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The Board determines the premium rate for its self-insured Standard, fee-for-service, group health benefit plan. This premium is established after review of claims experience, secular trends, etc., and after consultation with the Board's actuary. Once the Board has established the premium rates for the standard health plan, the Board opens the sealed "bids" for the alternate health benefit plans. The State of Wisconsin's current contribution toward the total premium for active employees (non-retired) for both single and family contracts is based on a tiered structure or, as determined by Statute and collective bargaining, the lesser of 90% of the standard plan in the employee's residence county or 105% of the lowest cost "qualified" alternate plan in the county where the subscriber's primary care provider is selected. Under the tiered structure, the Office of State Employment Relations has determined the Standard Plan to be placed in Tier 2 for purpose of determining premium contribution share for those subscribers who are active employees residing out of state. Plans become "qualified" by meeting the requirements in Addendum 2; number of providers and years of operation. Local employers must pay at least 50% but not more than 105% of the lowest cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10.

The tiered premium structure is based on recommendations from the Board's appointed actuary whereby each alternate plan's claims experience will be reviewed to determine which of the three premium contribution tiers each plan will be placed. This placement will be based on a risk-adjusted assessment of the plan's efficiency as determined by the Board's actuary. The most efficient plans will be placed in Tier 1, which will have the lowest employee premium contribution level. The moderately efficient plans will be placed in Tier 2. The least efficient plans will be placed in Tier 3, which will have the greatest employee premium contribution level. The employee premium contribution will be a fixed amount per tier, as determined by the non-represented compensation plan or collective bargaining agreement. The employer shall contribute the balance of the total premium. The Board reserves the right to make enrollment and eligibility decisions as necessary to implement this program, including whether to make a Tier 1 plan available in those counties in which otherwise no qualified health plan in Tier 1 exists. The Department may take such action as necessary to implement this intent.

In the event that the contribution is based on a percentage of the lowest cost qualified plan, if an alternate plan submits a premium rate, which is less than the employer contribution rate, the employer contribution (dollar amount) could represent 100% of the total alternate plan premium and the employee will pay no out-of-pocket premium contribution. Conversely, if a plan submits a premium rate, which is substantially higher than the employer contribution rate, the employee contribution will be the difference between the total premium rate and the employer contribution rate in the plan's area.

The Board is convinced that the development of "constructive competition" among providers of health care services will have a positive impact on improving the health-care delivery system. A health care plan with efficient, highly qualified providers, who effectively practice peer-review and utilization review, will draw patients away from inefficient providers by offering better service and/or lower premium costs. The eventual goal is to have comprehensive, alternate health care plans available to all public employees within the geographic confines of the State of Wisconsin.

The following Guidelines describe the requirements, which an organization must satisfy in order to secure approval from the Board to participate under the State of Wisconsin's Group Health Benefit program. They have been developed to explain and clarify the general requirements set forth under Wis. Stats. Subchapter IV of Chapter 40, and Chapters ETF 10 and 40, Wisconsin Administrative Code, Rules of the Department of Employee Trust Funds. Further, they set forth requirements, which are complementary to the statutory provisions contained in Wis. Stats. Chapters 150, 185 (185.981-.985), 600-646, and Public Laws 93-222 (the HMO Assistance Act of 1973) and 94-460 (Health Maintenance

annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles), and utilization statistics. (This information shall remain confidential insofar as permitted by Wisconsin Law.) Failure to file annual financial statements (prior to July 1 following the end of the preceding contract period) shall constitute sufficient grounds for the Board to deny future renewals, or consider the plan to be non-qualifying.

D. Comprehensive Health Benefit Plans Eligible for Consideration

1. The Board will only consider those plans, which provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The Board reserves the right not to contract with any plan whose premium is not satisfactory to the Board.

2. Plans that will be considered under these program guidelines to be allowed in any service area include any of the following types of Organizations defined in Wis. Stats. § 609.01 (2) and (4):

   a. Independent practice association HMO (IPA's).

   b. Prepaid group practice HMO.

   c. Staff model HMO.

   Plans that will be considered under these guidelines to be offered in any county also include:

   a. Point of service HMOs (POS-HMO).

   b. Preferred Provider Plan (PPP).

   Plans that embrace the characteristics of one or more of the type of organization models described above may be considered by the Group Insurance Board as meeting the definition of a comprehensive health benefit plan. Insuring organizations may not offer more than one of the above listed plan types in any geographic location. This allows organizations sufficient flexibility to develop innovative alternative plans while recognizing the Board's need for administrative efficiency and protection of the competitive environment.

3. Plans must provide for the Wisconsin State Employees' and Wisconsin Public Employers' Program benefits and services listed in Section 4.

4. Plans must demonstrate their efforts in encouraging and/or requiring network hospitals to participate in such quality standards as Leapfrog, Wisconsin Hospital Association quality accountability initiative and others as identified by the Department.

5. Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians. (Utilization Review; UR) Each plan shall report to the Board its capabilities and effectiveness.

   Examples of the minimum UR procedures that participating alternate plans should have in place include the following:

GUIDELINES

- Members are required to select primary care physicians who coordinate the member's care in the plan's network and approve referrals to specialists.

- Written guidelines that physicians must follow to comply with the plan's UR program for IPA model HMOs.

- Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.

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

- Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.

- Procedure to monitor emergency admissions to non-plan hospitals.

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

In its report, plans must certify that these (or equivalent) procedures are in place. Failure to provide effective UR may be grounds for non-qualification or non-participation.

6. Plans must cover emergency and urgent care and related catastrophic medical care received from plan or non-plan providers at the in-plan level of benefits. The emergency room copayment is applicable if the participant is not admitted to the hospital. This out-of-service area care may be subject to usual and customary charges.

7. 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 group health benefit program as a result of such termination of employment. (See Wis. Stat. § 632.897)

8. Plans must agree to participate in the regular "dual-choice" enrollment offering. A regular dual-choice enrollment offering is scheduled approximately 90 days prior to the end of each contract period. During such dual-choice enrollments the plan will accept any individual (active employee, continuant or retiree) who transfers from one health benefit plan to another without requiring evidence of insurability, or waiting periods, or exclusions for pre-existing conditions as defined in Wis. Adm. Code § INS 3.31 (3). Any individual who is confined as an inpatient at the time of such transfer shall remain the liability of the plan under which the individual was insured at the time of admission. The new plan shall assume liability for any subsequent services as provided for in 3.18 (3) of the Contract. Employees who enroll during prescribed enrollment periods shall not be subject to any waiting periods or evidence of insurability requirements.

pay at least 50% but not more than 105% of the lowest cost plan in the employer's area (except for eligible employees who work less than half-time for whom the minimum contribution shall be at least 25% of premium). Local government employers who determine the employee premium contribution based on the tiered structure established for state employees must do so in accordance with Wis. Adm. Code § ETF 40.10. The county of the employer is considered the service area for local employers. At the request of a participating employer, the Department will review the service area used to determine the least cost qualified plan used for determining the employer's maximum premium contribution. If the Department reviews the service area, it will be based on the zip code locations that includes at least 80% of the covered employees of the participating employer. Once the Department has made such an assessment, that service area will determine the least cost plan until it is demonstrated that there has been a significant change in employee residency and the area no longer meets the 80% criteria. A non-qualifying plan approved by the Board for participation in the state Group Health Insurance Program may market its plan in any area. However, only the lowest cost qualified plan's premium rate would be used in the above calculations. No plan may qualify for determining employer contributions in its first year of operation under the Board's program. PPPs are not qualified in areas served by SMP. The service area for PPP's will be considered the subscriber's county of residence.

