The State of Wisconsin Group Insurance Board intends these "Terms for Comprehensive Medical Plan Uniform Benefits and Contract with Group Insurance Board to Participate under the State of Wisconsin Group Health Benefit Program" (hereinafter referred to as "Guidelines") to accomplish the goals and objective stated below. Use of the term "Guidelines" is an historical anachronism and does not imply that the benefits and agreements stated herein are advisory rather than binding terms. Further, all parties contracting with the Group Insurance Board agree that these terms shall always be interpreted consistent with the objectives stated herein.

The Board's objective with alternate health care programming is: to encourage the growth of alternate health benefit plans which are able to deliver health care benefits in an efficient and economical fashion and to limit and discourage the growth of plans which do not; to provide employees the opportunity to choose from more than one comprehensive health benefit plan.

By statute, the Group Insurance Board (Board) has the authority to negotiate the scope and content of the group health insurance program(s) for employees and retired employees of the State of Wisconsin, as well as local units of government.

~~Local governments seeking to participate in the health insurance program must meet a 65% level of participation unless they are a small employer as defined under Wis. Stat. §635.02 (7). Local governments that are small employers must meet a participation level in accordance with Wis. Adm. Code § INS 8.46 (2) to participate wherein eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level. This participation requirement may be waived by the Department on a case-by-case basis for employers for whom the timing of collective bargaining agreements prevents the minimum participation level at any given time. The Board also may offer an optional deductible benefit structure for local governments.~~

The Board is committed to the concept of providing employees with comprehensive health benefit programs and ensuring that such benefits are delivered in an efficient and economical manner. The intent is to provide employees with the opportunity to be covered by health benefit program(s), which will provide benefits, and services, which are substantially similar to those provided under the standard, fee-for-service, group health insurance program. Therefore, the Board has developed these Guidelines by which alternate health delivery plans may be evaluated for possible inclusion under the State of Wisconsin's group health benefit program on a "dual-choice" basis.

"Dual-choice" refers to a program where employees (including retirees and continuants) who are currently insured have the opportunity to choose between at least two competing health benefit plans, the standard plan and one or more alternate plans. The mechanics of "dual-choice" are relatively simple. Once an alternate plan receives approval from the Board on the benefit structure, its proposed premium rate is submitted as a sealed bid. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the Board. The Board reserves the right to reject any proposal, which fails to include adequate documentation on the development of premium rates. These Guidelines provide a detailed explanation of the required documentation.

The current program requires alternate health care plans to submit their premium rate quotations for the following calendar year. The Board reserves the right to change to a fiscal year or to some other schedule that it deems appropriate.

Guidelines
Section I.

The Board determines the premium rate for its self-insured Standard, fee-for-service, group health benefit plan. This premium is established after review of claims experience, secular trends, etc., and after consultation with the Board's actuary. ~~Once the Board has established the premium rates for the standard health plan, the Board opens the sealed "bids" for the alternate health benefit plans.~~ The State of Wisconsin's current contribution toward the total premium for active employees (non-retired) for both single and family contracts is based on a tiered structure. Under the tiered structure, the Office of State Employment Relations has determined the Standard Plan to be placed in Tier 2 for purpose of determining premium contribution share for those subscribers who are active employees ~~residing~~ assigned to work out of state. ~~Plans become "qualified" by meeting the requirements in Addendum 2; number of providers and years of operation.~~

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~~Local employers must pay at least 50% but not more than 105% of the lowest cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10. If there is no "qualified" alternate health plan, the Board reserves the right to designate the State Maintenance Plan as the lowest cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.~~

The tiered premium structure is based on recommendations from the Board's appointed actuary whereby each alternate plan's claims experience will be reviewed to determine which of the three premium contribution tiers each plan will be placed. This placement will be based on a risk-adjusted assessment of the plan's efficiency as determined by the Board's actuary. The most efficient plans will be placed in Tier 1, which will have the lowest employee premium contribution level. The moderately efficient plans will be placed in Tier 2. The least efficient plans will be placed in Tier 3, which will have the greatest employee premium contribution level. The employee premium contribution will be a fixed amount per tier, as determined by the non-represented compensation plan or collective bargaining agreement. The employer shall contribute the balance of the total premium. Plans are determined to be qualified on a county by county basis. Plans become "qualified" by meeting the requirements in Addendum 2; number of providers and years of operation. The Board reserves the right to make enrollment and eligibility decisions as necessary to implement this program, including whether to make a Tier 1 plan available in those counties in which otherwise no qualified health plan in Tier 1 exists and/or a Tier 2 plan available in any county. The Department may take such action as necessary to implement this intent.

