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LOCAL EMPLOYERS TABLE OF CONTENTS

This CONTRACT sets forth the terms and conditions for the HEALTH PLAN to provide group health care BENEFITS for EMPLOYEES, ANNUITANTS, and their DEPENDENTS eligible for coverage offered to employers participating under the Wisconsin Retirement System by the Group Insurance Board pursuant to Wis. Stat. § 40.51 (7).

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 accredited 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 and student commitments after the semester ends such as student teaching. .

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

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

1.1110 "HEALTH PLAN" means the alternate health care plan signatory to this agreement.

1.1211 "INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

1.1312 "INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

1.1413 "LAYOFF" means the same as "leave of absence" as defined under Wis. Stat. § 40.02 (40).

1.1514 "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.

1.16~~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.

1.17~~16~~ "STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD.

1.18 ~~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.

ARTICLE 2 ADMINISTRATION

2.1 AMENDMENTS.

This CONTRACT may be amended by written agreement between the HEALTH PLAN and the BOARD at any time.

2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW.

(1) In the event of a conflict between this CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

(2) In connection with the performance of work under this CONTRACT, the contractor agrees not to discriminate against EMPLOYEES or applicants for employment because of age, race, religion, creed, color, handicap, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5); marital status, sex, sexual orientation, national origin, ancestry, arrest record, conviction record; or membership in the national guard, state defense force, or any reserve component of the military forces of the United States or this state. The HEALTH PLAN agrees to maintain a written affirmative action plan, which shall be available upon request to the DEPARTMENT.

(3) The HEALTH PLAN shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA) of 1990. Evidence of compliance with ADA shall be made available to the DEPARTMENT upon request.

(4) In cases where premium rate negotiations result in a rate that the BOARD'S actuary determines to be inadequately supported by data submitted by the HEALTH PLAN, the BOARD may take any action up to and including limiting new enrollment into that HEALTH PLAN.

2.3 CLERICAL AND ADMINISTRATIVE ERROR.

(1) Except for the constructive waiver provision of section 3.6, no clerical error made by the employer, the DEPARTMENT or the HEALTH PLAN shall invalidate CONTRACT BENEFITS of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated.

(2) Except for the constructive waiver provision of section 3.6, if an EMPLOYEE or ANNUITANT has made written application during a prescribed enrollment period for either individual or family coverage and has authorized the PREMIUM contributions, CONTRACT BENEFITS shall not be invalidated solely because of the failure of the employer or the DEPARTMENT, due to clerical error, to give proper notice to the HEALTH PLAN of such EMPLOYEE'S application.

(3) In the event that an employer erroneously continues to pay the PREMIUM for an EMPLOYEE who terminates employment, refunds of such PREMIUMS shall be limited to no more than two months of PREMIUMS paid.

(4) Except in cases of fraud, unreported death, misrepresentation, or when required by Medicare, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall not be made prior to January 1 of the previous calendar year. In situations where coverage is validly in force, the employer has not paid PREMIUM, and the EMPLOYEE does not have a required contribution, retroactive PREMIUM will be made for the entire period of coverage,

regardless of the discovery date. The HEALTH PLAN is responsible for resolving discrepancies in claims payments for all MEDICARE data match inquiries.

(5) In the event that an employer determines an effective date under Wis. Stat. § 40.51 (7) based on information obtained from the DEPARTMENT available at the time the application is filed, such application shall not be invalidated solely as a result of an administrative error in determining the proper EFFECTIVE DATE of employer contribution. No such error will result in providing coverage for which the EMPLOYEE would otherwise not be entitled.

2.4 REPORTING.

(1) EMPLOYEES and ANNUITANTS shall become or be SUBSCRIBERS if they have filed with the employer or DEPARTMENT, if applicable, an application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this CONTRACT, the law, the administrative rules, and regulations of the DEPARTMENT.

(2) On or before the effective date of this CONTRACT, the DEPARTMENT shall furnish a report to the HEALTH PLAN showing the INDIVIDUAL SUBSCRIBERS and FAMILY SUBSCRIBERS entitled to BENEFITS under the CONTRACT during the first month that it is in effect, and such other reasonable data as may be necessary for HEALTH PLAN administration. The DEPARTMENT shall furnish like reports for each succeeding month that the CONTRACT is in effect.

