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. If there is no "qualified" alternate health plan, the Board reserves the right to designate the State Maintenance Plan as the lowest cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.

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 and/or Tier 2 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,

period authorized by the Board may either require all employees insured by the plan to elect coverage under another plan or allow all employees insured by the plan the option to continue to be insured by the plan or to elect coverage under another plan.

10. Each plan will offer the uniform benefit level provided public employees under the standard health benefit coverage. Each plan must meet any and all applicable state or federal requirements concerning benefits which may be imposed on the State of Wisconsin as an employer, the plan as an insurer, or a federally qualified health benefit program. Rate adjustments, if any, required for such mandated benefit payments will occur on January 1 after the next contract period begins unless otherwise mutually agreed to in writing.

    Each plan will offer the uniform benefit level to annuitants. With respect to annuitants eligible for Medicare, each plan will offer the uniform benefit and carve-out the benefits paid by Medicare so that annuitants on Medicare receive the same uniform benefit level as provided active employees except that premium for annuitants on Medicare is reduced.

11. Contracting organizations must participate in both the state group and the local public employer group.

12. The Board may allow plans that have substantially but not completely met the requirements of these Guidelines to participate as a health care plan provider, but not be considered "qualifying" for purposes of establishing the employer contribution toward premium when the contribution is based on a percentage of the lowest cost qualified plan. The reasons a plan may be considered "non-qualifying" shall include, but not be limited to:

    a. Failure to submit required information in the format specified by the department,

    b. Insufficient provider coverage in a service area (determined by the Board),

    c. Failure to provide the benefit level as described in Section II. D., 3,

    d. Failure to substantiate premium rate proposals, or

    e. Failure to comply with the contract.

13. Non-qualifying plans. This section applies only to those for whom contributions are based on a percentage of the lowest cost qualified plan. The state contribution toward premium is determined separately on a county by county basis. That amount is equal to the lesser of 90% of the premium rate for Standard coverage or 105% of the lowest cost qualified alternate plan providing care in a county. Local government employers must pay at least 50% but not more than 105% of the lowest cost qualified 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

14. 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 and plans must notify the Department of subscribers terminating or reinstating coverage as described in Section I.

15. 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.

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

17. 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 plan only, the local employer's plan only or both plans.

    A participant's level of benefit, after commencing a treatment for orthodontia, will not be adversely impacted by a subsequent change in benefit level made by the plan. If a participant is in a course of orthodontic treatment and changes plans while covered under this program, and both the prior and succeeding plans provide orthodontic coverage, the succeeding plan must continue to cover the course of orthodontic treatment. The participant must use plan providers of the succeeding plan. Benefit accumulations from the prior plan will carry over and will be applied to the new benefit level.

18. PPPs and POSs may have different co-pay and deductible schedules for out-of-plan providers, except in the case of emergency, urgent care or when the service is not reasonably available from a Plan provider. If the participant resides in a plan's qualified This provision shall be considered as satisfied if arrangements have been made which prevent the enrollee from being held liable for hospital or professional charges except for those benefits which require the enrollee to satisfy a deductible; be paid on a co-payment basis; or in those instances where the individual failed to comply with published requirements for seeking medical care. Unauthorized referrals or the use of non-participating hospitals or medical personnel in violation of published plan requirements shall not be subject to the "hold-harmless" provision.

F. Capital Equipment and Expenditures

Each applicant must provide in its proposal a detailed explanation of how capital equipment and expenditures for the facility are authorized. If your organization is not specifically providing services but rather, functioning as a sponsor, include within your proposal the following statement:

"Item F. of the Guidelines is not applicable to this organization. The purchase of capital equipment, etc., is not subject to review by either the state or federal health agencies."