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Effective January 1, 2009, local governments seeking to participate in the health insurance program are subject to group underwriting and may be assessed a surcharge based on their risk, which is passed on to the health plan and prescription drug plan. Administration of the underwriting process is done by the Standard Plan administrator and actual assessment of the surcharge is determined by the Board's actuary.

Local governments must meet a 65% level of participation unless they are a small employer as defined under Wis. Stat. §635.02 (7). Local governments that are small employers must meet a participation level in accordance with Wis. Adm. Code § INS 8.46 (2) to participate wherein eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level. The Board also may offer an optional deductible benefit structure for local governments.

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Local employers must pay at least 50% but not more than 105% of the lowest cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10. If there is no "qualified" alternate health plan, the Board reserves the right to designate the State Maintenance Plan as the lowest cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.

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In the event that the contribution is based on a percentage of the lowest cost qualified plan, if an alternate plan submits a premium rate, which is less than the employer contribution rate, the employer contribution (dollar amount) could represent 100% of the total alternate plan premium and the employee will pay no out-of-pocket premium contribution. Conversely, if a plan submits a premium rate, which is substantially higher than the employer contribution rate, the employee contribution will be the difference between the total premium rate and the employer contribution rate in the plan's area.

The Board is convinced that the development of "constructive competition" among providers of health care services will have a positive impact on improving the health-care delivery system. A health care plan with efficient, highly qualified providers, who effectively practice peer-review and utilization review, will draw patients away from inefficient providers by offering better service and/or lower premium costs. The eventual goal is to have comprehensive, alternate health care plans available to all public employees within the geographic confines of the State of Wisconsin.

The following Guidelines describe the requirements, which an organization must satisfy in order to secure approval from the Board to participate under the State of Wisconsin's Group Health Benefit program. They have been developed to explain and clarify the general requirements set forth under Wis. Stats. Subchapter IV of Chapter 40, and Chapters ETF 10 and 40, Wisconsin Administrative Code, Rules of the Department of Employee Trust Funds. Further, they set forth requirements, which are complementary to the statutory provisions contained in Wis. Stats. Chapters 150, 185 (185.981-.985), 600-646, and Public Laws 93-222 (the HMO Assistance Act of 1973) and 94-460 (Health Maintenance Organization Amendments of 1976) and other applicable state/federal health benefit law provisions.

Participation in the program is not limited exclusively to organizations, which are considered "qualified" by the federal government as a health maintenance organization (HMO). The Board is interested in providing public employees with the opportunity to enroll in any comprehensive health benefit program, which is able to demonstrate financial responsibility, a successful operating experience, and meets the requirements outlined in these Guidelines.

D. Comprehensive Health Benefit Plans Eligible for Consideration

1. The Board will only consider those plans, which provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The Board reserves the right not to contract with any plan whose premium is not satisfactory to the Board.

2. Plans that will be considered under these program guidelines to be allowed in any service area include any of the following types of Organizations defined in Wis. Stats. § 609.01 (2) and (4):

   a. Independent practice association HMO (IPA's).

   b. Prepaid group practice HMO.

   c. Staff model HMO.

   Plans that will be considered under these guidelines to be offered in any county also include:

   a. Point of service HMOs (POS-HMO).

   b. Preferred Provider Plan (PPP).

   Plans that embrace the characteristics of one or more of the type of organization models described above may be considered by the Group Insurance Board as meeting the definition of a comprehensive health benefit plan. Insuring organizations may not offer more than one of the above listed plan types in any geographic location. This allows organizations sufficient flexibility to develop innovative alternative plans while recognizing the Board's need for administrative efficiency and protection of the competitive environment.

3. Plans must provide for the Wisconsin State Employees' and Wisconsin Public Employers' Program benefits and services listed in Section 4.

4. Plans must demonstrate, upon request by the Department, their efforts in encouraging and/or requiring network hospitals to participate in such quality standards as Leapfrog, Checkpoint, Wisconsin Hospital Association quality accountability initiative and others as identified by the Department.

