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 or 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 spouse elects family coverage, the other eligible spouse may be covered as a DEPENDENT but may not have any other coverage. PARTICIPANTS can only be covered under one State Group Health Insurance Program (including Wisconsin Public Employers State Group Health Insurance Program) contract. 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 or 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 spouses or DOMESTIC PARTNERS have coverage with different HEALTH PLANS at the time of marriage or 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 spouses become divorced or the domestic partnership terminated while carrying family coverage, the divorced spouse or former DOMESTIC PARTNER may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the divorce or termination of the domestic partnership.

(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 or SUBSCRIBER 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. If the DEPENDENT(S) is to be newly covered by a SUBSCRIBER that has single coverage, the contract may be converted to a family contract. 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., 11., 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., 11., 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.

(j) 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 CONTINUED 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. 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, 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 limits are combined for the HDHP, therefore, the prescription drug BENEFIT annual 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), 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, 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, 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.

ATTACHMENT A: TABLE 10A - PRELIMINARY BID SAMPLE
CALENDAR YEAR 2016 (for program year 2017)
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 1st, 2016 2:00pm CDT

STATE 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 0.86 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)	$ -		$ -	
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)	$ -		$ -	
Wellness Benefit Component (incl. above)				
11. Single		VALID		
12. Family (Shall be 2.5 times the individual rate)	$ -			

ATTACHMENT A: TABLE 11A - FINAL BEST BID SAMPLE
CALENDAR YEAR 2016 (for program year 2017)
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: Friday July 29th, 2016 2:00pm CDT

STATE EMPLOYEES

	2016 Inforce Rates (Monthly)	Validation	2017 BAFO Rates (Monthly)	Validation
Regular Coverage (Includes Wellness for 2016)				
1. Individual		VALID		VALID
2. Family (Shall be 2.5 times the individual rate)	$ -		$ -	
High Deductible Health Plan (HDHP)				
3. Individual (Shall be 0.86 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)	$ -		$ -	
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)	$ -		$ -	
Wellness Benefit Component (incl. above)				
11. Single		VALID		
12. Family (Shall be 2.5 times the individual rate)	$ -			

ATTACHMENT B: GRIEVANCE PROCEDURE

(Must include DEPARTMENT administrative review rights.)