3. STATE AND LOCAL CONTRACTS

State of Wisconsin 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 by the Group Insurance Board as required by Wis. Stat. § 40.51.

ARTICLE 1 DEFINITIONS

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

1.1 "ANNUITANT" means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System, a currently insured recipient of a long-term disability benefit under Wis. Adm. Code § ETF 50.40, a currently insured recipient of a disability benefit under Wis. Stat. § 40.65; or a terminated EMPLOYEE with 20 years of creditable service.

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

1.3 "BOARD" means the Group Insurance Board.

1.4 "CONTINUANT" means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in Article 2.9.

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

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

1.7 "DEPENDENT" means, as provided herein, the SUBSCRIBER'S:

- Spouse.
- DOMESTIC PARTNER, if elected.
- Child.
- Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19.
- Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
- Stepchild.
- Child of the DOMESTIC PARTNER insured on the policy.
- Grandchild if the parent is a DEPENDENT child.

(1) A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

(2) A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment. A DOMESTIC PARTNER and his or her children cease to be DEPENDENTS at the end of the month in which the domestic partnership is no longer in effect.

(3) All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except that:

(a) An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is dependent on the SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. The HEALTH PLAN will monitor eligibility annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The HEALTH PLAN will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

(b) After attaining age 26,as required by Wis. Stat. § 632.885, a DEPENDENT includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

(4) A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

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

(6) Any DEPENDENT eligible for BENEFITS who is not listed on an application for coverage will be provided BENEFITS based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the EMPLOYER, except as required under Wis. Stat. § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

1.8 "DOMESTIC PARTNER" means an individual that certifies in an affidavit along with his or her partner that they are in a domestic partnership as provided under Wis. Stat. § 40.02 (21d), which is a relationship between two individuals that meets all of the following conditions:

- Each individual is at least 18 years old and otherwise competent to enter into a contract.

- Neither individual is married to, or in a domestic partnership with, another individual.

- The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.

- The two individuals consider themselves to be members of each other's immediate family.

- The two individuals agree to be responsible for each other's basic living expenses.

- The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:

  - Only one of the individuals has legal ownership of the residence.

  - One or both of the individuals have one or more additional residences not shared with the other individual.

  - One of the individuals leaves the common residence with the intent to return.

1.9 "DUAL-CHOICE" means the enrollment period referred to in DEPARTMENT materials as the It's Your Choice enrollment period that is available at least annually to eligible EMPLOYEES and ANNUITANTS under Wis. Stat. § 40.51 (16) to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51.

1.10 "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.

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

1.12 "EMPLOYER" means an eligible State of Wisconsin agency as defined in Wis. Stat. § 40.02 (54).

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

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

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

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

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

1.18 "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.

1.19 "PREMIUM" means the rates shown on Attachment C plus the pharmacy rate and administration fees required by the BOARD. Those rates may be revised by the HEALTH PLAN annually, effective on each succeeding January 1 following the effective date of this CONTRACT. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

1.20 "STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD as provided by § 40.52 (1).

1.21 "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 HEALTH PLAN 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 the data submitted by the HEALTH PLAN, the BOARD may take any action up to and including limiting new enrollment into that HEALTH PLAN.

(5) The HEALTH PLAN shall comply with all state and federal laws regarding patient privacy. The HEALTH PLAN shall notify the DEPARTMENT within two business days of discovering that the protected health information (PHI) or personal information of one or more PARTICIPANTS has been breached, as defined by state and federal law, including Wis. Stat. § 134.98 and the federal Health Insurance Portability and Accountability Act of 1996. This notification requirement shall apply only to PHI or personal information received or maintained by the HEALTH PLAN pursuant to this agreement. The HEALTH PLAN shall make good faith efforts to communicate with the DEPARMENT about breaches by major provider groups if the HEALTH PLAN knows those breaches affect PARTICIPANTS.