5. Plans must demonstrate, upon request by the Department, their efforts in encouraging and/or requiring network providers, large multi-specialty groups, small group practices and systems of care to participate in such quality standards as the Wisconsin Collaborative for Quality Healthcare and others as identified by the Department.

6. Plans must demonstrate, upon request by the Department, their support for the Department's initiatives in monitoring and improving quality of care, such as collecting HEDIS measures and submitting quality improvement plans as directed by the Department. This may include providing actual contract language that specifies provider agreement or terms to participate in or report on quality improvement initiatives/patient safety measures and a description of their link, if any, to provider reimbursement.

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7. Plans are expected to fully incorporate available pharmacy claims data into data reporting, including, but not limited to, HEDIS data, information requested on the disease management survey and catastrophic claims data. Where appropriate, such as for the catastrophic claims data report, plans are expected to separate out pharmacy claims from the Department's pharmacy benefit manager from any pharmacy claims that are paid by the plan.

8. Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians, such as Utilization Review (UR), chronic care/disease management and wellness/prevention. Each plan shall report annually to the Board its utilization and disease management capabilities and effectiveness, demonstrating support for technology and automation (e.g., automated diabetic registry, electronic medical records, etc.) in the format as determined by the Department. Plans shall also include a report detailing the State of Wisconsin group experience by disease categories, place of services along with comparisons to aggregate benchmarks and any other measures the plan believes will be useful to Department staff and the Board in understanding the source of cost and utilization trends. The in a format may be as determined by each plan.

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   Examples of the minimum UR procedures that participating alternate plans should have in place include the following:

   - Written guidelines that physicians must follow to comply with the plan's UR program for IPA model HMOs.
   - Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.
   - Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.
   - Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.
   - Procedure to monitor emergency admissions to non-plan hospitals.
   - Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.
   - If members are required to select a primary care provider or primary care clinic, have a process to allow a participant to change providers in a reasonable time and to communicate to the participant how to make this change. Plans will assist in location of a provider and facilitate timely access, as necessary.

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   In its report, plans must certify that these (or equivalent) procedures are in place. Failure to provide effective UR may be grounds for non-qualification or non-participation.

1. If professional services are provided through contractual arrangements, such as an Independent Practice Association (IPA), a sample copy of the actual contractual agreement established between the organization and the participating physicians who will be providing professional services. If more than one type of contract is used then include a sample of each.

2. Detailed explanation of any relationship between the plan and hospitals which would be involved under the group health benefit program. Each applicant must specify whether there is a contractual relationship between the plan and the hospital(s) involved or if the relationship is limited only to the extent that physicians providing services under the program have staff privileges with the hospital(s).

3. Detailed explanation of how physicians and hospitals are compensated under the program including a description of any and all incentives involved. If physicians are salaried, a detailed explanation of how salaries are established, reviewed and changed, and who is the authorizing party for such action. The intent is to secure information on how a plan reimburses its providers; the Board is not interested in specific fees or salary information.

4. Detailed explanation of medical specialties associated directly or indirectly with the plan. For those plans where medical specialists are used as referral physicians rather than primary care, the plans must submit documentation to demonstrate that the referral physician(s) has, in fact, agreed to accept such referrals. If there is a contractual arrangement where an organization has contracted with a clinic/individual practitioner to provide either primary or referral care, such contractual agreements must be identified and included with the proposal.

5. Except for those benefits which require the enrollee to satisfy a deductible or be subject to co-payment, the contract for professional or hospital services must contain a provision whereby the physician and/or hospital and/or health care provider (as defined under Wis. Stat. § 655.001 (8)) agrees to accept the payments provided by the plan as full payment for covered services. Each plan must certify that it will "hold harmless" the enrollee from any effort(s) by third parties to collect payments for medical/hospital services.

   This provision shall be considered as satisfied if arrangements have been made which prevent the enrollee from being held liable for hospital or professional charges except for those benefits which require the enrollee to satisfy a deductible; be paid on a co-payment basis; or in those instances where the individual failed to comply with published requirements for seeking medical care. Unauthorized referrals or the use of non-participating hospitals or medical personnel in violation of published plan requirements shall not be subject to the "hold-harmless" provision.

6. Provider agreements for transplants are expected to specify that retransplantation due to immediate rejection that occurs within the first 30 days of a transplant shall be covered and is not subject to the Uniform Benefits exclusion on retransplantation.