If the approval of capital equipment and expenditures is subject to review by state and/or federal agencies, the applicant should provide information on ~~the organization(s) involved in general~~ all reporting requirements. ~~One such example would be Section 1122, Public Law 92-603.~~

G. Enrollment and Reporting

If an organization submits a proposal to participate under the State of Wisconsin's group health benefit program and the proposal receives approval by the Board, the plan will be offered to active and retired public employees at a time established by the Board (dual-choice enrollment) subject to the following:

1. Any plan, which receives approval from the Group Insurance Board, must:

   a. Secure a minimum of 100 subscriber contracts (state/local employees enrolled; this number does not include any dependents covered under the plan) or;
   b. Demonstrate that 10% of the eligible employees within the area to be serviced by the plan have opted to participate in the program.

2. The Board may waive the minimum participation requirement set forth under Section II., G., 1., provided the organization submits a marketing plan which demonstrates that this minimum number of contracts will be obtained at some future date. The marketing proposal should include some evidence that the benefit plan has been accepted to a similar extent by employees of other groups and the location is convenient to potential subscribers. This marketing plan will be considered confidential by the Board insofar as permitted by Wisconsin Law.

   As stated previously, each plan so approved will be required to offer annually, a "dual-choice enrollment" opportunity. The Board establishes when such dual-choice enrollment periods will be held. Each plan will be required to prepare informational materials in a form and content acceptable to the Board.

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. The Department reserves the right to audit the addendum and the other data the plan uses to support its bid. A bid based on data which an audit later determines is unsupported subject to re-opening and re-negotiating downward.

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 justified by experience and may not exceed ~~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.

[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.

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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 the Department the previous Friday. If the "Due Date" falls on a Sunday, materials should be received by the Department the following Monday.)

Due Date (Receipt by Dept)	Information Due	Date Submitted
April 17~~5~~, 2006~~5~~	• New plans only. Proposal to participate in the program (Section II., I, page 1-17~~6~~). Contract to be executed by plan/Board. (Section 3)	
May 1~~2~~, 2007~~5~~	• 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~~6~~, 2006~~5~~	• 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, 2006~~5~~	• Documentation of financial stability (2 copies each): 1. Balance sheet 2. Statement of Operations 3. Annual <u>audited</u> 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. • <u>Actual contract language that specifies provider agreement or terms to participate in or report on Quality Improvement initiatives/patient safety measures. Also indicate their link, if any, to provider reimbursement.</u>	
June 15, 2006~~5~~	• HEDIS information is required for the prior calendar year. • Plan Utilization and Rate Review Information (Addendum #1A). This information is to be mailed directly to: Julie Maendel Deloitte ~~& Touche~~ <u>Consulting</u> 400 One Financial Plaza 120 South Sixth St Minneapolis, MN 55402-1844 • Addendum 1B and Table 8A describing catastrophic data. • <u>Objective documentation to determine credible programs/processes specific to those represented in the comparison of health plan features in the "It's Your Choice" brochure.</u>	

Due Date (Receipt by Dept)	Information Due	Date Submitted
June 30, 2006~~5~~	• Table 8D describing catastrophic cases.	

Addendum 1C - pg. 2-36

Plan Name ______________________________

ADDENDUM 1C: UTILIZATION REVIEW/QUALITY IMPROVEMENT 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	
		UTILIZATION REVIEW
☐	☐	Written guidelines that physicians must follow to comply with the HMO's or PPP's UR program.
☐	☐	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.
☐	☐	If PCP or PCC is required, have a process to allow a participant to change providers in a reasonable time and to communicate to the participant how to make that change. The plan will assist in location of a provider and facilitate timely access, as necessary.
		QUALITY IMPROVEMENT
☐	☐	Send correspondence to network hospitals and large multi-specialty groups or systems of care requesting ~~that~~ their~~y~~ participation~~e~~ AND increased performance results in the public reporting initiatives of ~~in the~~ Leapfrog (National), Checkpoint (Wisconsin) and Collaborative for Quality Healthcare (Wisconsin) by April of plan year~~survey~~.
~~☐~~	~~☐~~	~~Send correspondence to network providers and request that they participate in the Wisconsin Collaborative for Healthcare Quality.~~