(6) The HEALTH PLAN shall maintain a written contingency plan describing in detail how it will continue operations and administration of benefits in certain events including, but not limited to, strike and disaster, and shall submit it to the DEPARTMENT upon request.

(7) The DEPARTMENT reserves the right to require HEALTH PLANS to assist with drafting and mailing the federally required Summary of Benefits and Coverage (SBC) to PARTICIPANTS in a manner similar to the annual informational mailing process.

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 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 application during a prescribed enrollment period for either individual or family coverage and has authorized the PREMIUM contributions, 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 prior to the current month of coverage.

(4) Except in cases of fraud, material misrepresentation, resolution of BOARD appeal, or when required by Medicare, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to no more than six months of PREMIUMS paid. In cases where Medicare is the primary payer, retroactive adjustments to PREMIUM or claims for coverage not validly in force shall correspond with the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six months and in accordance with § 3.16 (3). No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. 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 payment for all Medicare data match inquiries.

(5) In the event that an EMPLOYER determines an EFFECTIVE DATE under Wis. Stat. § 40.51 (2) 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, except as required by law.

2.4 REPORTING

(1) EMPLOYEES, ANNUITANTS and CONTINUANTS 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 electronic eligibility files 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 electronic eligibility files while 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 in a file format as identified by the DEPARTMENT after seeking input from the HEALTH PLANS. The HEALTH PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number and unique DEPARTMENT identifier) 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 at least annually collect from SUBSCRIBERS coordination of benefits information necessary to coordinate BENEFITS under the Wisconsin Administrative Code 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 Healthcare Effectiveness Data and Information Set (HEDIS) for its commercial membership by a date specified by the DEPARTMENT 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 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. The data will be supplied in a format specified by the DEPARTMENT.

(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 the DEPARTMENT may impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties of no more than $100 per day per occurrence, to begin on the 2nd day following the date notice of non-compliance is delivered to the HEALTH PLAN. Such financial penalty will not exceed $5,000 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 indicating the EFFECTIVE DATE of coverage, a listing of all available providers and their available locations, information on accessing and completing the Health Risk Assessment tool, and pre-authorization and referral requirements.

(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. Four (4) 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.

(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

By the end 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 pharmacy premium and 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 24th day of the calendar month for the current month's coverage. The remittance by the EMPLOYER shall be the amount invoiced by the DEPARTMENT.

(2) The EMPLOYER shall immediately validate and enter into the DEPARTMENT'S myETF Benefits system the completed applications filed by newly eligible EMPLOYEES or require EMPLOYEES to submit their request directly through myETF Benefits. For any requests submitted by a newly eligible EMPLOYEE through myETF Benefits, the EMPLOYER shall immediately validate and approve the completed 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. §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. 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 BENEFITS or claims arising under the terms and conditions of the CONTRACT shall first be submitted for resolution through the HEALTH PLAN'S and/or Pharmacy Benefit Manager's (PBM) internal grievance process and may then, if necessary and appropriate, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint for review with an Ombudsperson at the DEPARTMENT. 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). However, the DEPARTMENT will not issue a determination regarding denials of coverage by a HEALTH PLAN and/or PBM based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the independent review process under Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11.

(2) The PARTICIPANT may also request an independent review as provided under Wis. Stat. § 632.835 and 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. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.

(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., 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 other 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 DEPARTMENT Administrative Review 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 and their right to request a review by an Independent Review Organization in accordance with Wis. Adm. Code § INS 18.11, using the language approved by the DEPARTMENT. In all final grievance decision letters, the HEALTH PLAN shall cite the specific Uniform Benefits contractual provision(s) upon which the HEALTH PLAN bases its decision and relies on to support its decision. In the event they disagree with the grievance committee's 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 PARTICIPANTS. Upon completion of the DEPARTMENT review and in the event that PARTICIPANTS disagree with the outcome, PARTICIPANTS may file a written request for determination from the DEPARTMENT. The request must be received by the DEPARTMENT within 60 days of the date of the DEPARTMENT final review letter.