7. Plans are expected to incorporate into hospital and provider agreements the guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors.

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H. Rate-Making Process

Each plan must include in its proposal to the Board a detailed explanation as to how initial premium rates were determined, and how premium rates will be determined for subsequent periods. The organization shall identify whether the rate which will be proposed represents a community rate (factored or not factored for different time periods or for different benefit provisions) or as a projection of claims/benefits based on expected experience of the state/local group or other groups, etc. This information will be treated confidential by the Board insofar as permitted by Wisconsin Law. Rates shall be uniform statewide, except that plans may submit different rates which result from mutually exclusive provider networks in separate geographic locations. Plans ~~may~~ are encouraged to separate higher cost providers within geographic areas under the tiered structure into separate plans. The state and local groups must be separately rated in accordance with generally accepted actuarial principles. The local group is to be rated as a single entity for each plan. Plans shall provide rates for both the regular and deductible options for the local group. Plans shall not provide claims or other rating information to individual local employers participating in the program.

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The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates. The Department reserves the right to audit, at the expense of the plan, the addendum and the other data the plan uses to support its bid. A bid based on data which an audit later determines is unsupported subject to re-opening and re-negotiating downward.

Any health plan approved by the Board will be subject to the provisions of Wis. Stats. Chapter 40, and the rules of the Department of Employee Trust Funds. The Board limits plans to the following premium categories, and each plan to be qualified must provide coverage for each premium category:

- Individual (Employee Only)
- Family (Employee Plus Eligible Dependents)
- Medicare Coordinated

  - Individual
  - Family (~~2 Medicare Eligible~~all insureds under Medicare)
  - Family (at least 1 under Medicare, at least 1 other not under Medicare)

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- Graduate Assistants[1]:
  - Individual
  - Family
- Deductible Option for Local Program

1. Family rates (regular coverage) must be 2.5 times the individual rate.

[1] Graduate Assistants and employees-in-training at the University of Wisconsin are covered by Wis. Stats. § 40.52 (3). Employees who are employed at least one-third of full-time are eligible for a contribution toward premium as determined by collective bargaining agreements.

J. Time Table and Due Dates For Annual Information Submittals to the Department of Employee Trust Funds

(Note: Unless otherwise specified, if the "Due Date" listed below falls on a Saturday, materials should be received by the Department the previous Friday. If the "Due Date" falls on a Sunday, materials should be received by the Department the following Monday.)

Due Date (Receipt by Dept)	Information Due	Date Submitted
April 15, 20098	• New plans only. Proposal to participate in the program (Section II., I, page 1-18). Contract to be executed by plan/Board. (Section 3)	
May 12, 20098	• Estimated premium rate proposal for next calendar year.	
May 156, 20098	• For PPPs and POSs – Any change to the level of benefits for out-of-plan services for the next benefit year must be submitted.	
June 12, 20098	• Documentation of financial stability (2 copies each): 1. Balance sheet 2. Statement of Operations 3. Annual audited financial statement • Preliminary identification of planned service areas by county for the next calendar year. • Plan Utilization and Rate Review Information (Addendum 1A). This information is to be mailed directly to: Julie Maendel Deloitte Consulting 50 South Sixth Street Suite 2800 Minneapolis, MN 55402-1538 • ~~Addendum 1B and~~ Tables 8A and 8B describing catastrophic data. • ~~Addendum 1C – Utilization Review Worksheet, including actual contract language that specifies provider agreement or terms to participate in or report on Quality Improvement initiatives/patient safety measures. Also indicate their link, if any, to provider reimbursement.~~ • Initial data files of: (1) Addendum 2 provider counts and (2) primary physicians and specialty providers under contract by county (and zip code) for the next calendar year.	
June 156, 20098	• HEDIS information is required for the prior calendar year in the format as determined by the Department.	
July 101, 20098	• If the plan offers dental coverage, final dental plan benefit description is due if the dental coverage is first being offered or if there is any benefit change to the dental benefit. • Information of the plan's features, including objective documentation as requested, for use in the health plan features comparison summary in the "It's Your Choice" brochure.	
July 178, 20098	• Premium rate quotations for next calendar year. (Annually, about July 17, each plan will be provided with a rate quotation form.) • The plan's address and telephone number as it should appear in the Dual-Choice brochure.	

