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 as required by 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 PARTICIPANT.

(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 at the end of the month on the earliest of the following dates:

(a) The effective date of change to another HEALTH 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. As required by 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. HEALTH PLANS must notify the DEPARTMENT within one month of the effective date of termination due to non-payment of PREMIUM. PREMIUM refunds to the HEALTH PLAN are limited to one month following the termination date.

(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 or CONTINUANT for whom the EMPLOYER has no reporting responsibilities, or a later date as specified on the cancellation of coverage notice. If the ANNUITANT or CONTINUANT contacts the HEALTH PLAN directly to cancel coverage, the HEALTH PLAN is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to the DEPARTMENT.

(e) The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, end of a domestic partnership, etc.). As required by Wis. Stat. §632.897, 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 of continuation of coverage rights 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 continuation period for which the PARTICIPANT is allowed to continue under paragraph (4) below, as required by state and federal law.

(g) The effective date of coverage obtained with another employer group health plan of PARTICIPANT who continues under paragraph (4) below. Terminations due to enrollment in medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care may be retroactive to the effective date of coverage upon request by the subscriber and determination by the DEPARTMENT.

(h) The earliest date federal or state continuation provisions permit termination of coverage for any reason.

(i) The end of the month in which the SUBSCRIBER terminates employment.

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

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

(l) Upon date of death. No refund of PREMIUM may be granted for the month in which the coverage ends. If deceased subscriber has covered dependents, see 3.14 CONTUNUED COVERAGE OF SURVIVING DEPENDENTS.

(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 voluntary 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, or DEPENDENT may elect to continue group coverage as required by state and federal law. 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.

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 effective the first of the month following completion of the grievance process and approval of the BOARD. Coverage may be transferred to the STANDARD PLAN only, with options to enroll in alternate HEALTH PLANS during subsequent 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 the situation where the EMPLOYER violates the terms of the CONTRACT, coverage for all its PARTICIPANTS, including ANNUITANTS and CONTINUANTS, 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 MAXIMUMS, DEDUCTIBLES, AND OUT-OF-POCKET LIMITS 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, deductibles, or out-of-pocket limits under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the EFFECTIVE DATE of coverage with the new HEALTH PLAN with the exception of the prescription drug BENEFIT annual out-of-pocket maximum for the IYC Health Plan. The deductibles and out-of-pocket accumulation will start over if the PARTICIPANT changes insurers.

(2) If a PARTICIPANT changes the level of coverage (e.g., single to family), or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual BENEFIT maximums, deductibles, and out-of-pocket limits will continue to accumulate for that year. NOTE: No accumulations transfer if an employee moves from state to local (or vice versa) coverage, or to another local employer, regardless if they remain covered by the same insurer.

(3) The HEALTH PLAN shall provide the PARTICIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of a plan explanation of benefits.

(4) The HEALTH PLAN shall apply any and all Maximum Out-of-Pocket limits as required by state and federal law.

3.21 EMPLOYER CONTRIBUTIONS TOWARD PREMIUM

(1) The EMPLOYER contribution toward PREMIUM for any EMPLOYEE shall be at least 50% but not more than 88% of the gross PREMIUM of the average cost qualified alternate health 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: TABLE 10B - PRELIMINARY BID SAMPLE
CALENDAR YEAR 2016 (for program year 2017)
PREMIUM RATE QUOTATION WITHOUT PRESCRIPTION DRUGS
LOCAL EMPLOYEES

Preliminary Rates

Health Plan Name:

Service Area (including counties):

Date (MM/DD/YYYY):

Calendar Year:

Signature (Authorized Representative):

All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar.
No other rate structure is permitted.
Please bid on your proposed service area.
The blue highlighted cells are the only rates that the plan must enter, the rest of the rates will be calculated.
If an invalid rate is entered into a blue cell an ERROR warning will appear to the right of the cell.