The Standard Plan premium rates for state employees will be the same statewide. However, premium rates for the Standard Plan for the local government program will depend upon the geographic location of the municipality. The state has been divided into the following premium areas:

Geographic Area	Cost Factor
Balance of State	1.0
Dane, Grant, Jefferson, LaCrosse, Polk, St. Croix Counties	1.03
Kenosha, Ozaukee, Racine, Washington, Waukesha Counties	1.07
Milwaukee County, Out of State	1.1

13. Subscriber premium payments will be arranged through deductions from salary, accumulated sick leave account (state employees only), or annuity. For all other subscribers, premiums will be paid directly to the plan.

14. Plans will assist with all reasonable requests for data and other information as needed for the PBM to administer the pharmacy benefit program and receive any necessary data in a file format as identified by the PBM and Department after seeking input from plans.

15. Plans shall not recoup any payments it has made for prescriptions filled by participants on and after January 1, 2004.

16. Optional Dental Coverage. Plans may offer optional dental coverage if the Department receives a description of benefit level prior to the annual premium bid on a date specified by the Department. The eligibility and enrollment provisions will be the same as the medical coverage provisions as specified by the Guidelines. If a plan offers dental coverage, it will be offered to all participants who enroll for medical coverage with the plan. However, a plan may offer dental coverage under the state employee's

GUIDELINES

H. Rate-Making Process

Each plan must include in its proposal to the Board a detailed explanation as to how initial premium rates were determined, and how premium rates will be determined for subsequent periods. The organization shall identify whether the rate which will be proposed represents a community rate (factored or not factored for different time periods or for different benefit provisions) or as a projection of claims/benefits based on expected experience of the state/local group or other groups, etc. This information will be treated confidential by the Board insofar as permitted by Wisconsin Law. Rates shall be uniform statewide, except that plans may submit different rates which result from mutually exclusive provider networks in separate geographic locations. Plans may separate higher cost providers within geographic areas under the tiered structure into separate plans.

The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates.

Any health plan approved by the Board will be subject to the provisions of Wis. Stats. Chapter 40, and the rules of the Department of Employee Trust Funds. The Board limits plans to the following premium categories, and each plan to be qualified must provide coverage for each premium category:

- Individual (Employee Only)
- Family (Employee Plus Eligible Dependents)
- Medicare Coordinated
  - Individual
  - Family (2 Medicare Eligible)
  - Family (1 under Medicare, at least 1 other not under Medicare)
- Graduate Assistants[1]:
  - Individual
  - Family

1. Family rates (regular coverage) must be 2.5 times the individual rate.

2. Medicare Coordinated Coverage: Individual rate must be no more than 50% of the single rate for regular coverage; 2 eligible rate shall be 2 times the individual Medicare coordinated rate; family rate (1 under Medicare, 1 or more not eligible), shall be the sum of the individual rate (regular coverage) and individual rate (Medicare eligible).

3. Graduate Assistants: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate; family rate must be within a range of 65% to 75% of the family regular coverage rate.

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[1] Graduate Assistants and employees-in-training at the University of Wisconsin are covered by Wis. Stats. § 40.52 (3). Employees who are employed at least one-third of full-time are eligible for a contribution toward premium as determined by collective bargaining agreements.

GUIDELINES

I. Submission of Proposals

Proposals to participate in the state group health insurance program must be submitted to the Board. In addition to requirements previously cited, each plan proposal must be received by April 15 and include:

1. Fifteen (15) copies

2. Specific listing of the plan's pre-authorization and referral requirements

3. A draft of the contract to be executed between the Plan and the Board (see Addendum #3). Premium quotations, however, are not due until July 23.

4. A list of providers under contract arranged by county of practice for state employees, and by zip code for local employees. The Board will expect an updated listing by July 30 in order to determine what areas will constitute your service area.

5. A copy of your detailed contingency plan in the event of strike, disaster, etc. Such a plan must address the method used for providing services and processing claims under such circumstances.

The Board will treat all proposals as confidential insofar as is permitted by applicable law, except as may be necessary for the proper evaluation of the proposal.

J. Time Table and Due Dates For Annual Information Submittals to the Department of Employee Trust Funds

(Note: Unless otherwise specified, if the "Due Date" listed below falls on a Saturday, materials should be received by ETF the previous Friday. If the "Due Date" falls on a Sunday, materials should be received by ETF the following Monday.)

Due Date (Receipt by ETF)	Information Due	Date Submitted
April 15, 2004	• New plans only. Proposal to participate in the program (Section II., I, page 1-16). Contract to be executed by plan/Board. (Section 3)	
April 30, 2004	• Estimated premium rate proposal for next calendar year. This is due by April 30 of odd-numbered years (e.g., 2001, 2003) to coincide with the timing of collective bargaining	
May 15, 2004	• For PPPs and POSs – Any change to the level of benefits for out-of-plan services for the next benefit year must be submitted.	
June 1, 2004	• Documentation of financial stability (2 copies each): 1. Balance sheet 2. Statement of Operations 3. Annual audited financial statement • Preliminary identification of planned service areas by county for the next calendar year. • Initial data files of: (1) Addendum 2 provider counts and (2) primary physicians and specialty providers under contract by county (and zip code) for the next calendar year. • Addendum 1C – Utilization Review Worksheet.	
June 1, 2004 or date due to NCQA, whichever is later	• HEDIS information is required for the prior calendar year.	
June 15, 2004	• Plan Utilization and Rate Review Information (Addendum #1A). This information is to be mailed directly to: James A. Scearcy Deloitte & Touche 400 One Financial Plaza 120 South Sixth St Minneapolis, MN 55402-1844 And simultaneously e-mailed to sonya.sidky@etf.state.wi.us • Addendum 1B – Tables describing catastrophic cases. (Table 8)	
July 15, 2004	• If the plan offers dental coverage, final dental plan benefit description is due if the dental coverage is first being offered or if there is any benefit change to the dental benefit.	
July 23, 2004	• Premium rate quotations for next calendar year. (Annually, about July 15, each plan will be provided with a rate quotation form and a special mailing envelope.)	