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Due Date (Receipt by Dept)	Information Due	Date Submitted
July 20, 2009	• Report ~~on utilization and disease management capabilities and effectiveness~~ detailing the State of Wisconsin group experience with comparisons to aggregate benchmarks. [Section II., D., 8.]	
July 2~~4~~5, 2009~~8~~	• Final data files of: 1) Addendum 2 and 2) providers under contract by county (and zip code) for the next calendar year. (Note: This date will be moved up by one week at the discretion of the Department's Data Manager for any individual plans for whom the June 1~~2~~ data submission was unacceptable.)	
July 31, 2009~~8~~	• Text to be printed in the plan description section of the annual Dual-Choice brochures. Plans must use the format provided by the Department and list major providers and hospitals in its network for all counties the Board has determined the plan to be qualified.	
August 7~~8~~, 2009~~8~~	• Final best premium bid or withdrawal notice due. • Due date for a plan to notify the Department that it is terminating its contract with the Board.	
August 1~~4~~5, 2009~~8~~	• Request for state employee home address labels (by zip code) for plan use during Dual-Choice Enrollment Period. Note this information can only be used for plans to send informational materials related to the Dual-Choice Enrollment Period.	
August 2~~5~~6, 2009~~8~~	• Group Insurance Board meeting to set the Standard plans' premium rates (fee-for-service plan) and to open for the public alternate plan rate submittals.	
August 2~~8~~9, 2009~~8~~	• Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice Enrollment period. • Complete list of the plan's key contacts as stated in Section II., G., 3., j.	
September 1~~4~~5, 2009~~8~~	• Draft of dental benefit description that will be provided to members if the plan offers dental coverage. This must include the exclusions and limitations. Department approval, prior to September 21, is required. • For plans not participating in the group health insurance program in 201~~0~~7, a draft of the letter the plan will mail subscribers notifying them that the plan will not be offered in 201~~0~~7. Department approval by September 21 is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 2~~4~~5~~6~~.** • Draft of letter the plan will mail to current subscribers summarizing dental benefit and provider network changes for the new calendar year, including a description of referral requirements. Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the Department. Department approval, prior to September 21, is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 2~~4~~5~~6~~, WITH FORWARDING REQUESTED.**	
September 21 – December 31, 2009	• Put a PDF copy of your plan's provider directory for the upcoming benefit year on your plan's web site and provide ETF with the URL of the location. The URL must remain the same through the end of the calendar year.	

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Guidelines
Section II., J.

Due Date (Receipt by Dept)	Information Due	Date Submitted
September 24, 20098 (TBD)	• Dual-Choice kick off meeting in Madison.	
September 30, 20098	• Completed contract, signed and dated. This must include all applicable attachments, the "Vendor Information" and W-9 forms, and two (2) copies of the contract signature page and all applicable attachments. • Provide five (5) copies of all informational materials in final form to the Department. • Final dental benefit description that will be provided to members if the plan offers dental coverage.	
October 1, 2009	• Report on utilization and disease management capabilities and effectiveness. [Section II., D., 8.]	
October 23, 20098	• Confirmation to ETF that the letter to current subscribers summarizing changes for the new calendar year has been sent.	
October 6 – 24, 20098 (TBD)	• Dual-Choice Enrollment Period.	
October 30 – December 8, 20098 (TBD)	• Send to appropriate subscribers a standardized letter, designed by the Department, requesting verification of student and disabled dependent status. • Report the student status and disabled dependent status in the file format and frequency as determined by the Department.	
January 12, 20109	• Identification cards must be issued to all new Dual-Choice enrollees. Explanation of referral and grievance procedures must be included.	
January 15, 20109	• Issuance of new identification cards, if applicable, to continuing subscribers. Written notification to the Department confirming completion is also due.	
March 12, 20109	• Report summary of grievances received during previous calendar year period, by number, type and resolution/outcome [Section II., G., 3., d., (3.)] and a sample grievance decision letter to participants that incorporates Department administrative review rights.	
April 1, 20109	• A Quality Improvement plan in the format set forth by the Department.	
By Noon on Second Monday of Each Month, or as Directed by the Department	• HIPAA compliant Full File Compare Submissions. • Report direct pay terminations and reinstatements in the format as determined by the Department.	
Monthly	• Research and report proposed resolution to the Full File Compare discrepancies identified by the Department.	