(3) Monthly or upon request by the DEPARTMENT, the HEALTH PLAN shall submit a data file (or audit listing, if requested by the DEPARTMENT) to establish or update the DEPARTMENT'S membership files. The HEALTH PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number) determined by the DEPARTMENT. The HEALTH PLAN shall create separate files for SUBSCRIBERS and DEPENDENTS, in a format and timeframe specified by the DEPARTMENT, and submit them to the DEPARTMENT or its designated database administrator. When the DEPARTMENT sends HEALTH PLAN error reports showing SUBSCRIBER and DEPENDENT records failing one or more edits, the HEALTH PLAN shall correct and resubmit the failed records with its next update. The HEALTH PLAN shall annually collect from SUBSCRIBERS coordination of benefits information according to coordination of benefits under the Wisconsin Administrative Code. And report this information to the Department at least annually.

(4) Unless individually waived by the BOARD, each HEALTH PLAN will submit the current applicable version of the Health Plan Employer Data and Information Set (HEDIS) by June 1 for the previous calendar year. The data set will be for both the entire HEALTH PLAN membership and the state group membership where applicable. The data will be supplied in a format specified by the DEPARTMENT. The HEALTH PLAN will include the state group membership prescription drug data from the pharmacy benefit manager in their reported prescription drug measures consistent with NCQA requirements.

(5) HEALTH PLANS shall submit all reports and comply with all material requirements set forth in the GUIDELINES or the BOARD may terminate the CONTRACT between the HEALTH PLAN and the BOARD at the end of the calendar year, restrict new enrollment into the HEALTH PLAN, or impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties for no more than $100 per day per occurrence, to begin on the 5th day following the date notice of non-compliance is delivered to the HEALTH PLAN. Such

financial penalty will not exceed $5000 per occurrence. The penalty may be waived if timely submission is prevented for due cause, as determined by the DEPARTMENT.

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.

2.6 FINANCIAL ADMINISTRATION.

Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the administration fees required by the BOARD.

2.7 INSOLVENCY (OR SOLVENCY).

(1) ATTACHMENT B provides documentation that, in the event the HEALTH PLAN becomes insolvent or otherwise unable to meet the financial provisions of this CONTRACT, bonding or reinsurance exists to pay those obligations. Such bonding or reinsurance shall continue BENEFITS for all PARTICIPANTS at least until the end of the calendar month in which insolvency is declared. For a PARTICIPANT then confined as an INPATIENT, BENEFITS shall continue until the confinement ceases, the attending physician determines confinement is no longer medically necessary, the end of 12 months from the date of insolvency, or the CONTRACT maximum is reached, whichever occurs first. The DEPARTMENT will establish enrollment periods during which SUBSCRIBERS may transfer to another HEALTH PLAN.

(2) The HEALTH PLAN shall submit to the DEPARTMENT on an annual basis, information on its financial condition including a balance sheet, statement of operations, financial audit reports, and utilization statistics.

2.8 DUE DATES.

(1) Reports and remittances from employers required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 20th day of the calendar month for the following month's coverage.

(2) The employer shall immediately forward to the HEALTH PLAN the "carrier advance registration" copy of applications filed by newly eligible EMPLOYEES. The HEALTH PLAN shall issue ID cards based upon the carrier advance registration copy of the application.

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 postmarked 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 HEALTH PLAN must notify a PARTICIPANT at least 60 days prior to loss of eligibility for COBRA coverage and will also notify the PARTICIPANT of other available options, including the availability of conversion coverage and HIRSP. This does not include termination of coverage due to non-payment of premium. -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~~.~~ along with the Uniform Benefit contractual provision(s) upon which the denial is based.

(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.

(8) Notification of Legal Action.

If a PARTICIPANT files a lawsuit naming the HEALTH PLAN as a defendant, the HEALTH PLAN must notify the DEPARTMENT'S chief legal counsel within ten working days of notification of the legal action. This requirement does not extend to cases of subrogation.

(9) If a departmental determination overturns a HEALTH PLAN'S decision on a PARTICIPANT'S grievance, the HEALTH PLAN must comply with the determination within 90 days of the date of the determination or a $500 penalty will be assessed for each day in excess of 90 days. As used in this section, "comply" means to take action as directed in the departmental determination or to appeal the determination to the BOARD within 90 days.

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. As ~~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. The surcharge is determined by the BOARD's actuary and cannot be appealed.

(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 resolution may provide for underwriting or rate differential as deemed appropriate by the BOARD'S actuary to be passed back to the HEALTH PLANS as determined by the DEPARTMENT in consultation with 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. EMPOYEES who previously declined coverage for payment have a special enrollment opportunity within 30 days of the ceasing of the op-out provision. 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. The EMPLOYER cannot later have a bargaining unit drop from this health insurance program and carry other coverage.

(5) The employer may retain a second plan, as described in (4) above, or temporarily waive the participation requirements due to timing of collective bargaining, as described in (2) above, by executing the appropriate Resolution to Participate. The employer may later enroll the EMPLOYEES in the collective bargaining unit that did not enroll during the employer's initial enrollment period due to the employer retaining a second plan or due to the timing of collective bargaining. The employer must notify the DEPARTMENT, in writing, of this enrollment at least 30 days prior to the EFFECTIVE DATE of coverage for these EMPLOYEES. These EMPLOYEES may elect any available plan if they enroll with no lapse of coverage when their coverage under the other plan terminates.