Due Date (Receipt by ETF)	Information Due	Date Submitted
July 27, 2004	• Final data files of: 1) Addendum 2 and 2) providers under contract by county (and zip code) for the next calendar year. (Note: This date will be moved up by one week at the discretion of the Department's Data Manager for any individual plans for whom the June 1 data submission was unacceptable.)	
August 1, 2004	• Text to be printed in the plan description section of the annual Dual-Choice brochures. Plans must use the format provided by the Department and list major providers and hospitals in its network for all counties the Board has determined the plan to be qualified.	
August 13, 2004	• Request for state employee home address labels (by zip code) for plan use during Dual-Choice Enrollment Period. • The plan's address and telephone number as it should appear in the Dual-Choice brochure.	
August 13, 2004 (Approximately)	• Final best premium bid or withdrawal notice due. • Due date for a plan to notify the Department that it is terminating its contract with the Board.	
August 24, 2004	• Group Insurance Board meeting to set the Standard plans' premium rates (fee-for-service plan) and to open alternate plan rate submittals.	
September 1, 2004	• Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice Enrollment period. • Complete list of the plan's key contacts as stated in Section II., G., 3., j.	
September 15, 2004	• Draft of dental benefit description that will be provided to members if the plan offers dental coverage. This must include the exclusions and limitations. Department approval, prior to October 1, is required. • Draft of letter the plan will mail to current subscribers summarizing dental benefit and provider network changes for the new calendar year, including a description of referral requirements. Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the Department. Department approval, prior to October 1, is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY OCTOBER 1, WITH FORWARDING REQUESTED.** • In order to le[GUIDELINES]during the Dual-Choice Enrollment period, the plan, its representatives and informational materials shall advise participants that only those providers listed in its current provider directory should be considered when making their health plan choice.	
September 30, 2004	• Completed contract, signed and dated. This must include <u>two</u> (2) copies of the contract and all applicable attachments. • Provide five (5) copies of all informational materials in final form to the Department. • Final dental benefit/exclusion description which will be provided to members if the plan offers dental coverage.	

Due Date (Receipt by ETF)	Information Due	Date Submitted
October 1, 2004 (approx)	• Dual-Choice Kick-off meeting in Madison. Address labels for state employees for plan informational mailings will be available.	
October 4 – 22, 2004	• Dual-Choice Enrollment Period.	
October 8, 2004	• Confirmation that letter to current subscribers summarizing changes for the new calendar year has been sent.	
October 30 – December 1, 2004	• Send to appropriate subscribers a standardized letter, designed by the Department, requesting verification of student status. • On or before December 1, report complying with HIPAA to ETF and to the employing agency any subscribers whose level of coverage has changed (e.g., family to single) as a result of the annual student status questionnaire.	
January 2, 2005	• Identification cards must be issued to all new Dual-Choice enrollees. Explanation of referral and grievance procedures must be included.	
January 15, 2005	• Issuance of new ID cards, if applicable, to continuing subscribers. Letter to ETF confirming completion is also due.	
March 1, 2005	• Report summary of grievances received during previous calendar year period, by number and type. [Section II., G., 3., d., (3.)]	
April 1, 2005	• A Quality Improvement plan in the format set forth by the Department.	
18th of Each Month	• Report identifying direct pay terminations and reinstatements or, if none, statement indicating no data to report.	
Quarterly or Monthly as directed by the Department	• HIPAA compliant Full File Compare Submissions.	

ADDENDUM

Plan Name _____

ADDENDUM 1C: Utilization Review Worksheet

Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians. (Utilization Review; UR)

Check YES, if requirement is in place. Plans must certify that these (or equivalent) procedures are in place.
If "NO" is answered to any question, plans must provide, in writing, a description of the equivalent process.

YES	NO	
☐	☐	Written guidelines that physicians must follow to comply with the HMO's or PPP's UR program (for IPA model HMOs).
☐	☐	Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.
☐	☐	Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.
☐	☐	Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.
☐	☐	Procedure to monitor emergency admissions to non-plan hospitals.
☐	☐	Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.
☐	☐	Send correspondence to network hospitals and require those in metropolitan areas to complete the Leapfrog survey and educate those in rural areas about Leapfrog.
☐	☐	Send correspondence to network hospitals encouraging participation in the Wisconsin Hospital Association quality accountability initiative.

ADDENDUM 2: PLAN QUALIFICATIONS/PROVIDER GUARANTEE

Providers Under Contract Physically Located in Each Major City/County/Zip Code
State and Local Employees

Using the format provided by ETF, record the number of providers under contract sorted by zip-code who are physically located within each county and major city in the service area. Major cities are those that have over 33% of the county population. Those cities are Antigo, Appleton, Ashland, Eau Claire, Florence, Fond du Lac, Green Bay, Janesville, Kenosha, LaCrosse, Madison, Manitowoc, Menomonie, Merrill, Milwaukee, Monroe, Oshkosh, Prairie du Chien, Racine, Sheboygan, Stevens Point, Sturgeon Bay, and Superior.

Provider Guarantee:
Providers listed here and/or on any of the plan's publications of providers are either under contract and available as specified in such publications for all of the ensuing calendar year or the plan will pay charges for benefits on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the subscriber is held harmless and indemnified. The intent of this provision is to allow patients of plan providers to continue appropriate access to any plan provider until the participant is able to change plans through the next dual-choice enrollment. This applies in the event a provider or provider group terminates its contract with the plan, except that loss of physicians due to normal attrition (death, retirement, a move from the service area;) or as a result of a formal disciplinary action relating to quality of care shall not require fee-for-service payment. If a participant is in her second or third trimester of pregnancy when the provider's participation in the plan terminates, the participant will continue to have access to the provider until the completion of postpartum care for the woman and infant. Providers also agree to accept new patients unless specifically indicated otherwise. When providers terminate their contractual relationship, subscribers must be notified by the plan prior to the Dual-Choice Enrollment period. Plans shall keep a record of this notification mailing and shall provide documentation, by subscriber and indicating the mailing address used, upon the Department's request.

If a plan clinic or hospital closes during the contract year, participants using that facility must be notified, in writing, 30 days in advance of the closing. This notice may be provided by the provider. The notification must indicate the participant's options for other plan clinics or hospitals. If a physician leaves the plan mid-year, his or her patients must be notified, in writing, no less than 14 days prior to that event. In either instance, the subscriber must be advised of the provider guarantee.

This form must be filed annually by all current and new plans with the Department of Employee Trust Funds. The initial listing is due on June 1; the final copy is due on July 30. It is used to determine qualification for the plan's premium rate to be used in calculation of the employer contribution toward premium. Generally, those qualifications are:

1. The ratio of full time equivalent (FTE) primary physicians accepting new patients to total plan members in a country or major city is at least 1.0/2,000 with a minimum of 5 physicians/county or major city. The primary physicians counted for this qualification requirement must be able to admit patients to a plan hospital in the county where the plan is qualified.