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TABLE 8A - CLAIMS IN EXCESS OF $100,000

Line 1 - is the total amount of paid claims for individuals with paid claims of $100,000 or greater. Paid claims are defined as medical and pharmacy claims paid by the health plan; do not include pharmacy claims paid by the Department's pharmacy benefit manager in this calculation. For example, if you had five cases with paid claims of $150,000 each, you would enter the value of $150,000 X 5 = $750,000.

Line 2 - is the number of individuals with paid claims of $100,000 or greater.

Line 3 – is the total amount of claims of $100,000 or greater on an individual basis. For example, if you had five cases with paid claims of $150,000 each, this cell would calculate as follows: $150,000*5 - $100,000*5 = $250,000.

Line 4 - is the estimated percentage of paid claims for the specified reporting period that have not yet been recorded or paid. Incurred claims will be calculated as (1 + Incurred Claim Factor) multiplied by the Paid Charges.

Line 5 - is the number of months of experience that have been included in Paid Charges beyond the specific incurred reporting period of 4/1/2007 – 3/31/2008. For example, if a plan includes experience for claims that were incurred from 4/1/2007 – 3/31/2008 and paid through 5/31/2008, the Runout Months would equal two.

Line 6 - will be calculated as (1 + Completion Factor) multiplied by the Paid Charges. This represents the total amount of claims of $100,000 or greater that have been incurred in the Reporting Period.

TABLE 8B - CLAIMS IN EXCESS OF $100,000 DETAIL

Table 8B requests ~~a detailed list~~ member level claims data by major cost category of large paid claims of $100,000 or greater during the defined report period. Table 8B is a separate data submission that is submitted to the Department only. Additional data may be requested on different subgroups throughout the year.

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TABLE 9A – QUESTIONS REGARDING SUBMITTED DATA

TABLE 9A requests responses to a few questions regarding the submitted data. We prefer that plans provide responses to the questions in the space provided in TABLE 9A. TABLE 9A is considered a part of the required data and must be provided at the same time as all other information.

TABLE 9B – SCHEDULE OF DENTAL BENEFITS

TABLE 9B requests plans submit their 2007 and 2008 schedule of dental benefits in the prescribed format. TABLE 9B is considered a part of the required data and must be provided at the same time as all other information.

~~**ADDENDUM 1B: CATASTROPHIC CASE DATA**~~

~~Catastrophic cases, (defined to be those members with paid charges in excess of $100,000 in a calendar year) will be reported in a predefined format showing in total for the group and for each member whose claims totals meets this definition. This information may include the following:~~

~~A. The age, sex, enrollment status (i.e., subscriber, dependent, active, graduate assistants, retiree, or continuation).~~

~~B. Hospital charges by:~~
~~1. Name and type of facility~~
~~2. Diagnosis code(s) and description~~
~~3. Procedure code(s) and description~~
~~4. Number of admissions~~
~~5. Days per admission~~
~~6. Severity of illness (if available).~~

~~C. Physician charges by:~~
~~1. Inpatient~~
- ~~Total~~
- ~~Surgical~~
- ~~Pathology~~
- ~~Radiology~~

~~2. Other than inpatient~~
- ~~Total~~
- ~~Pathology~~
- ~~Other~~

~~D. Others:~~
~~1. Prescription Drugs~~
~~2. All Others~~

Plan Name _____

ADDENDUM 1C: UTILIZATION REVIEW / QUALITY IMPROVEMENT WORKSHEET

Plans must demonstrate effective and appropriate means of monitoring and directing patient's care by participating physicians.

Check YES, if requirement is in place. Plans must certify that these (or equivalent) procedures are in place.

If "NO" is answered to any question, plans must provide, in writing, a description of the equivalent process.

YES	NO	
		UTILIZATION REVIEW
☐	☐	Written guidelines that physicians must follow to comply with the HMO's or PPP's UR program.
☐	☐	Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.
☐	☐	Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.
☐	☐	Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.
☐	☐	Procedure to monitor emergency admissions to non-plan hospitals.
☐	☐	Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.
☐	☐	If PCP or PCC is required, have a process to allow a participant to change providers in a reasonable time and to communicate to the participant how to make that change. The plan will assist in location of a provider and facilitate timely access, as necessary.
		QUALITY IMPROVEMENT
☐	☐	Send correspondence to network hospitals and large multi-specialty groups or systems of care requesting their participation AND increased performance results in the public reporting initiatives of Leapfrog (National), Checkpoint (Wisconsin) and Collaborative for Quality Healthcare (Wisconsin) by April of plan year.
☐	☐	Submit to the Department actual contract language that specifies provider agreement or terms to participate in or report on quality improvement initiatives/patient safety measures. Also indicate their link, if any, to provider reimbursement.
☐	☐	Complete and submit to the Department objective documentation (or participate in a Department requested survey/audit) to determine credible programs/processes specific to those used to compare health plan features in the "It's Your Choice" brochure.
☐	☐	Complete and submit a Quality Improvement plan to the Department as described in Section J of the Guidelines.