(7) Provision of Complaint Information

All information and documentation pertinent to any decisions or actions taken regarding any PARTICIPANT complaint or grievance by a HEALTH PLAN shall be made available to the DEPARTMENT upon request. If an authorization from the PARTICIPANT is necessary, the HEALTH PLAN shall cooperate in obtaining the authorization and shall accept the DEPARTMENT'S form that complies with all applicable laws regarding patient privacy, 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, resolve disputes or to formulate 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

3.3 SELECTION OF COVERAGE

(1) If coverage is not elected under this section, it shall be subject to the deferred coverage provision of section 3.10. Except as otherwise provided in this section, coverage shall be effective on the first day of the month, which begins on or after the date the application is received by the EMPLOYER. No application for coverage may be rescinded on or after the EFFECTIVE DATE of coverage.

(2) (a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, coverage to be effective as of the first day of the month that first occurs during the 30-day period, or by electing coverage prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM coverage to be effective upon becoming eligible for EMPLOYER contribution. In accordance with Wis. Stat. § 40.51 (2), an EMPLOYEE who enrolls for single coverage within 30 days of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for EMPLOYER contribution toward PREMIUM. The EMPLOYEE and his or her DEPENDENTS shall not be subject to any waiting periods or evidence of insurability requirements. However, when the EMPLOYEE terminates employment prior to the EFFECTIVE DATE of coverage, the application is void and any premiums paid or deducted will be refunded.

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

(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 and CONTINUANTS shall submit the application to the DEPARTMENT.

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

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

(a) Employment is resumed within 180 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) As required by state and federal law, a SUBSCRIBER enrolled with single coverage although eligible for family coverage, or an EMPLOYEE who deferred the selection of coverage, has a special enrollment opportunity to add eligible children as required by a National Medical Support Notice.

(7) (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 is a member of the US Armed Forces, or is a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE or a DEPENDENT loses eligibility for that other coverage or the EMPLOYER'S contribution towards the other coverage ceases, the EMPLOYEE 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) If permitted by state or Federal law, as determined by the DEPARTMENT, an eligible EMPLOYEE may defer or dis-enroll from coverage for themselves or a DEPENDENT if he/she is covered under medical assistance (Medicaid), the Children’s Health Insurance Program (CHIP), or Tri-Care. Termination may be retroactive to the effective date of the other coverage upon request by the subscriber. Family status changes under this provision remain subject to Section 125 of the Internal Revenue Code. If the EMPLOYEE or DEPENDENT loses eligibility for that coverage or becomes eligible for a premium assistance subsidy for this program, the EMPLOYEE may elect coverage under this section by filing an application with the EMPLOYER within 60 days of the loss of eligibility or the date it is determined the EMPLOYEE or DEPENDENT is eligible for premium assistance and by providing evidence satisfactory to the DEPARTMENT.

(c) An EMPLOYEE who deferred coverage may enroll if he or she has a new DEPENDENT as a result of birth, adoption, placement for adoption, marriage or domestic partnership, provided he or she submits an application within 60 days of the birth, adoption or placement for adoption, or within 30 days of the marriage or effective date of the domestic partnership.

(d) Coverage under this provision shall be effective on the date of termination of the prior plan or the date of the event described in (b) or (c) 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.

(8) In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician, clinic or care system that is not available in the plan selected, the HEALTH PLAN shall immediately notify the EMPLOYER. The SUBSCRIBER shall be allowed to correct the plan selected to one which has that physician, clinic or care system 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 may not simply reassign a primary physician, clinic or care system.

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

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

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

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

(10) Eligible retired EMPLOYEES or former EMPLOYEES of the State who have reenrolled under section 3.10 (4) may select any offered plan.

