual BENEFIT maximums will continue to accumulate for that year.**	**(1) If a PARTICIPANT changes HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums, deductibles, or out-of-pocket limits, under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the EFFECTIVE DATE of coverage with the new HEALTH PLAN with the exception of the prescription drug BENEFIT annual out-of-pocket maximum for the IYC Health Plan. The deductibles and out-of-pocket limits are combined for the HDHP, therefore, the prescription drug BENEFIT annual out-of-pocket accumulation will start over if the PARTICIPANT changes insurers.** **(2) If a PARTICIPANT changes the level of coverage (e.g., single to family), transfers to another State agency, or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual BENEFIT maximums, deductibles, and out-of-pocket limits, will continue to accumulate for that year. Note: No accumulations transfer if an employee moves from state to local (or vice versa) coverage, regardless if they remain covered by the same insurer.**

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19	Disabled adult dependent when subscriber deceases	Uniform Benefits: II. DEFINITIONS: DEPENDENT	Revise "support test" language for situations where adult disabled dependent's parent, the subscriber, is deceased.	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.	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.
20	Make necessary clarification Re: Rx OOPL for HDHP	Uniform Benefits: I. SCHEDULE OF BENEFITS, Prescription Drugs and Insulin (Except Specialty Medications): (after the SOB matrices)	Need explanation of how HDHP OOPL works.	**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.	**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 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 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 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):~~ Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows: - IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus, IYC Local Traditional (PO2/12), IYC Local Deductible (PO4/14), IYC Local Health Plan (PO6/16): $600 per individual or $1,200 per family for all Participants. - IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $1,500 for single coverage, or $3,000 for family coverage. When the OOPL is met, You pay no more out-of-pocket expenses for covered medical services or prescription drugs ~~, except:~~

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					~~$1,000 per individual or $2,000 per family for State and Wisconsin Public Employer Participants enrolled in the Standard Plan.~~ **Level 3 Annual OOPL** Level 3 out-of-pocket costs accumulate toward OOPLs as follows: - IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus, IYC Local Traditional (PO2/12), IYC Local Deductible (PO4/14), IYC Local Health Plan (PO6/16): **no annual OOPL**. - IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $1,500 for single coverage, or $3,000 for family coverage. When the OOPL is met, You pay no more out-of-pocket expenses for covered medical services or prescription drugs.
21	Rx detail in Schedule of Benefits	Uniform Benefits: I. SCHEDULE OF BENEFITS, Specialty Medications (after the SOB matrices)	Need explanation of how HDHP OOPL works.	**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.	**Specialty Drug Cost Share** ~~**Copayments:**~~ Level 4 Copayment: $50 ~~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.~~ Level 4 Coinsurance: 40% ($200 max) ~~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~~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)** **There is no OOPL for Non-Preferred Specialty Medications.** You must continue to pay Level 4 Coinsurance for Non-Preferred Specialty Medications ~~even after other annual~~

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					~~OOPLs have been met, up to~~ until You meet the Federal MOOP of $7,150 individual / $14,300 family. ~~(~~The maximum annual amount You pay for Your Level 4 Preferred Specialty Medications.~~)~~ Level 4 Preferred Specialty Medications out-of-pocket costs accumulate toward OOPLs as follows: - IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus, IYC Local Traditional (PO2/12), IYC Local Deductible (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family ~~for all Participants~~. - IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $1,500 for single coverage, or $3,000 for family coverage. When the OOPL is met, You pay no more out-of-pocket expenses for covered medical services or prescription drugs.
22	**Biometric screenings**	**Uniform Benefits: III. BENEFITS AND SERVICES, A. Medical/Surgical Services, 5. Medical Services, j.**	**New: add clarification about biometric screenings**	**N/A**	**Participant requested biometric screening provided annually at no participant cost. Biometric screenings shall at a minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings may be administered as non-fasting in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines.**
23	**Habilitation services**	**Uniform Benefits: III. BENEFITS AND SERVICES, 11. Outpatient Rehabilitation, Physical, Speech and Occupation Therapy**	**Clarify the habilitation services benefit, not illness or injury only.**	**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.**	**Medically Necessary Habilitation or Rehabilitation services and treatment ~~as a result of Illness or Injury, provided by a Plan Provider~~. 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.**
24	**Gender reassignment**	**Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, 1. Surgical Services, a.**	**Remove the exclusion for Section 1557 compliance.**	**Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment.**	**~~Procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment.~~**
25	Habilitation services	Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, 2. Medical, b. Therapies	Revise exclusion to be clearer.	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.)	Except for services covered under the HABILITATION SERVICES therapy benefit, and mandated benefits for autism spectrum disorders under Wis. Stat. §632.895 (12m) 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.)~~

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26	Sexual transformation	Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, 11. General, ah.	**Revise the exclusion for Section 1557 compliance.**	Sexual counseling services related to infertility and sexual transformation.	Sexual counseling services related to infertility ~~and sexual transformation~~.
27	Marriage counseling	Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, 11. General, ak.	Expand exclusion on marriage counseling to couples/family counseling	ak. Marriage counseling.	ak. Marriage/couples/family counseling.