(6) The EMPLOYER electing the deductible option coverage shall not pay the deductible on behalf of the EMPLOYEE/PARTICIPANTS unless it is under a Section 125 Health Savings Account.

(76) If participation by an employer is approved in accordance with Sub. (2) and the subsequent participation falls under the minimum requirement, the BOARD may terminate employer participation at the end of the calendar year by notifying the employer prior to October 1.

(87) The employer is responsible for notifying ANNUITANTS of the availability of coverage.

(98) The employer is responsible for notifying any SUBSCRIBERS covered under continuation of the prior group plan of the employer's change of coverage to or from this health insurance program. Notification and application should be sent to his/her last known address.

3.2 EMPLOYER TERMINATION.

(1) The governing body of an employer may terminate group health insurance under Wis. Stat. § 40.51 (7), for all PARTICIPANTS for whom rights to coverage were secured by the employer's participation by adopting a resolution in a form prescribed by the BOARD.

(2) A certified copy of the resolution in sub. (1) must be received in the DEPARTMENT by October 1 for termination to be effective at the end of the calendar year.

(3) If the employer fails to comply with (1) or (2) above, or if the employer fails to maintain the required participation level in the program, the DEPARTMENT may impose enrollment restrictions on the employer as it deems appropriate to preserve the integrity of the program. The DEPARTMENT may terminate the employer's participation in the program on the first of the month following notification to the employer that it has violated the terms of the CONTRACT. The DEPARTMENT may also restrict the employer's re-enrollment in the program beyond the restrictions set forth in item (4) below.

(4) Any employer who terminates participation under this section may not again elect participation earlier than three years after the date of termination. The employer is responsible for notifying ANNUITANTS and continuants of coverage termination.

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 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. No application for coverage may be rescinded on or after the effective date of coverage.

(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 180 ~~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 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 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.

3.4 DUAL-CHOICE ENROLLMENT.

(1) The BOARD shall establish enrollment periods, which shall permit eligible and currently covered EMPLOYEES and ANNUITANTS to transfer coverage to any health care coverage plan offered by the BOARD pursuant to Wis. Stat. § 40.51 (7). Unless otherwise provided by the BOARD, the Dual-Choice enrollment period shall be held once annually in the fall of each year with coverage effective the following January 1.

(2) If a SUBSCRIBER has not received a Dual-Choice enrollment opportunity as determined by the DEPARTMENT, an enrollment opportunity may be offered prospectively.

(3) An EMPLOYEE who returns from leave of absence during which coverage lapsed and which encompassed the entire previous Dual-Choice enrollment period will be allowed a Dual-Choice enrollment provided an application is filed during the 30 day period which begins on the date the EMPLOYEE returns from leave of absence.

(4) An EMPLOYEE or ANNUITANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines ~~out of the HEALTH PLAN'S service area~~ for a minimum of three months. A move from a medical facility to another facility by the SUBSCRIBER is not considered a residential move. An application must be filed during the 30 day period which begins on the date the SUBSCRIBER moves.

(5) A SUBSCRIBER under sections 3.4 (3) and (4) above who does not file an application to change plans within this 30-day enrollment period, may change only to the STANDARD PLAN, and shall be subject to the pre-existing condition clause contained in the STANDARD PLAN contract. Coverage shall be effective the first day of the calendar month which begins on or after the date the application is received by the employer.

(6) The HEALTH PLAN shall accept any individual who transfers from one health care coverage plan to another or from individual to family coverage without requiring evidence of insurability, waiting periods, or exclusions for pre-existing conditions as defined in Wis. Adm. Code § INS 3.31 (3).

(7) If the HEALTH PLAN offers more than one network to PARTICIPANTS and the service areas of those networks change on January 1st, a SUBCRIBER who failed to make a Dual-Choice election to change networks in order to maintain access to his or her current providers may still change to the appropriate network within that same HEALTH PLAN. The effective date of the change in networks is effective on January 1st or the first day of the month after the employer receives the SUBSCRIBER'S request to change networks.

(8) Applications from ANNUITANTS changing plans during the Dual Choice enrollment period must be received by the DEPARTMENT postmarked no later that the last day of the Dual Choice enrollment period, unless otherwise authorized by the DEPARTMENT.

3.5 INITIAL PREMIUMS.

When coverage becomes effective, multiple PREMIUM payments may be required initially to make PREMIUM payments current.