2. There must be at least one general hospital per county or major city. If a hospital is not present in the county, plans must sufficiently describe how they provide access to providers per standards set forth under Wis. Adm. Code § INS 9.34 (2). The Department will review requests for qualification on an individual basis and make recommendations to the Board.

3. If optional dental coverage is offered, a dentist must be available in each county (or major city

ADDENDUM

if applicable).

4. A chiropractor must be available in each county (or major city if applicable).

5. The plan must have a minimum of one year of operation.

6. After being offered to state employees for one year, the plan must have achieved an enrollment of 100 subscribers or 10% of the employees in the service area. Service area means the entire geographic area in which the plan is qualified.

Health plans are responsible for submitting two types of reports to ETF
(1) A listing that includes all providers of any type. All providers should be listed by name. Under no circumstances, should a clinic be listed in lieu of provider names.
(2) Health plans must also submit counts of providers and institutions used by ETF to determine plan qualification by county. Summary counts must be provided for every County and Major City in which a health plan has at least one PCP. ETF not only determines qualification status from the provider counts, but also determines whether or not a health plan will be listed in the "It's Your Choice" booklet as a non-qualified plan. Generally, if a health plan has at least one PCP in a county, the health plan will be listed in the "It's Your Choice" booklet although ETF may choose not to list a plan if it is not practical to do so. For example, ETF would not list a health plan that has a low number of providers in a high population county.

Please note that all providers that health plans make available to participants or publish in the provider listings sent to members must be reflected in both the provider listing and the provider counts. Specific instructions on how to submit the information detailed above will be provided to the health plans in advance of the due date. ETF reserves the right to modify instructions and data requests as needed and may also request updated reports from health plans as needed.

SAMPLE FORMAT

Date: _____
Plan: We-Care (Name of Plan) La Crosse (Location/Service Area)

Counties and Major Cities in Service Area	No. Dentists	No. Chiropractors	No. General Hospital Routinely Utilized	No. FTE Primary Care Providers*	Total Members
Crawford	17	3	0	4	
Juneau	10	3	0	3	
La Crosse (City)	7	2	2	29	
La Crosse (County)	18	4	3	102	

NA Means no benefit available (i.e., if no dental benefit offered, indicate NA)

* Primary care provider as defined in Uniform Benefits and utilized by the plan in the manner described in the definition.

STATE CONTRACT

ARTICLE 1 DEFINITIONS

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

1.1 "ANNUITANT" means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System; or a terminated EMPLOYEE with 20 years of creditable service or a disability benefit under Wis. Stat. § 40.65.

1.2 "BENEFITS" means those items and services as listed in Attachment A.

1.3 "BOARD" means the Group Insurance Board.

1.4 "CONTRACT" means this document which includes all attachments, supplements, endorsements or riders.

1.5 "DEPARTMENT" means the Department of Employee Trust Funds.

1.6 "DEPENDENT" means the spouse of the SUBSCRIBER and his or her unmarried children (including legal wards who become legal wards of the SUBSCRIBER prior to age 19 but not temporary wards, adopted children or children placed for adoption as provided for in Wis. Stat. § 632.896, and stepchildren), who are dependent on the SUBSCRIBER (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a dependent for federal income tax purposes (whether or not the child is claimed), and children of those DEPENDENT children until the end of the month in which the DEPENDENT child turns age 18. Adoptive children become DEPENDENTS when placed in the custody of the parent as provided by Wis. Stat. § 632.896. Children born outside of marriage become DEPENDENTS of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health and Family Services or equivalent if the birth was outside the state of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. A spouse and stepchildren cease to be DEPENDENTS at the end of the month in which a divorce decree is entered. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other Children cease to be DEPENDENTS at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

(1) Children age 19 or over who are full-time students, if otherwise eligible, cease to be DEPENDENTS at the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.

(2) Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school" includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools, intersession courses (for example, courses during winter break), and night schools.

(3) If otherwise eligible children are, or become, incapable of self-support on account of a physical or mental disability which can be expected to be of long-continued or indefinite duration of at

least one year or longer, they continue to be or resume their status of DEPENDENTS regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible DEPENDENT under this program in order to resume coverage. The HEALTH PLAN will monitor mental or physical disability at least annually and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the initial HEALTH PLAN determination.

(4) A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

(5) Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility not on the date of notification to the HEALTH PLAN.

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

1.8 "EMPLOYEE" means an eligible EMPLOYEE of the State of Wisconsin as defined under Wis. Stat. § 40.02 (25) (a), 1., 2., or (b), 1m., 2., 2g., 2m., or 8.

1.9 "FAMILY SUBSCRIBER" means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

1.10 "HEALTH PLAN" means the alternate health care plan signatory to this agreement.

1.11 "INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

1.12 "INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

1.13 "LAYOFF" means the same as "leave of absence" as defined under Wis. Stat. § 40.02 (40).

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

1.15 "PREMIUM" means the rates shown on ATTACHMENT C plus the pharmacy rate and administration fees required by the BOARD. Those rates may be revised by the HEALTH PLAN annually, effective on each succeeding January 1 following the effective date of this CONTRACT.

1.16 "STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD.

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

2.9 CONTINUATION OR CONVERSION OF INSURANCE.

(1) Except when coverage is canceled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the employer is not notified of the PARTICIPANT'S loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the employer notice, whichever is later. Application must be received by the DEPARTMENT within 60 days of the date the PARTICIPANT is notified by the employer of the right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for required PREMIUMS. The HEALTH PLAN may not apply a surcharge to the PREMIUM, even if otherwise permitted under State or federal law.

If the PARTICIPANT does not reside in a county listing a primary physician for the SUBSCRIBER'S HEALTH PLAN at the time continuation coverage is elected, the PARTICIPANT may elect a participating plan in the county where the PARTICIPANT resides.

(2) Such PARTICIPANT may also elect to convert to individual coverage, without underwriting, if application is made directly to the HEALTH PLAN within 30 days after termination of group coverage as provided under Wis. Stat. Stat. §632.897. The PARTICIPANT shall be eligible, to apply for the direct pay conversion contract then being issued provided coverage is continuous and the PREMIUMS then in effect for the conversion contract are paid without lapse. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation of group coverage.

(3) Children born or adopted while the parent is continuing group coverage may be covered for the remainder of the parent's period of continuation. A PARTICPANT who has single coverage must elect family coverage within 60 days of the birth or adoption in order for the child to be covered. The HEALTH PLAN will automatically treat the child as a qualified DEPENDENT as required by COBRA and provide any required notice of COBRA rights.