(11) A SUBSCRIBER who does not request coverage for a DOMESTIC PARTNER, or an adult child when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling

the DOMESTIC PARTNER or child when the DOMESTIC PARTNER or child become newly eligible due to the loss of eligibility for other coverage or the loss of EMPLOYER contribution for the other coverage. The SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days after the event and coverage for the DEPENDENT will be effective on the event date. This paragraph does not prevent a SUBSCRIBER from adding the eligible DEPENDENT during the DUAL-CHOICE enrollment period for coverage effective the following January 1.

Coverage for the DEPENDENT eligible under this section remains in effect until the DEPENDENT is no longer eligible, the family coverage is terminated, the SUBSCRIBER requests to terminate coverage for the adult DEPENDENT within 30 days of the DEPENDENT'S eligibility and enrollment in other health insurance coverage, or the SUBSCRIBER requests to terminate the coverage for the DEPENDENT during the annual DUAL-CHOICE enrollment effective the following January 1, whichever occurs first.

(12) An eligible EMPLOYEE who is insured as a DEPENDENT child on another policy in this program can enroll for coverage by submitting an application during the annual DUAL-CHOICE enrollment period for coverage effective the following January 1.

(13) For the purposes of selecting a HIGH DEDUCTIBLE HEALTH PLAN, a completed application requires the submission and acceptance of a Health Savings Account application to the third party administrator. The Health Savings Account application must be submitted concurrently with the HIGH DEDUCTIBLE HEALTH PLAN application.

3.4 DUAL-CHOICE ENROLLMENT PERIODS

(1) The BOARD shall establish enrollment periods, which shall permit eligible EMPLOYEES, ANNUITANTS and currently insured CONTINUANTS to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51. 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, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines 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 (3) and (4) above who does not file an application to change plans within this 30 day enrollment period may change plans at the next DUAL-CHOICE enrollment period.

(6) As required by Federal law, an insured EMPLOYEE or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, domestic partnership, birth, adoption, placement for adoption, loss of other coverage or loss of EMPLOYER contribution for the other coverage may change HEALTH PLANS after the event if an application is submitted within 30 days of the event. This enrollment opportunity also applies when adding a dependent due to a National Medical Support Notice or establishment of paternity. This also applies to ANNUITANTS as if Federal law required it. Coverage with the new HEALTH PLAN will be effective the first day of the calendar month, which begins on or after the date the EMPLOYER receives the application selecting the new HEALTH PLAN.

(7) The HEALTH PLAN shall accept any individual who transfers from one 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).

(8) 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, whichever is later.

(9) Applications from ANNUITANTS and CONTINUANTS changing plans during the DUAL-CHOICE enrollment period must be received by the DEPARTMENT postmarked no later than 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 prospectively waived coverage upon a 30-day notice to the EMPLOYEE, unless all required PREMIUMS are paid. 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).

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 OR TRANSFERRED EMPLOYEE COVERAGE

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

(2) Rehired ANNUITANTS who terminate their annuity and participate in the Wisconsin Retirement System may continue the same health insurance coverage by filing an application with the EMPLOYER within 30 days following the Wisconsin Retirement System participation begin date.

Rehired ANNUITANTS at the UW System are not eligible for the health insurance program under Wis. Stat. § 40.52 (3) for graduate assistants regardless of whether they are eligible to participate in the Wisconsin Retirement System.

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

3.10 DEFERRED COVERAGE ENROLLMENT

(1) Any EMPLOYEE actively employed with the state who does not elect coverage during the enrollment period provided under section 3.3, 3.12 (3), or who constructively waives coverage under section 3.6 or who subsequently cancels coverage elected under sections 3.3 or 3.4, may be insured only by electing coverage during the DUAL-CHOICE enrollment period as provided in section 3.4 (1).

(2) An EMPLOYEE or ANNUITANT enrolled for individual coverage, though eligible for family coverage may only elect family coverage during the DUAL-CHOICE enrollment period, except as provided in section 3.3.