3.6 CONSTRUCTIVE WAIVER OF COVERAGE.

Any enrolled EMPLOYEE in active pay status for whom the EMPLOYEE portion of PREMIUMS has not been deducted from salary by the employer for a period of 12 consecutive months, shall be deemed to have waived coverage. Coverage then may be obtained only under the deferred coverage provisions of section 3.10.

3.7 BENEFITS NON-TRANSFERABLE.

No person other than a PARTICIPANT, as recorded in the office of the HEALTH PLAN, is entitled to BENEFITS under this CONTRACT. The SUBSCRIBER or any of his or her DEPENDENTS who assigns or transfers their rights under the CONTRACT, aids any other person in obtaining BENEFITS or knowingly presents or causes to be presented a false or fraudulent claim shall be guilty of a Class A misdemeanor as prescribed under Wis. Stat. § 943.395, and subject to the penalties set forth under Wis. Stat. § 939.51 (3) (a). Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an employer where coverage is available and is limited to the STANDARD PLAN with a 180-day waiting period for pre-existing conditions.

3.8 NON-DUPLICATION OF BENEFITS.

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

3.9 REHIRED EMPLOYEE COVERAGE.

Any insured EMPLOYEE who terminates employment with an employer participating under Wis. Stat. § 40.51 and is re-employed 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.

3.10 DEFERRED COVERAGE ENROLLMENT.

(1) Any EMPLOYEE actively employed with an employer participating under Wis. Stat. § 40.51 who does not elect coverage during the enrollment period provided under section 3.3 or constructively waives coverage under section 3.6 or who subsequently cancels coverage elected under sections 3.3 or 3.4, may be insured only under the STANDARD PLAN, subject to any eligibility criteria and pre-existing condition clause contained in the STANDARD PLAN contract. Coverage shall be effective the first day of the calendar month, which begins on or after the date the application is received by the employer.

(2) An EMPLOYEE or ANNUITANT enrolled for individual coverage, though eligible for family coverage, and who subsequently elects family coverage after initial eligibility period specified in section 3.3 (3) shall be eligible for family coverage under the STANDARD PLAN.

DEPENDENTS shall be subject to any pre-existing condition clause contained in the STANDARD PLAN contract.

(3) This section does not preclude an insured EMPLOYEE or ANNUITANT from changing to an alternate health care coverage plan during a dual-choice enrollment period offered under section 3.4.

3.11 COVERAGE OF SPOUSE.

If both spouses are ANNUITANTS or employed through the same employer and both are eligible for coverage, each may elect individual coverage. 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. If, at the time of marriage, the spouses have coverage with different HEALTH PLANS, they may elect family coverage with either HEALTH PLAN. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage without lapse if the employer received the application within 30 days of the divorce. An employer may, at its option, allow both spouses to enroll for family coverage or one for single and one for family.

3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE.

(1) Any insured EMPLOYEE may continue coverage during any employer approved leave of absence or LAYOFF for up to 36 months. Insurance coverage may be continued beyond 36 months if the approved leave is a union service leave as provided for under Wis. Stats. § 40.02 (56) and 40.03 (6) (g). A return from a leave of absence under Wis. Stat. § 40.02 (40) is deemed to be the first day the EMPLOYEE returns to work if the EMPLOYEE resumes active performance of duty for 30 consecutive days for at least 50% of the EMPLOYEE'S normal work time. If the EMPLOYEE does not complete 30 days of duty, coverage as an active EMPLOYEE shall not be resumed.

(2) Except as provided in section 3.21, the insured EMPLOYEE is responsible for payment of the full PREMIUM which must be paid in advance, and each payment must be received by the employer at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid.

(3) Any insured EMPLOYEE for whom coverage lapses or who allows family coverage to lapse during the leave of absence but continues individual coverage as a result of non-payment of premium may reinstate coverage by filing an application with the employer within 30 days of the return from leave. Coverage is effective the 1st day of the month on or after the date the employer receives the application. If such an EMPLOYEE was on a leave under the Family Medical Leave Act (FMLA) coverage is effective upon the date of re-employment in accordance with federal law. 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.

3.13 COVERAGE DURING APPEAL FROM REMOVAL OR DISCHARGE.

(1) An insured EMPLOYEE who has exercised a statutory or contractual right of appeal from removal or discharge from his or her position, or who within 30 days of discharge becomes a party to arbitration or to legal proceedings to obtain judicial review of the legality of the discharge, may continue to be insured from the date of the contested discharge until a final

decision has been reached. Within 30 days of the date of discharge the EMPLOYEE must submit to the employer the initial PREMIUM payment to keep the coverage in force. Additional payments may be made until a determination has been reached, but shall be submitted to the employer at least 30 days prior to the end of the coverage period for which PREMIUMS were previously paid.