2.10 GRIEVANCE PROCEDURE.

(1) Any dispute about health insurance BENEFITS or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through the HEALTH PLAN'S internal grievance process and may then, if necessary, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint for review with the Quality Assurance Services Bureau. The PARTICIPANT may also request a departmental determination. The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code § ETF 11.01 (3). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12).

(2) The PARTICIPANT may also request an independent review as provided under Wis. Adm. Code § INS 18.11. In this event, the DEPARTMENT must be notified by the HEALTH PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In accordance with Wis. Adm. Code § INS 18.11 any determination by an Independent Review Organization is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered.

(3) The HEALTH PLAN'S grievance procedure must be included as ATTACHMENT E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.03 or any other statutes or administrative codes that relate to managed care grievances. This extends to any "carve-out"

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services (e.g., dental, chiropractic, m[illegible])

(4) The PARTICIPANT must be provided with notice of the right to grieve and a minimum period of 60 days to file a grievance after written denial of a BENEFIT or occurrence of the cause of the grievance.

(5) Investigation and resolution of any grievance will be initiated within 5 days of the date the grievance is filed by the complainant in an effort to effect early resolution of the problem. Grievances related to an urgent health concern will be handled within four business days of the HEALTH PLAN'S receipt of the grievance.

(6) Notification of Determination Rights.

In final grievance decision letters, the HEALTH PLAN shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision. In the event they disagree with the final decision, PARTICIPANTS may submit a written request to the DEPARTMENT within 60 days of the date of the final grievance decision letter. The DEPARTMENT will review, investigate, and attempt to resolve complaints on behalf of PARTICIPANTS. Upon completion of the DEPARTMENT review and in the event that PARTICIPANTS disagree with the outcome, PARTICIPANTS may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within 60 days of the date of the DEPARTMENT final review letter.

(7) Provision of Complaint Information.

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a HEALTH PLAN shall be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the HEALTH PLAN shall cooperate in obtaining the authorization and shall accept the DEPARTMENT'S form, when signed by the PARTICIPANT or PARTICIPANT'S representative, to give written authorization for release of information to the DEPARTMENT. Information may include complete copies of grievance files, medical records, consultant reports, customer service contact worksheets or any other documentation the DEPARTMENT deems necessary to review a PARTICIPANT complaint resolving disputes or when formulating determinations. Such information must be provided at no charge within fifteen working days, or by an earlier date as requested by the DEPARTMENT.

ARTICLE 3 COVERAGE

3.3 SELECTION OF COVERAGE.

(1) If coverage is not elected under this section, it shall be subject to the deferred coverage provision of section 3.10. Except as otherwise provided in this section, coverage shall be effective on the first day of the month, which begins on, or after the date the application is received by the employer.

(2) (a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the employer within 30 days of hire, to be effective on the first day of the month following receipt of the application by the employer, or prior to becoming eligible for employer contributions to be effective upon becoming eligible for employer contribution. In accordance with Wis. Stat. § 40.51 (2), 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. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements.

(b) Notwithstanding paragraph (2) a. above, an EMPLOYEE who is not insured but who is eligible for an employer contribution under Wis. Stat. § 40.05 (4) (ag)1 may elect coverage prior to becoming eligible for an employer contribution under Wis. Stat. § 40.05 (4) (ag)2 to be effective upon the date of the increase in the employer contribution. An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in employer contribution shall have coverage effective on the first day of the month following receipt of the application by the employer.

(3) (a) An EMPLOYEE eligible and enrolled for individual coverage only may change to family coverage effective on the date of change to family status including transfer of custody of eligible DEPENDENTS if an application is received by the employer within 30 days after the date of the change to family status. The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS shall submit the application to the DEPARTMENT.

(b) Notwithstanding paragraph 3 (a) above, the birth or adoption of a child to a SUBSCRIBER under a single plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the employer within 60 days of the birth, adoption or placement for adoption.

(4) In addition to any enrollment period required under Wis. Stat. § 40.05 (4g), an EMPLOYEE enrolled for coverage at the time of being called into active military service whose coverage lapses shall be entitled to again enroll upon resumption of eligible employment with the same employer subject to the following:

(a) Employment is resumed within 90 days after release from active military service, and

(b) The application for coverage is received by the employer within 30 days after return to employment.

(c) An EMPLOYEE who is enrolled for individual coverage and becomes eligible for family coverage between the time of being called into active military service and the return to employment may elect family coverage within 30 days upon re-employment without penalty.

(d) Coverage is effective upon the date of re-employment. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

(5) If a person is erroneously omitted from participation under the Wisconsin Retirement System and the omission is corrected retroactively, including payment of all WRS required contributions for the retroactive period, the DEPARTMENT is empowered to fix a deadline for submitting an application for prospective group health care coverage if the person would have been eligible for the coverage had the error never occurred.

(6) (a) An eligible EMPLOYEE may defer the selection of coverage under this section 3.3 if he/she is covered under another health insurance plan, or under medical assistance (Medicaid), or as a member of the US Armed Forces, or as a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE loses eligibility for that other coverage or the employer's contribution towards the other coverage ceases, he/she may elect coverage under any plan by filing an application with the employer within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. An EMPLOYEE enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS covered under another plan lose eligibility for that coverage or the employer's PREMIUM contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

(b) An EMPLOYEE who deferred coverage because he or she is covered under another plan may enroll for family coverage if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption, or marriage provided he or she submits an application for family coverage within 60 days of that event.

(c) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event described in (b) above. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

(7) In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician who is not available in the plan selected, the HEALTH PLAN shall immediately reject the application and return it to the employer. The SUBSCRIBER shall be allowed to correct the plan selected to one, which has that physician available, upon notice to the employer that the error occurred. The application shall be effective the later of first of the month following receipt of the application or the effective date of the original application. The HEALTH PLAN shall also immediately reject the application and return it to the employer if the SUBSCRIBER fails to list a primary physician. The HEALTH PLAN may not simply reassign a primary physician.

(8) PARTICIPANTS who have escrowed their sick leave or have their sick leave preserved as provided for in statute may reenroll in any HEALTH PLAN without underwriting restrictions as follows:

(a) Coverage for those who have escrowed under Wis. Stat. § 40.05 (4) (b) and (be) may enroll during the dual choice enrollment period and be effective the first day of the month selected by the PARTICIPANT of the following year as provided in section 3.4(1).

(b) For the PARTICIPANTS defined in Wis. Stat. § 40.02 (25) (b) (6e) and (6g) whose sick leave has been preserved under Wis. Stat. § 40.05 (4) (bc), coverage will begin on the first of the month following the DEPARTMENT'S receipt of the health insurance application, unless otherwise specified on the application.

(c) PARTICIPANTS losing eligibility for other coverage or the employer's contribution towards the other coverage ceases, may elect coverage under any plan by filing an application with the DEPARTMENT within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. A PARTICIPANT enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS are covered under the other plan and lose eligibility for that coverage or the employer's PREMIUM contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage. Coverage shall be effective on the date of termination of the prior plan or the date of the event. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.