(3) This section does not preclude an insured EMPLOYEE or ANNUITANT from changing to an alternate HEALTH PLAN during a DUAL-CHOICE enrollment period offered under section 3.4.

(4) A retired EMPLOYEE of the state who is receiving a retirement annuity or has received a lump sum payment under Wis. Stat. § 40.25 (1); or an EMPLOYEE of the state who terminates creditable service after attaining 20 years of creditable service, remains a participant in the Wisconsin Retirement System and is not eligible for an immediate annuity may enroll for coverage during the DUAL-CHOICE enrollment period.

(5) An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40) who is not enrolled for coverage, may enroll in the STANDARD PLAN 30 days prior to retirement for the purpose of delaying initiation of post-retirement EMPLOYER premium

contribution per Wis. Stat. § 40.05 (4) (b). An EMPLOYEE is not allowed to enroll in the High Deductible Health Plan option as part of this provision.

3.11 COVERAGE OF SPOUSE, DOMESTIC PARTNER, OR DEPENDENT

(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one spouse elects family coverage, the other eligible spouse may be covered as a DEPENDENT but may not have any other coverage. If both spouses are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one spouse to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the spouses have coverage with different HEALTH PLANS at the time of marriage or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the divorce.

(2) If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one DOMESTIC PARTNER elects family coverage, the other eligible DOMESTIC PARTNER may be covered as a DEPENDENT but may not have any other coverage except if necessary to avoid imputed income. If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage. As permitted by Section 125 of the Internal Revenue Code, two single contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one DOMESTIC PARTNER to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the DOMESTIC PARTNERS have coverage with different HEALTH PLANS at the time of the effective date of the domestic partnership or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the domestic partnership terminate while carrying family coverage, the former DOMESTIC PARTNER may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the termination of domestic partnership.

(3) A DEPENDENT cannot be covered at the same time by two separate SUBSCRIBERS of the State Group Health Insurance Program (including the Wisconsin Public Employers State Group Health Insurance Program). In the event it is determined that a DEPENDENT is covered by two separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have 30 days to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.

3.12 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, the EMPLOYEE is not deemed to have returned from leave and coverage will continue as an EMPLOYEE on leave of absence.

(2) The EMPLOYER contribution toward PREMIUM continues for the first three months of the LAYOFF or leave of absence for which PREMIUMS have not already been deducted, after which the insured EMPLOYEE is responsible for payment of the full PREMIUM that must be paid in advance. 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. Retroactive EMPLOYER refunds resulting from termination for non-payment of PREMIUM by the EMPLOYEE are not allowed.

(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 after the return to work. Coverage is effective the 1st day of the month on or after the date the EMPLOYER receives the application. The EMPLOYEE becomes eligible for the EMPLOYER contribution toward PREMIUM for the coverage month the leave of absence ends.

(4) 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. EMPLOYEES shall also have the enrollment opportunities as described in section 3.3 (7) (a) while on leave of absence. 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) For the purpose of this provision and in accordance with Wis. Stat. §40.05 (4g), an eligible EMPLOYEE includes National Guard and Military Reserve personnel on an unpaid military leave of absence for active duty for reasons other than for training. The EMPLOYEE must be receiving EMPLOYER contributions for health insurance on the date he or she is activated for duty. The thirty-six month limitation for continuing coverage, described in (1) above, does not apply.

The EMPLOYEE may elect to:

(a) Continue health insurance coverage and establish prepayment of PREMIUMS while on active duty; or

(b) Within 60 days of being activated for coverage, let his or her coverage lapse for nonpayment of PREMIUM after being activated for duty and reinstate coverage while on leave by filing a health insurance application; or

(c) Allow his or her coverage to lapse and reapply for coverage within 30 days of return to employment, provided the EMPLOYEE applies for re-employment within 90 days after release from active duty, and resumes employment within 180 days.