(2) If the final decision is adverse to the EMPLOYEE, the date of termination of employment shall, for purposes of health care coverage, be the end of the month in which the decision becomes final by expiration without appeal of the time within which an appeal might have been perfected, or by final affirmation on appeal.

(3) The PREMIUMS referred to in this section shall be the gross amount paid to the HEALTH PLAN for the particular coverage, and the EMPLOYEE shall be required to pay any amounts normally considered the employer contribution. If the right of the EMPLOYEE to the position is sustained, the employer shall refund to the EMPLOYEE any amounts paid in excess of the normal EMPLOYEE
contribution.

3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS.

(1) The surviving insured DEPENDENT of an insured EMPLOYEE or ANNUITANT shall continue coverage, either individual or family, if the DEPARTMENT receives an application for coverage from the surviving DEPENDENT within 90 days after the death of the insured EMPLOYEE or ANNUITANT or 30 days of the date the DEPARTMENT notifies the DEPENDENT of the right to continue, whichever is later. A DEPENDENT that regains eligibility and was previously insured under a contract of a decades EMPLOYEE or ANNUITANT will be eligible for coverage until such time that they are no longer eligible.

(2) Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT and shall remain in effect until such time as the DEPENDENT coverage would normally cease.

PREMIUMS shall be paid:

(a) By deductions from an annuity that the surviving DEPENDENT is receiving from the Wisconsin Retirement System. If the annuity is insufficient to allow premium deductions, then

(b) Directly to the HEALTH PLAN.

3.15 COVERAGE OF EMPLOYEES AFTER RETIREMENT.

(1) Coverage for an insured EMPLOYEE shall be continued if the EMPLOYEE:

(a) Retires on an immediate annuity as defined under Wis. Stat. § 40.02 (38), and submits verification from the employer of insured status.

(b) EMPLOYEES who receive a disability annuity and remain continuously covered under the group shall be considered to have met the requirements for an immediate annuity for health insurance purposes.

(c) Terminates employment after attaining 20 years of creditable service and is eligible for an immediate annuity but defers application. An application for continued coverage must be filed with the DEPARTMENT within 90 days of the termination of employment.

(d) Receives a long-term disability benefit as provided for under Wis. Adm. Code § ETF 50.40.

(2) Coverage for a person otherwise eligible who is entitled to:

(a) and applies for an immediate annuity under Wis. Stat. § 40.02 (38), may be reinstated even if during any period preceding retirement, insurance has not been in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S benefit approval notice. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(b) and applies for an LTDI benefit under Wis. Adm. Code § ETF 50.40, or a duty disability benefit under Wis. Stat. § 40.65, may be reinstated even if, during the period proceeding the benefit approval, no insurance was in effect while no earnings were received, or insurance has been continued under COBRA continuation through the State's health insurance program. An application for health insurance must be received by the DEPARTMENT within 30 days after the date of the DEPARTMENT'S benefit approval notice. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

(3) The DEPARTMENT may authorize PREMIUM payments to be made directly to the HEALTH PLAN where circumstances require such. Failure to make required PREMIUM payments by the due dates established by the HEALTH PLAN and approved by the DEPARTMENT shall cause the health care coverage to be irrevocably canceled.

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~~and the Department will direct the HEALTH PLAN to~~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. The plan will make claims adjustments prospectively.

(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.

(5) Enrollment under the federal plans for hospital care for the aged (Medicare) by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the insured EMPLOYEE, ANNUITANT, or DEPENDENT is required to pay a premium to enroll in the hospital portion of Medicare (Part A). However, if Part A is not elected, the reduced premium rate is not available.

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

(7) If the EMPLOYEE, ANNUITANT, or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, this ~~HEALTH PLAN~~ plan shall pay as the primary payor for the first thirty months after he or she becomes eligible for Medicare due to the kidney disease, whether or not the EMPLOYEE, ANNUITANT, or DEPENDENT is enrolled in Medicare. The premium rate will be the non-Medicare rate during this period. Medicare becomes the primary payor after this thirty-month period. If the EMPLOYEE, ANNUITANT, or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty-month period during which this ~~HEALTH PLAN~~ plan will again be the primary payor. No reduction in premium is available for active EMPLOYEES under this section.

3.17 CONTRACT TERMINATION.

(1) The CONTRACT terminates on the date specified on the signatory page. The BOARD, by September 1, or the HEALTH PLAN, by August 15, shall provide notice of its intent not to CONTRACT for the following year by providing notice to the other party. The HEALTH PLAN must provide written notification to its SUBCRIBERS that it will not be offered during the next calendar year. This notification must be sent prior to the dual-choice enrollment period.