(9) Eligible retired EMPLOYEES or former EMPLOYEES of the State who have re-enrolled under section 3.10 (4) of the GUIDELINES may select any offered plan.

3.9 REHIRED OR TRANSFERRED EMPLOYEE COVERAGE.

(1) Any insured EMPLOYEE who terminates employment with the state and is re-employed by the state in a position eligible for health insurance within 30 days or who terminates employment for a period of more than 30 days that does not comply with Wis. Adm. Code § ETF 10.08 (2) and (3) shall be deemed to have been on leave of absence for that time and is limited to previous coverage.

(2) If an insured EMPLOYEE transfers from one state agency to another, an application must be filed within 30 days to maintain continuous coverage. If no application is filed within the 30-day enrollment period, continuous coverage may be reinstated by filing an application and paying back PREMIUM. The constructive waiver of coverage under section 3.6 will apply.

3.16 COVERAGE OF ANNUITANTS AND SURVIVING DEPENDENTS ELIGIBLE FOR MEDICARE.

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS 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.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month which begins on or after the date the Medicare hospital and medical insurance benefits (Parts A and B) become effective.

(3) Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT who does not enroll in Medicare Part B when it is first available as the primary carrier shall be limited in accordance with Uniform Benefits IV., A., 12., b. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity and the HEALTH PLAN shall 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.

3.18 INDIVIDUAL TERMINATION OF COVERAGE.

(1) A PARTICIPANT'S coverage shall terminate on the earliest of the following dates:

(a) The effective date of change to another health care plan through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to Federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the HEALTH PLAN'S requirement for the amount that must be paid. However, the HEALTH PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage, while on a leave of absence or LAYOFF expires, as provided in section 3.12.

(d) The end of the month in which a notice of cancellation of coverage is received by the employer or by the DEPARTMENT in the case of an ANNUITANT or a later date as specified on the cancellation of coverage notice.

ARTICLE 1 DEFINITIONS

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

1.1 "ANNUITANT" means any retired EMPLOYEE of a participating employer: receiving an immediate annuity under the Wisconsin Retirement System; or a person with 20 years of creditable service who is eligible for an immediate annuity but defers application; or a person receiving an annuity through a program administered by the DEPARTMENT under Wis. Stat. § 40.19 (4) (a) or a benefit under Wis. Stat § 40.65.

1.2 "BENEFITS" means those items and services as listed in Attachment A.

1.3 "BOARD" means the Group Insurance Board.

1.4 "CONTRACT" means this document which includes all attachments, supplements, endorsements or riders.

1.5 "DEPARTMENT" means the Department of Employee Trust Funds.

1.6 "DEPENDENT" means the spouse of the SUBSCRIBER and his or her unmarried children (including legal wards who become legal wards of the SUBSCRIBER prior to age 19 but not temporary wards, adopted children or children placed for adoption as provided for in Wis. Stat. § 632.896, and stepchildren), who are dependent on the SUBSCRIBER (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a dependent for federal income tax purposes (whether or not the child is claimed), and children of those DEPENDENT children until the end of the month of which the DEPENDENT child turns age 18. Adoptive children become DEPENDENTS when placed in the custody of the parent as provided by Wis. Stat. § 632.896. Children born outside of marriage become DEPENDENTS of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity is filed with the Department of Health and Family Services or equivalent if the birth was outside the state of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. A spouse and stepchildren cease to be DEPENDENTS at the end of the month in which a divorce decree is entered. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other Children cease to be DEPENDENTS at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

(1) Children age 19 or over who are full-time students, if otherwise eligible, cease to be DEPENDENTS at the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.

(2) Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school" includes elementary schools, junior and senior high schools, colleges, universities, and technical trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools, intersession courses (for example, courses during winter break), and night schools.

(3) If otherwise eligible children are, or become, incapable of self-support on account of a physical or mental disability which can be expected to be of long-continued or indefinite duration of at least one year or longer, they continue to be or resume their status of DEPENDENTS regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible DEPENDENT under this program in order to resume coverage. The HEALTH PLAN will monitor mental or physical disability at least annually and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the initial HEALTH PLAN determination.

(4) A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

(5) Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility not on the date of notification to the HEALTH PLAN.

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

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

1.9 "FAMILY SUBSCRIBER" means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

1.10 “HEALTH PLAN” means the alternate health care plan signatory to this agreement.

1.11 "INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

1.12 "INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

1.13 "LAYOFF" means the same as "leave of absence" as defined under Wis. Stat. § 40.02 (40).

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

1.15 "PREMIUM" means the rates shown on ATTACHMENT C which may be revised by the HEALTH PLAN annually plus the pharmacy rate and administration fees required by the BOARD, effective on each succeeding January 1 following the effective date of this CONTRACT.

2.5 BROCHURES AND INFORMATIONAL MATERIAL

(1) The HEALTH PLAN shall provide the SUBSCRIBER with identification cards and a listing of all available providers and available locations, and pre-authorization and referral requirements. If the HEALTH PLAN offers dental coverage, it must provide the PARTICIPANT a description of the dental network BENEFITS, limitations and exclusions.

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the HEALTH PLAN. Five (5) copies of all informational materials in final form must be provided to the DEPARTMENT. At its discretion, the DEPARTMENT may designate a common vendor who shall provide the annual Description of BENEFITS and such other information or services it deems appropriate, including audit services. The vendor shall be reimbursed by the HEALTH PLAN at cost, but not to exceed $.12 per member per month. HEALTH PLANS will be advised of the amount of the charge prior to the due date for premium bids. The HEALTH PLAN will be responsible for any costs assessed to the HEALTH PLAN even if the HEALTH PLAN is withdrawing from the program.

(3) 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]."

(4) If erroneous or misleading information is sent to SUBSCRIBERS by a provider or subcontractor, the DEPARTMENT may require a HEALTH PLAN mailing to correctly inform PARTICIPANTS.

2.9 CONTINUATION OR CONVERSION OF INSURANCE.

(1) Except when coverage is canceled, PREMIUMS are not paid when due, coverage is terminated as permitted by state or federal law, or the employer is not notified of the PARTICIPANT'S loss of eligibility as required by law, a PARTICIPANT who ceases to be eligible for BENEFITS may elect to continue group coverage for a maximum of 36 months from the date of the qualifying event or the date of the employer notice, whichever is later. Application must be received by the DEPARTMENT within 60 days of the date the PARTICIPANT is notified by the employer of the right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for required PREMIUMS. The HEALTH PLAN may not apply a surcharge to the PREMIUM, even if otherwise permitted under State or federal law.