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YES	NO	
☐	☐	Send correspondence to network hospitals encouraging participation in the Wisconsin Hospital Association Checkpoint.
☐	☐	Submit to the Department actual Provider contract language that specifies provider encouraging agreement or terms by the provider to participate in or report on quality improvement initiatives and/or patient safety measuresment. Also indicate their link, if any, to provider reimbursement by June of plan year.
☐	☐	Complete and submit to the Department objective documentation (or participate in a Department requested survey/audit) to determine credible programs/processes specific to those used to compare health plan features in the "It's Your Choice" brochure by June of plan year.
☐	☐	Complete and submit a Quality Improvement plan to the Department as described in Section J of the Guidelines.

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, including subcontracted 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 25~~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 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~~, and if applicable, include the provider's DEA number~~. 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	560
Juneau	10	3	0	3	90
La Crosse (City)	7	2	2	29	340
La Crosse (County)	18	4	3	102	680

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

described in the definition.

Contract - pg. 3-2

CONTRACT TO PARTICIPATE UNDER GROUP HEALTH BENEFIT PROGRAM

Wis. Stats. § 40.03 (6) (a) 1, 40.51 (6) and (7), 40.51 (4)

This CONTRACT is between the State of Wisconsin Group Insurance Board at 801 West Badger Road, P.O. Box 7931, Madison WI 53707-7931 ("BOARD") and *(Insert name and official address of the Health Care Plan)*

____
(hereinafter referred to as the "HEALTH PLAN").

The *"Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits"* dated April 2004, including all attachments and addenda (known as "the GUIDELINES"), are hereby incorporated by reference as if set forth in full.

The HEALTH PLAN agrees that in consideration of participating in the State of Wisconsin group health insurance program, it shall observe and comply with all the GUIDELINES' stated terms and conditions, including without limitation the General Requirements, HEALTH PLAN utilization addenda, terms of the described Uniform Benefits, state EMPLOYEE and local public EMPLOYEE group health insurance plans. The HEALTH PLAN affirmatively represents that it meets and shall continue to meet all requirements described in the General Requirements of the GUIDELINES.

The period of this CONTRACT shall be from January 1, 2006 through December 31, 2006, unless this agreement is otherwise modified or terminated as provided under the GUIDELINES.

The HEALTH PLAN further agrees that the BENEFITS and obligations under this agreement are not assignable or transferable except by written agreement of the BOARD and that this agreement is executed with the HEALTH PLAN as presently constituted. Any change in the ownership or controlling interest of the HEALTH PLAN, any acquisition by the HEALTH PLAN of another comprehensive medical plan with which the Group Insurance Board has contracted to participate in the state group health program, and any merger between the HEALTH PLAN and any other entity is a significant event requiring notification of the BOARD.

By and on behalf of the HEALTH PLAN:	By and on behalf of the BOARD:
~~(~~Name of Authorized Company Representative~~and Title)~~ (Type or Print)	~~(Chairman, Group Insurance Board)~~Name of Authorized Representative (Type or Print)
Signature of Above	Signature of Above
	Chairman, Group Insurance Board
Title	Title
~~(~~Date~~)~~	~~(~~Date~~)~~
Federal Employer Identification No.	

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 (that is, continues to be a DEPENDENT for support and maintenance and is not married), cease to be DEPENDENTS:

(a) ~~a~~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.

(b) At the end of the month in which they cease to be DEPENDENT for support or maintenance or marry, 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); 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, terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled, 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.

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, resolution of BOARD appeal, 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~~.~~ ~~A~~and report this information to the Department at least annually. HEALTH PLANS must follow the DEPARTMENT'S file transfer protocols (FTP), such as using the DEPARTMENT'S secured FTP site to submit and retrieve files.

(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.

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 of the Internal Revenue Code~~Health Savings Account~~.

(7) 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.

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

(9) 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.

3.15 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~~ health insurance 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~~ health insurance 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.