(2) If the HEALTH PLAN terminates this CONTRACT pursuant to sub. (1), any PARTICIPANT who is receiving BENEFITS as an INPATIENT on the date of termination shall continue to receive all BENEFITS otherwise available to INPATIENTS until the earliest of the following dates:

(a) The CONTRACT maximum is reached.

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

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

(d) Confinement ceases.

(3) If the HEALTH PLAN ceases to be offered after a PARTICIPANT has fully satisfied a deductible, which is required initially, but not in subsequent time periods, but prior to the completion of the treatment program, liability for such services remains the responsibility of the HEALTH PLAN without requiring further PREMIUM payments. However, an acceptable alternative would be for the HEALTH PLAN to refund the deductible amount to the SUBSCRIBER.

(4) If the BOARD terminates this CONTRACT pursuant to sub. (1), then all rights to BENEFITS shall cease as of the date of termination. The HEALTH PLAN will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include but are not limited to: transferring the patient to another institution; billing the BOARD a fee for service rendered; or permitting non-plan physicians to assume responsibility for rendering care. The overall intent is to be in the best interest of the patient.

(5) If the HEALTH PLAN terminates this CONTRACT, the HEALTH PLAN shall not again be considered for participation in the program under Wis. Stat. § 40.03 (6) (a) for a period of three CONTRACT years.

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, 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.

(e) The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, etc.). If family coverage remains in effect and the EMPLOYEE fails to notify the employer of divorce, coverage for the ex-spouse ends the last day of the month in which notification occurs. The employer may collect premium retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for family coverage to remain in effect.

(f) The expiration of the 36 months for which the PARTICIPANT is allowed to continue under paragraph (4), as required by state and federal law.

(g) The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of PARTICIPANT who continues under section 3.18 (4) of this section.

(h) The earliest date Federal or State continuation provisions permit termination of coverage for any reason, except the BOARD specifically allows the EMPLOYEE to maintain coverage for 36 months instead of 18.

(i) ~~(i)~~ The first day of the month following the DEPARTMENT'S written notice to an EMPLOYEE who is ineligible for coverage but, due to employer or DEPARTMENT error, was enrolled for coverage as an EMPLOYEE. The EMPLOYEE (and any eligible DEPENDENTS) will be offered a special continuation period of 36 months. The continuation period will be administered in accordance with paragraph (4).

(j) The effective date of the termination of EMPLOYER participation for all participants for whom coverage was secured as a result of the EMPLOYERS participation.

(2) No refund of any PREMIUM under sub. (e) may be made unless the employer, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted.

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

(4) A PARTICIPANT who ceases to meet the definition of EMPLOYEE/ANNUITANT/ DEPENDENT may elect to continue group coverage for a maximum of 36 months. Application must be postmarked within 60 days of the date the PARTICIPANT is notified 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 the required premium.

(5) No person other than a PARTICIPANT is eligible for health insurance BENEFITS. The SUBSCRIBER'S rights to group health insurance coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an employer where coverage is available and is limited to the STANDARD PLAN with a 180-day waiting period for pre-existing conditions.

Change to an alternate HEALTH PLAN is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

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

(6) In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate primary care physician, disenrollment efforts may be initiated by the HEALTH PLAN or

the BOARD. The SUBSCRIBER'S disenrollment is the beginning of the month following completion of the grievance process and approval of the BOARD. Coverage may be transferred to the STANDARD PLAN only, with options to enroll in alternate HEALTH PLANS during subsequent dual-choice enrollment periods. Re-enrollment in the HEALTH PLAN is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

(7) In situation where the EMPLOYER violates the terms of the contract, all PARTICIPANTS, including ANNUITANTS, coverage terminates the first of the month following notification from the DEPARTMENT of 30 days or more.

3.19 COVERAGE CERTIFICATION.

The HEALTH PLAN certifies that providers listed on Addendum #2 or on any of the HEALTH PLAN'S publications of providers are either under contract for all of the ensuing calendar year or the HEALTH PLAN will pay charges for BENEFITS on a fee-for-service basis. Those providers have agreed to accept new patients unless specifically indicated otherwise.

3.20 ADMINISTRATION OF BENEFIT ~~ANNUAL~~ MAXIMUMS UNDER UNIFORM BENEFITS.

(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.

(2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual benefit maximums will continue to accumulate for that year.

(3) The HEALTH PLAN shall give reasonable notice to the PARTICIPANT when the PARTICIPANT reaches approximately 75% of their benefit maximum(e.g. lifetime maximum). The HEALTH PLAN shall provide the PARTCIPANT with benefit accumulations upon request. This requirement can be satisfied through mailing of a plan explanation of benefits.

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 lowest cost qualified alternate ~~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 qualified alternate 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.