If the PARTICIPANT does not reside in a county listing a primary physician for the SUBSCRIBER'S HEALTH PLAN at the time continuati[on] [P]ARTICIPANT may elect a participating plan in the county where

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(2) Such PARTICIPANT may also elect to convert to individual coverage without underwriting if application is made directly to the HEALTH PLAN within 30 days after termination of group coverage as provided under Wis. Stat. Stat. §632.897. The PARTICIPANT shall be eligible to apply for the direct pay conversion contract then being issued provided coverage is continuous and the

PREMIUMS then in effect for the conversion contract are paid without lapse. The right to a conversion contract will also be offered when the PARTICIPANT reaches the maximum length of continuation of group coverage.

(3) Children born or adopted while the parent is continuing group coverage may also be covered for the remainder of the parent's period of continuation. A PARTICIPANT who has single coverage must elect family coverage within 60 days of the birth or adoption in order for the child to be covered. The HEALTH PLAN will automatically treat the child as a qualified DEPENDENT, as required by COBRA and provide any required notice of COBRA rights.

2.10 GRIEVANCE PROCEDURE.

(1) Any dispute about health insurance BENEFITS or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through the HEALTH PLAN'S internal grievance process and may then, if necessary, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint for review with the Quality Assurance Services Bureau. The PARTICIPANT may also request a departmental determination. The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code § ETF 11.01 (3). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12).

(2) The PARTICIPANT may also request an independent review as provided under Wis. Adm. Code § INS 18.11. In this event, the DEPARTMENT must be notified by the HEALTH PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In accordance with Wis. Adm. Code § INS 18.11 any determination by an Independent Review Organization is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered.

(3) The HEALTH PLAN'S grievance procedure must be included as ATTACHMENT E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.03 or any other statutes or administrative codes that relate to managed care grievances. This extends to any "carve-out" services (e.g., dental, chiropractic, mental health).

(4) The PARTICIPANT must be provided with notice of the right to grieve and a minimum period of 60 days to file a grievance after written denial of a BENEFIT or occurrence of the cause of the grievance.

(5) Investigation and resolution of any grievance will be initiated within 5 days of the date the grievance is filed by the complainant in an effort to effect early resolution of the problem. Grievances related to an urgent health concern will be handled within four business days of the HEALTH PLAN'S receipt of the grievance.

(6) Notification of Determination Rights.

In the final grievance decision letters, the HEALTH PLAN shall inform PARTICIPANTS of their right to request a DEPARTMENT review of the grievance committee's final decision. In the event they disagree with the final decision, PARTICIPANTS may submit a written request to the DEPARTMENT within 60 days of the date of the final grievance decision letter. The DEPARTMENT will review, investigate, and attempt to resolve complaints on behalf of the PARTCIPANTS. Upon completion of the DEPARTMENT review and in the event that PARTICIPANTS disagree with the outcome,

PARTICIPANTS may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within 60 days of the date of the DEPARTMENT final review letter.

(7) Provision of Complaint Information.

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a HEALTH PLAN shall be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the HEALTH PLAN shall cooperate in obtaining the authorization and shall accept the DEPARTMENT'S form, when signed by the PARTICIPANT or PARTICIPANT'S representative, to give written authorization for release of information to the DEPARTMENT. Information may include complete copies of grievance files, medical records, consultant reports, customer service contact worksheets or any other documentation the DEPARTMENT deems necessary to review a PARTICIPANT complaint, resolving disputes or when formulating determinations. Such information must be provided at no charge within fifteen working days, or by an earlier date as requested by the DEPARTMENT.

ARTICLE 3 COVERAGE

3.1 EFFECTIVE DATE.

(1) The group health insurance program pursuant to Wis. Stat. § 40.51 (7), and under which the HEALTH PLAN is participating according to the terms of this CONTRACT, shall be available beginning July 1, 1987. If recommended by the DEPARTMENT'S actuary and approved by the BOARD, underwriting requirements may apply to municipalities joining the program and a surcharge applied when the risk as determined through the underwriting process is determined to be detrimental to the existing pool.

(2) The governing body of an employer shall adopt a resolution for regular or deductible option coverage in a form prescribed by the DEPARTMENT. The resulution may provide for underwriting or rate differential as deemed appropriate by the BOARD'S actuary. The EFFECTIVE DATE of coverage shall be the beginning of the calendar month on or after 90 days following receipt by the DEPARTMENT of the resolution, unless the resolution specifies a later month and is approved by the DEPARTMENT. At least 30 days prior to the EFFECTIVE DATE, the DEPARTMENT must receive from the employer all EMPLOYEE and ANNUITANT applications for which coverage will begin on the EFFECTIVE DATE. If the number of EMPLOYEE applications received does not represent the minimum participation level of at least 65% of the eligible EMPLOYEES or for small employers as defined under Wis. Stat. § 635.02 (7), the minimum participation level in accordance with Wis. Adm. Code § INS 8.46 (2), the resolution shall become void, unless the employer is granted a waiver of the participation requirement by the DEPARTMENT. EMPLOYEES who are on a leave of absence and not insured under the employer's plan are eligible to enroll only under section 3.10 if they returned to active employment. For ANNUITANTS and EMPLOYEES on leave of absence to be eligible under this section, they must be insured under the employer's current group health plan. Eligible EMPLOYEES who are not insured under the employer's current group health plan at the time the resolution to participate is filed or evidence of insurability is required, or those insured for single coverage who are enrolling for family coverage, shall be subject to the deferred coverage provisions of section 3.10. This limitation will not apply to PARTICIPANTS insured under another group health insurance plan administered by the DEPARTMENT.

(3) Notwithstanding section 3.2, any employer for whom the resolution made under section 3.1 resulted in coverage effective January 1, 1988 or after shall be required to remain in the program for a minimum of 12 months and any employer who files a resolution after December 20, 1990, and who offers a non-participating plan pursuant to sub. (4) shall be required to remain in the program a minimum of three years.

(4) The employer may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD nor provide payments to employees in lieu of coverage under this program. However, the DEPARTMENT may allow any employer to offer a non-participating plan to a group of its EMPLOYEES if it can be demonstrated to the satisfaction of the DEPARTMENT that: (1) collective bargaining barriers require such other coverage; and (2) there will be no adverse impact to the program; and (3) that the minimum number of all of the employer's Wisconsin Retirement System participating EMPLOYEES, including those who are in the non-participating health plan, become insured under the program of the BOARD to meet the required participation levels as defined in (2) above. The Plan Stabilization Contribution may be increased for that employer if less than 50% of the participating EMPLOYEES elect the STANDARD PLAN coverage.

3.3 SELECTION OF COVERAGE.

(1)(a) If coverage is not elected under this section, it shall be subject to the deferred coverage

provision of section 3.10. Except as LOCAL CONTRACT tion, coverage shall be effective on the first day of the month which begins on or after the date the application is received by the employer.