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 pursuant to 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 long-term disability benefit under Wis. Adm. Code § ETF 50.40, a disability benefit under Wis. Stat. § 40.65; or a terminated EMPLOYEE with 20 years of creditable service ~~or a disability benefit under Wis. Stat. § 40.65~~.

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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 the SUBSCRIBER'S:

- Spouse.
- Unmarried child.
- Legal ward who becomes a legal ward of the SUBSCRIBER prior to age 19 but not a temporary ward.
- Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
- Stepchild.
- Grandchild if the parent is a DEPENDENT child. The DEPENDENT grandchild will be covered until the end of the month in which the DEPENDENT child turns age 18.

A DEPENDENT child must be 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.

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 acknowledgement of paternity is filed with the Department of ~~Health and Family Services~~ Children and Families or equivalent if the birth was outside of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity or a court order is filed within 60 days of the birth.

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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. Other children cease to be DEPENDENTS at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

(1) A child age 19 or over who is a full-time student, if otherwise eligible (that is, continues to be a DEPENDENT for support and maintenance and is not married), cease to be a DEPENDENT:

- At the end of the calendar year in which the child ceases to be a full-time student or in which the child turns age 25, whichever occurs first.
- At the end of the month in which the child marries.

~~Student status includes any intervening vacation period if the child continues to be a full-time student.~~ As defined in Wis. Adm. Code § ETF 10.01 (5), student means a person who is enrolled in and attending an accredited institution, which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled and includes any intervening vacation period if the child continues to be a full-time student. Per the Internal Revenue Code, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools and similar on-line programs, intersession courses (for example, courses during winter break), night schools and student commitments after the semester ends, such as student teaching. As required by Wis. Stat. §632.895 (15), eligibility will continue up to one year when the DEPENDENT ceases to be a full-time student due to a medically necessary leave of absence.

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(2) A 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, so long as the child remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a DEPENDENT for federal income tax purposes and is not married). The HEALTH PLAN will monitor mental or physical disability at least annually, terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled, and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

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

(4) Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of ~~eligibility, not on the date of~~ notification ~~to the HEALTH PLAN and/or pharmacy benefit manager~~ with coverage effective the first of the month following receipt of the application by the EMPLOYER, except as required under Wis. Stat. § 632.895 (5) and 632.896.

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1.8 "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.

1.9 "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., 2m., or 8.

1.10 “EMPLOYER” means an eligible State of Wisconsin agency as defined in Wis. Stat. § 40.02 (54).

2.2 COMPLIANCE WITH THE CONTRACT AND APPLICABLE LAW

(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.

(6) The HEALTH PLAN shall maintain a written contingency plan describing in detail how it will continue operations and administration of benefits in the event of strike, disaster, etc., and shall submit it to the DEPARTMENT upon request.

2.3 CLERICAL AND ADMINISTRATIVE ERROR

(4) Except in cases of fraud, unreported death, 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~~not be made prior to January 1 of the previous calendar year~~. 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.

2.5 BROCHURES AND INFORMATIONAL MATERIAL

(2) All brochures and other informational material as defined by the DEPARTMENT must receive approval by the DEPARTMENT before being distributed by the HEALTH PLAN. Five (5) copies of all informational materials in final form must be provided to the DEPARTMENT. At its discretion, the DEPARTMENT may designate a common vendor, which shall provide the annual description of BENEFITS and such other information, or services it deems appropriate, including audit services. The vendor shall be reimbursed by the HEALTH PLAN at cost, but not to exceed $.0~~4~~6 per member per month. HEALTH PLANS will be advised of amount of this charge prior to the due date for PREMIUM bids. The HEALTH PLAN will be responsible for any costs assessed to the HEALTH PLAN even if the HEALTH PLAN is withdrawing from the program.