ATTACHMENT A: ***Description of BENEFITS.***

Includes Uniform Benefits, with the exception of Section III., D., Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM).

ATTACHMENT B: ***Documentation of Bonding or Reinsurance (If different than state).***

ATTACHMENT C

TABLE 10C
CALENDAR YEAR 20065
PREMIUM RATE QUOTATION WITHOUT DENTAL AND PRESCRIPTION DRUGS
LOCAL EMPLOYEES

HMO_____ _____
(Name) **(Service Area)**

Date_____
(Mo/Day/Yr)

Year_____ **Signature**_____
(Calendar Year) **(Authorized Representative)**

Rate quotations shall be accepted only if received annually by 4:30 p.m. on July 223, 20054 and rates are quoted for each of the following 10 categories. All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar. No other rate structure is permitted. Rates submitted outside the ranges specified shall be adjusted by the BOARD upward or downward to the nearest percentage within that range.

RATES WITHOUT DENTAL	20054 INFORCE RATES	CALCULATED RATE	PROPOSED RATE
Regular Coverage			
• Individual	$_____	$_____	$_____
• Family *(Shall be 2.5 times the individual rate)*	$_____	$_____	$_____
Medicare Coordinated – Regular Coverage			
• Individual *(Shall be no more than 50% of the regular individual coverage rate)*	$_____	$_____	$_____
• Family - 2 persons eligible for Medicare *(Shall be equal to 2 times the individual Medicare Coordinated rate)*	$_____	$_____	$_____
• Family - 1 person eligible for Medicare *(Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)*	$_____	$_____	$_____
Deductible Coverage - $500 Ind. / $1000 Family			
• Individual *(Shall be within the range of 85%-90% of the regular individual coverage rate)*	N/A	$_____	$_____
• Family *(Shall be 2.5 times the individual rate)*	N/A	$_____	$_____
Medicare Coordinated – $500 Ind. / $1000 Family Deductible Coverage			
• Individual *(No more than 50% of individual rate)*	N/A	$_____	$_____
• Family - 2 persons eligible for Medicare *(Equal to 2 times the individual Medicare rate)*	N/A	$_____	$_____
• Family - 1 person eligible for Medicare *(Sum of the individual and individual Medicare rates)*	N/A	$_____	$_____

ATTACHMENT C

TABLE 10D
CALENDAR YEAR 20065
PREMIUM RATE QUOTATION WITH DENTAL AND WITHOUT PRESCRIPTION DRUGS
LOCAL EMPLOYEES

HMO_____ _____
(Name) **(Service Area)**

Date_____
(Mo/Day/Yr)

Year_____ **Signature**_____
(Calendar Year) **(Authorized Representative)**

Rate quotations shall be accepted only if received annually by 4:30 p.m. on July 223, 20054 and rates are quoted for each of the following 13 categories. All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar. No other rate structure is permitted. Rates submitted outside the ranges specified shall be adjusted by the BOARD upward or downward to the nearest percentage within that range.

RATES WITH DENTAL	20054 INFORCE RATES	CALCULATED RATE	PROPOSED RATE
Regular Coverage			
• Individual	$_____	$_____	$_____
• Family *(Shall be 2.5 times the individual rate)*	$_____	$_____	$_____
Medicare Coordinated			
• Individual *(Shall be no more than 50% of the regular individual coverage rate)*	$_____	$_____	$_____
• Family - 2 persons eligible for Medicare *(Shall be equal to 2 times the individual Medicare Coordinated rate)*	$_____	$_____	$_____
• Family - 1 person eligible for Medicare *(Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)*	$_____	$_____	$_____
Deductible Coverage - $500 Ind. / $1000 Family			
• Individual *(Shall be within the range of 85%-90% of the regular individual coverage rate)*	N/A	$_____	$_____
• Family *(Shall be 2.5 times the individual rate)*	N/A	$_____	$_____
Medicare Coordinated – $500 Ind. / $1000 Family Deductible Coverage			
• Individual *(No more than 50% of individual rate)*	N/A	$_____	$_____
• Family - 2 persons eligible for Medicare *(Equal to 2 times the individual Medicare rate)*	N/A	$_____	$_____
• Family - 1 person eligible for Medicare *(Sum of the individual and individual Medicare rates)*	N/A	$_____	$_____
Dental Benefit Component (included in above)			
• Composite	$_____	$_____	$_____
• Single	$_____	$_____	$_____
• Family	$_____	$_____	$_____

ATTACHMENT C

TABLE 11C
CALENDAR YEAR 2006~~5~~ – FINAL BEST BID
PREMIUM RATE QUOTATION WITHOUT DENTAL AND PRESCRIPTION DRUGS
LOCAL EMPLOYEES

HMO_____ _____
(Name) **(Service Area)**

Date_____
(Mo/Day/Yr)

Year_____ **Signature**_____
(Calendar Year) **(Authorized Representative)**

Rate quotations shall be accepted only if received annually by 4:00 p.m. on August 1~~2~~3, 2005~~4~~ and rates are quoted for each of the following 10 categories. No upward revision of the July 2~~2~~3 bid is permitted. All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar. No other rate structure is permitted. Rates submitted outside the ranges specified shall be adjusted by the BOARD upward or downward to the nearest percentage within that range.