(b) An EMPLOYEE shall be insured if coverage is selected as provided for in section 3.1 (2). If the EMPLOYEE is not eligible for employer contribution toward PREMIUM at that time, section 3.3 (3) applies.

(2)(a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the employer within 30 days of hire, or before the effective date of the employer contribution toward the PREMIUM, to be effective the beginning of the month on or after the effective date of the date of employer contribution toward premium. 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. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements.

(b) Notwithstanding paragraph (2) (a) above, an EMPLOYEE who is not insured but who is eligible for an employer contribution under Wis. Adm. Code § ETF 40.10 (2)(a) may elect coverage prior to becoming eligible for an employer contribution under Wis. Adm. Code § ETF 40.10 (2)(b) to be effective upon the date of the increase in the employer contribution. An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in employer contribution shall have coverage effective on the first day of the month following receipt of the application by the employer.

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

(b) Notwithstanding paragraph 2 (a) above, the birth or adoption of a child to a SUBSCRIBER under a single plan, who was previously eligible for family coverage, will allow the SUBSCRIBER to change to family coverage if an application is received by the employer within 60 days of the birth, adoption or placement for adoption.

(4) An EMPLOYEE enrolled for coverage at the time of being called into active military service shall be entitled to again enroll upon resumption of eligible employment with the same employer subject to the following:

(a) Employment is resumed within 90 days after release from active military service, and

(b) The application for coverage is received by the employer within 30 days after return to employment.

(c) An EMPLOYEE who is enrolled for individual coverage and becomes eligible for family coverage between the time of being ca LOCAL CONTRACT e and the return to employment may elect family coverage within 30 da ut penalty.

(d) Coverage is effective upon the date of re-employment. A full month's PREMIUM is due for

that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

(5) If a person is erroneously omitted from participation under the Wisconsin Retirement System and the omission is corrected retroactively, including payment of all WRS required contributions for the retroactive period, the DEPARTMENT is empowered to fix a deadline for submitting an application for prospective group health care coverage if the person would have been eligible for the coverage had the error never occurred.

(6)(a) An eligible EMPLOYEE may defer the selection of coverage under this section 3.3 if he/she is covered under another health insurance plan, or under medical assistance (Medicaid), or as a member of the US Armed Forces, or as a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE loses eligibility for that other coverage or the employer's premium contribution towards the other coverage ceases, he/she may elect coverage under any plan by filing an application with the employer within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility. An EMPLOYEE enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS covered under the other plan lose eligibility for that coverage or the employer's contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

(b) An EMPLOYEE who deferred coverage because he or she is covered under another plan may enroll for family coverage if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption or marriage, provided he or she submits an application within 60 days of that event.

(c) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event as described in b. above. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire premium for that month is waived.

(7) In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician who is not available in the plan selected, the HEALTH PLAN shall immediately reject the application and return it to the employer. The SUBSCRIBER shall be allowed to correct the plan selected to one which has that physician available, upon notice to the employer that the error occurred. The application shall be effective the later of first of the month following receipt of the application or the effective date of the original application. The HEALTH PLAN shall also immediately reject the application and return it to the employer if the SUBSCRIBER fails to list a primary physician. The HEALTH PLAN may not simply reassign a primary physician.

(8) An ANNUITANT shall be covered if a completed DEPARTMENT application form is received as specified in section 3.1 (2).

(9) If the DEPARTMENT determines it could effectively monitor it, an ANNUITANT with comparable coverage may escrow sick leave, if available, and reenroll in any HEALTH PLAN without underwriting restrictions with coverage effective on the first of the month following the DEPARTMENT'S receipt of the health insurance application.

3.9 REHIRED EMPLOYEE COVERAGE.

Any insured EMPLOYEE who terminates employment with an employer participating under Wis. Stat. § 40.51 and is reemployed by the same employer within 30 days in a position eligible for health insurance or who terminates employment for a period of more than 30 days that does not comply with Wis. Adm. Code § ETF 10.08 (2) and (3) shall be deemed to have been on leave of absence for that time and is limited to previous coverage.

3.16 COVERAGE OF ANNUITANTS AND SURVIVING DEPENDENTS ELIGIBLE FOR MEDICARE.

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS 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.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the Medicare hospital, and medical insurance benefits (Parts A and B) become effective.

(3) Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT who does not enroll in Medicare Part B when it is first available as the primary carrier shall be limited in accordance with Uniform Benefits IV,. A., 12., b. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity and the HEALTH PLAN shall 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.

(4) Enrollment under the federal plans for hospital and medical care for the aged (Medicare) by EMPLOYEES and ANNUITANTS who are eligible for those programs is waived if the EMPLOYEE remains covered as an active EMPLOYEE of the participating employer. Enrollment in Medicare Part B is required for the EMPLOYEE or DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT or an ANNUITANT'S spouse is covered under an active employee's group health insurance policy with another employer and that policy is the primary payor, the ANNUITANT or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare rates for coverage under this program.

3.18 INDIVIDUAL TERMINATION OF COVERAGE

(1) A PARTICIPANT'S coverage shall terminate on the earliest of the following dates:

(a) The effective date of change to another health care plan through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to Federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the HEALTH PLAN'S requirement for the amount that must be paid. However, the HEALTH PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

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(c) The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage while on a leave of absence or LAYOFF, as provided in section 3.12.

(d) The end of the month in which a notice of cancellation of coverage is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT for whom the employer has no reporting responsibilities, or a later date as specified on the cancellation of coverage notice.

3.21 EMPLOYER CONTRIBUTIONS TOWARD PREMIUM.

(1) The employer contribution toward PREMIUM for any EMPLOYEE shall be at least 50% but not more than 105% of the gross PREMIUM of the least costly health care coverage plan approved by the BOARD which is in the service area of the employer. Employers who determine the EMPLOYEE premium contribution based on the tiered structure established for state EMPLOYEES must do so in accordance with Wis. Adm. Code § ETF 40.10. The DEPARTMENT shall determine the service area of the employer. The effective date of the employer contribution shall not be later than the first of the month after which the EMPLOYEE completes 6 months service with the employer under the Wisconsin Retirement System.

(2) Notwithstanding sub. (1), the amount of employer contribution toward PREMIUM for ANNUITANTS, EMPLOYEES on approved leave of absence or LAYOFF, or those whose coverage is continued under section 2.9 (1) shall be at the discretion of the employer.

(3) The minimum contribution for an EMPLOYEE who is appointed to work less than 1,044 hours per year shall be 25% of the lowest cost plan that is in the service area of the employer and approved by the BOARD.

(4) If the amount of employer contribution changes, a new dual-choice offering may be made to its EMPLOYEES as determined by the DEPARTMENT.

(5) ANNUITANTS for whom the employer contributes toward the PREMIUM shall be treated as EMPLOYEES for the purpose of PREMIUM and coverage reporting.