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, including the pharmacy and administrative fees. 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) As required by Wis. Adm. Code § ETF 40.01, the surviving insured DEPENDENT of an insured EMPLOYEE or ANNUITANT shall have the right to continue coverage, either individual or family. A DEPENDENT that regains eligibility and was previously insured under a contract of a deceased EMPLOYEE or ANNUITANT or a child of the EMPLOYEE or ANNUITANT who is in the process of being adopted by the deceased EMPLOYEE or ANNUITANT or born within nine months after the death of the EMPLOYEE or ANNUITANT will be eligible for coverage under the survivor’s contract 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 had the death not occurred.

(3) PREMIUMS shall be paid:

(a) From accumulated leave credits until exhausted, then

(b) 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

(c) 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),

(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. If the disability annuity terminates and the PARTICIPANT continues to meet the definition of eligible EMPLOYEE under Wis. Stat. § 40.02 (25), the individual is eligible to continue using accumulated leave credits until exhausted under Wis. Stat. § 40.05 (4) (b).

(c) Terminates employment after attaining 20 years of creditable service. An application for continued coverage must be filed with the DEPARTMENT within 90 days of the termination of employment if the terminated EMPLOYEE is not eligible for an immediate annuity.

(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 notification of eligibility for health insurance. 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 preceding 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 notification of eligibility for health insurance. 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 cancelled.

3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS 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 PARTICIPANT is eligible for the Medicare hospital and medical insurance benefits (Parts A and B) as the primary payor and coverage is provided under an annuitant group number.

(3) Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage shall be limited in accordance with Uniform Benefits IV., A., 12., b. However, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six months. This may limit the amount of PREMIUM refund for the SUBSCRIBER. In such a case, the PARTICIPANT must enroll in Medicare Part B at the next available opportunity.

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV., A., 12., b. In such cases, the HEALTH PLAN will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

(4) Enrollment under the federal plans for hospital and medical care for the aged (Medicare) by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as an active EMPLOYEE of the state. 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 for Part A and Part B charges, 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 reduced PREMIUM 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, CONTINUANT or DEPENDENT is eligible for Medicare due to permanent kidney failure or end-stage renal disease, this 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, CONTINUANT 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 upon enrollment in Medicare Parts A and B. If the EMPLOYEE, ANNUITANT, CONTINUANT or DEPENDENT has more than one period of Medicare enrollment based on kidney disease, there is a separate thirty-month period during which this plan will again be the primary payor. No reduction in PREMIUM is available for active EMPLOYEES under this section.

(8) As required by Medicare rules, Medicare is the primary payor for DOMESTIC PARTNERS age 65 and older who are enrolled in Medicare, regardless of the work status of the SUBSCRIBER. The reduction in PREMIUM is available only when the coverage is provided under a non-employer group number.

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 the date specified in the Guidelines, section II., J., shall provide notice of its intent not to contract for the following contract 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 as required by 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 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 or sick leave escrow application is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT or CONTINUANT, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. 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.

(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. Except that when coverage ends by reason of termination of employment, refunds shall be made back to the end of the month in which employment terminates.

(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) Except in cases of fraud or where an individual makes an intentional misrepresentation of material fact, under federal law, an EMPLOYER must not retroactively cancel or rescind coverage, except to the extent attributable to a failure to pay timely premiums

towards coverage. It is not considered a rescission where due to administrative delay in record-keeping the EMPLOYER retroactively cancels coverage back to the date of termination of employment.

(8) Upon determination that a SUBSCRIBER is ineligible for the HIGH DEDUCTIBLE HEALTH PLAN (HDHP), coverage shall revert to the coinsurance Uniform Benefit with the same HEALTH PLAN retroactive to either January 1 of the plan year in which the eligibility error was discovered, or the HDHP effective date if after January 1 of the current plan year. PREMIUMS and claims shall be retroactively adjusted.

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 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 with the exception of the prescription annual out-of-pocket maximum.