RATES WITHOUT DENTAL	2005~~4~~ INFORCE RATES	PRELIMINARY BID	PROPOSED RATE
Regular Coverage			
• Individual	$_____	$_____	$_____
• Family *(Shall be 2.5 times the individual rate)*	$_____	$_____	$_____
Medicare Coordinated – Regular Coverage			
• Individual *(Shall be no more than 50% of the regular individual coverage rate)*	$_____	$_____	$_____
• Family - 2 persons eligible for Medicare *(Shall be equal to 2 times the individual Medicare Coordinated rate)*	$_____	$_____	$_____
• Family - 1 person eligible for Medicare *(Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)*	$_____	$_____	$_____
Deductible Coverage - $500 Ind. / $1000 Family			
• Individual *(Shall be within the range of 85%-90% of the regular individual coverage rate)*	N/A	$_____	$_____
• Family *(Shall be 2.5 times the individual rate)*	N/A	$_____	$_____
Medicare Coordinated – $500 Ind. / $1000 Family Deductible Coverage			
• Individual *(No more than 50% of individual rate)*	N/A	$_____	$_____
• Family - 2 persons eligible for Medicare *(Equal to 2 times the individual Medicare rate)*	N/A	$_____	$_____
• Family - 1 person eligible for Medicare *(Sum of the individual and individual Medicare rates)*	N/A	$_____	$_____

ATTACHMENT C

TABLE 11D
CALENDAR YEAR 2006~~5~~ – FINAL BEST BID
PREMIUM RATE QUOTATION WITH DENTAL AND WITHOUT PRESCRIPTION DRUGS
LOCAL EMPLOYEES

HMO_____ _____
(Name) **(Service Area)**

Date_____
(Mo/Day/Yr)

Year_____ **Signature**_____
(Calendar Year) **(Authorized Representative)**

Rate quotations shall be accepted only if received annually by 4:00 p.m. on August 1~~2~~3, 200~~5~~4 and rates are quoted for each of the following 13 categories. No upward revision of the July 2~~2~~3 bid is permitted. All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar. No other rate structure is permitted. Rates submitted outside the ranges specified shall be adjusted by the BOARD upward or downward to the nearest percentage within that range.

RATES WITH DENTAL	200~~5~~4 INFORCE RATES	PRELIMINARY BID	PROPOSED RATE
Regular Coverage			
• Individual	$_____	$_____	$_____
• Family *(Shall be 2.5 times the individual rate)*	$_____	$_____	$_____
Medicare Coordinated			
• Individual *(Shall be no more than 50% of the regular individual coverage rate)*	$_____	$_____	$_____
• Family - 2 persons eligible for Medicare *(Shall be equal to 2 times the individual Medicare Coordinated rate)*	$_____	$_____	$_____
• Family - 1 person eligible for Medicare *(Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)*	$_____	$_____	$_____
Deductible Coverage - $500 Ind. / $1000 Family			
• Individual *(Shall be within the range of 85%-90% of the regular individual coverage rate)*	N/A	$_____	$_____
• Family *(Shall be 2.5 times the individual rate)*	N/A	$_____	$_____
Medicare Coordinated – $500 Ind. / $1000 Family Deductible Coverage			
• Individual *(No more than 50% of individual rate)*	N/A	$_____	$_____
• Family - 2 persons eligible for Medicare *(Equal to 2 times the individual Medicare rate)*	N/A	$_____	$_____
• Family - 1 person eligible for Medicare *(Sum of the individual and individual Medicare rates)*	N/A	$_____	$_____
Dental Benefit Component (included in above)			
• Composite	$_____	$_____	$_____
• Single	$_____	$_____	$_____
• Family	$_____	$_____	$_____

ATTACHMENT D: ***Specimen Conversion Contract (If different than state).***

ATTACHMENT E: ***Grievance Procedure (If different than state)*** ~~***Include copies of standard correspondence to PARTICIPANTS that may be used during the grievance process.***~~

Include a sample copy of a grievance decision letter to PARTICIPANTS that incorporates ETF administrative review rights.

ATTACHMENT F: *Other*

Additional documents, if necessary, and cited individually, i.e., Attachments F, G, H, etc.