Due Date: Friday July 1st, 2016 2:00pm CDT

LOCAL EMPLOYEES

	2016 Inforce Rates (Monthly)	Validation	2017 Preliminary Rates (Monthly)	Validation
Regular Coverage				
1. Individual		VALID		VALID
2. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
High Deductible Health Plan (HDHP)				
3. Individual (Shall be 0.81 times the Regular individual rate)	$ -		$ -	
4. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
5. Individual (Shall be no more than 50% of the regular individual coverage rate)		VALID		VALID
6. Family 2 - All persons eligible for Medicare (Shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
7. Family 1 (Regular) - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (Shall be equal to the sum of the individual regular coverage rate and the individual Medicare Coordinated rate)	$ -		$ -	
8. Family 1 (HDHP) - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (Shall be equal to the sum of the individual HDHP coverage rate and the individual Medicare Coordinated rate)	$ -		$ -	
Coinsurance Coverage - Same Benefits as State Coverage				
9. Individual (Shall be 94% of the regular individual coverage rate)	$ -		$ -	
10. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
11. Individual (Shall be same as regular individual rate)	$ -		$ -	
12. Family 2 - all persons eligible for Medicare (Equal to 2 times the individual Medicare rate)	$ -		$ -	
13. Coinsurance Family 1 - at least 1 person eligible for Medicare and at least 1 person is not eligible for Medicare (Sum of the individual and individual Medicare rates)	$ -		$ -	
Deductible Coverage - $500 Ind./$1000 Fam.				
14. Individual (Shall be 92% of the regular individual coverage rate)	$ -		$ -	
15. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - $500 Ind./$1000 Fam. Ded.				
16. Individual (Shall be no more than 50% of individual rate)		VALID		VALID
17. Family 2 - all persons eligible for Medicare (Equal to 2 times the individual Medicare rate)	$ -		$ -	
18. Family 1 - at least 1 person eligible for Medicare and at least 1 person is not eligible for Medicare (Sum of the individual and individual Medicare rates)	$ -		$ -	
Wellness Benefit Component (incl. above)				
19. Single		VALID		
20. Family (Shall be 2.5 times the individual rate)	$ -			

ATTACHMENT A: TABLE 11B - FINAL BEST BID SAMPLE
CALENDAR YEAR 2016 (for program year 2017)
PREMIUM RATE QUOTATION WITHOUT PRESCRIPTION DRUGS
LOCAL EMPLOYEES

Best and Final Rates

Health Plan Name:	
Service Area (Including counties):	
Date (MM/DD/YYYY):	
Calendar Year:	
Signature (Authorized Representative):	

All rates must be exactly divisible by 2 and rounded to the nearest tenth of a dollar.
No other rate structure is permitted.
Rates valid on your proposed service area.
The blue highlighted cells are the only rates that the plan must enter; the rest of the rates will be calculated.
If an invalid rate is entered into a blue cell an ERROR warning will appear to the right of the cell.

Due Date: Friday July 29th, 2016 2:00pm CDT

LOCAL EMPLOYEES

	2016 In-force Rates (Monthly)	Validation	2017 BAFO Rates (Monthly)	Validation
Regular Coverage (Including Wellness for 2016)				
1. Individual		VALID		VALID
2. Family (2 Full Ded 2.2 times the Individual rate)	$ -		$ -	
High Deductible Health Plan (HDHP)				
3. Individual (2 Full Ded 2.31 times the Regular Individual rate)	$ -		$ -	
4. Family (2 Full Ded 2.2 times the Individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
5. Individual (2 Full Ded no more than 2.07% of the Regular Individual average rate)		VALID		VALID
6. Family 2 - 3 persons eligible for Medicare (2 Full Ded equal to 2.2 times the Individual Medicare Coordinated rate)	$ -		$ -	
7. Family 1 (Regular) - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (2 Full Ded equal to the sum of the Individual regular average rate and 2 the Individual Medicare Coordinated rate)	$ -		$ -	
8. Family 1 (HDHP) - at least 1 person is eligible for Medicare and at least 1 person is not eligible for Medicare (2 Full Ded equal to the sum of the Individual HDHP average rate and 2 the Individual Medicare Coordinated rate)	$ -		$ -	
Coinsurance Coverage - Same Benefits as Wide Choice Coverage				
9. Individual (2 Full Ded 0.85 of the regular Individual average rate)	$ -		$ -	
10. Family (2 Full Ded 2.2 times the Individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
11. Individual (2 Full Ded same as regular Individual rate)	$ -		$ -	
12. Family 2 - all persons eligible for Medicare (Equal to 2.2 times the Individual Medicare rate)	$ -		$ -	
13. Coinsurance Family 1 - at least 1 person eligible for Medicare and at least 1 person is not eligible for Medicare (Sum of the Individual and Individual Medicare rate)	$ -		$ -	
Deductible Coverage - $500 Ind./$1000 Fam.				
14. Individual (2 Full Ded 92% of the regular Individual average rate)	$ -		$ -	
15. Family (2 Full Ded 2.2 times the Individual rate)	$ -		$ -	
Medicare Coordinated - $500 Ind./$1000 Fam. Ded.				
16. Individual (2 Full Ded no more than 2.07% of Individual rate)		VALID		VALID
17. Family 2 - all persons eligible for Medicare (Equal to 2.2 times the Individual Medicare rate)	$ -		$ -	
18. Family 1 - at least 1 person eligible for Medicare and at least 1 person is not eligible for Medicare (Sum of the Individual and Individual Medicare rate)	$ -		$ -	
Wellness Benefit Component (not allowed)				
19. Single		VALID		
20. Family (2 Full Ded 2.2 times the Individual rate)	$ -			

ATTACHMENT B: GRIEVANCE PROCEDURE

(If different than state; must include DEPARTMENT administrative review rights.)