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

(3) The HEALTH PLAN shall provide the PARTICIPANT with medical BENEFITaccumulations 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 asrequired by state and federal law.

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***

ATTACHMENT C: TABLE 10A- PRELIMINARY BID SAMPLE
CALENDAR YEAR 2015 (for program year 2016)
PREMIUM RATE QUOTATION WITHOUT PRESCRIPTION DRUGS
STATE
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 3rd, 2015 2:00pm CDT

STATE EMPLOYEES

	2015 Inforce Rates (Monthly)	Validation	2016 Preliminary Rates (Monthly)	Validation
Regular Coverage				
1. Individual - Baseline (2015 Benefit Design)		VALID		VALID
2. Individual - 2016 New Benefit Design without $250 Deductible				VALID
3. Individual - 2016 New Benefit Design				VALID
4. Family (Shall be 2.5 times the individual rate) of line 3 - 2016 New Benefit Design	$ -		$ -	
High Deductible Health Plan (HDHP)				
5. Individual (Shall be 0.86 times the 2016 Regular rate)	$ -		$ -	
6. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
7. Individual (Shall be no more than 50% of the regular individual coverage rate)		VALID		VALID
8. Family 2 - All persons eligible for Medicare (Shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
9. 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)	$ -		$ -	
10. 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)	$ -		$ -	
Graduate Assistants				
9. Individual (Shall be within the range of 65%-75% of the regular individual coverage rate)		VALID		VALID
10. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Dental Benefit Component (incl. above for 2015)				
19. Single		VALID		
20. Family (Shall be 2.5 times the individual rate)				
Wellness Benefit Component (incl. above)				
13. Single		VALID		VALID
14. Family (Shall be 2.5 times the individual rate)	$ -		$ -	

ATTACHMENT C:TABLE 11A– FINAL BEST BID SAMPLE
CALENDAR YEAR 2015 (for program year 2016)
PREMIUM RATE QUOTATION WITHOUT PRESCRIPTION DRUGS
STATE 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.
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: Tuesday August 4th, 2015 2:00pm CDT

STATE EMPLOYEES

	2015 Inforce Rates (Monthly)	Validation	2016 Preliminary Rates (Monthly)	Validation
Regular Coverage				
1. Individual - Baseline (2015 Benefit Design)		VALID		
2. Individual - 2016 New Benefit Design without $250 Deductible			$ -	
3. Individual - 2016 New Benefit Design				VALID
4. Family (Shall be 2.5 times the individual rate) of line 3 - 2016 New Benefit Design	$ -		$ -	
High Deductible Health Plan (HDHP)				
5. Individual (Shall be 0.86 times the 2016 Regular rate)	$ -		$ -	
6. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Medicare Coordinated - Regular Coverage				
7. Individual (Shall be no more than 50% of the regular individual coverage rate)		VALID		VALID
8. Family 2 - All persons eligible for Medicare (Shall be equal to 2 times the Individual Medicare Coordinated rate)	$ -		$ -	
9. 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)	$ -		$ -	
10. 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)	$ -		$ -	
Graduate Assistants				
9. Individual (Shall be within the range of 65%-75% of the regular individual coverage rate)		VALID		VALID
10. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
Dental Benefit Component (incl. above for 2015)				
19. Single		VALID		
20. Family (Shall be 2.5 times the individual rate)				
Wellness Benefit Component (incl. above)				
13. Single		VALID		VALID
14. Family (Shall be 2.5 times the individual rate)	$ -		$ -	

ATTACHMENT D: ***Specimen Conversion Contract***

ATTACHMENT E: ***Grievance Procedure (Must include DEPARTMENT administrative review rights.)***

ATTACHMENT F: ***Dental Description (if applicable) and Other***

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

Check appropriate line and comment as needed.

Offering Uniform Dental: _Yes_____No_____

Network offering:

HMO:_____
PPO:_____
Other (specify): _____