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2.8 DUE DATES

(2) The EMPLOYER shall immediately forward to the ~~HEALTH PLAN~~ DEPARTMENT the "~~carrier~~ ETF ~~a~~Advance ~~c~~Copy" of applications filed by newly eligible EMPLOYEES. ~~The HEALTH PLAN shall issue identification cards based upon the carrier advance registration copy of the applications.~~

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2.10 GRIEVANCE PROCEDURE

(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.

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3.1 EFFECTIVE DATE

(2) The governing body of an EMPLOYER shall adopt a resolution for regular or deductible option coverage in a form prescribed by the DEPARTMENT. The resolution may provide for underwriting or rate differential as deemed appropriate by the BOARD'S actuary to be passed back to the HEALTH PLANS as determined by the DEPARTMENT in consultation with the BOARD'S actuary. The EFFECTIVE DATE of coverage shall be the beginning of the calendar month, or the beginning of the quarter for EMPLOYERS receiving a rate differential as determined through underwriting, on or after 90 days following receipt by the DEPARTMENT of the resolution, unless the resolution specifies a later month and is approved by the DEPARTMENT. At least 30 days prior to the EFFECTIVE DATE, the DEPARTMENT must receive from the EMPLOYER all EMPLOYEE and ANNUITANT applications for which coverage will begin on the EFFECTIVE DATE. If the number of EMPLOYEE applications received does not represent the minimum participation level of at least 65% of the eligible EMPLOYEES or for small EMPLOYERS as defined under Wis. Stat. § 635.02 (7), the minimum participation level in accordance with Wis. Adm. Code § INS 8.46 (2), the resolution shall become void~~, unless the EMPLOYER is granted a waiver of the participation requirement by the DEPARTMENT~~. EMPLOYEES who are on a leave of absence and not insured under the EMPLOYER'S plan are eligible to enroll only under section 3.10 if they returned to active employment. For ANNUITANTS and EMPLOYEES on leave of absence to be eligible under this section, they must be insured under the EMPLOYER'S current group health plan. Eligible EMPLOYEES who are not insured under the EMPLOYER'S current group health plan at the time the resolution to participate is filed or evidence of insurability is required, or those insured for single coverage who are enrolling for family coverage, shall be subject to the deferred coverage provisions of section 3.10. This limitation will not apply to PARTICIPANTS insured under another group health insurance plan administered by the DEPARTMENT. Those insured through the employer's group coverage at the time the resolution is filed who do not meet the definition of eligible employee under this program may elect continuation coverage for up to 36 months or the length of time continuation coverage would be available under the previous insurer, whichever is less.

(3) Notwithstanding section 3.2, any EMPLOYER for whom the resolution made under section 3.1 resulted in coverage effective January 1, 1988 or after shall be required to remain in the program for a minimum of 12 months. ~~and a~~Any EMPLOYER who files a resolution after December 20, 1990, and who offers a non-participating plan pursuant to sub. (4) shall be required to remain in the program a minimum of three years. Any EMPLOYER who is assessed a surcharge as determined by the underwriting process shall be required to remain in the program a minimum of three years.

(4) The EMPLOYER may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD nor provide payments to or on behalf of EMPLOYEES in lieu of coverage under this program. EMPLOYERS providing payments in lieu of coverage must make a good faith effort to end the practice as soon as practical. The BOARD reserves the right to assess a surcharge as determined by the BOARD's actuary if this is not done within three years. EMPLOYEES who previously declined coverage for payment have a special enrollment opportunity within 30 days of the ceasing of the opt-out provision. However, the DEPARTMENT may allow any EMPLOYER to offer a non-participating plan to a group of its EMPLOYEES if it can be demonstrated to the satisfaction of the DEPARTMENT that: (1) collective bargaining barriers require such other coverage; and (2) there will be no adverse impact to the program;

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and (3) that the minimum number of all of the EMPLOYER'S Wisconsin Retirement System participating EMPLOYEES, including those who are in the non-participating health plan, become insured under the program of the BOARD to meet the required participation levels as defined in (2) above. The Plan Stabilization Contribution may be increased for that EMPLOYER if less than 50% of the participating EMPLOYEES elect the STANDARD PLAN coverage. The EMPLOYER cannot later have a bargaining unit drop from this health insurance program and carry other coverage.

(5) ~~The~~ A Large EMPLOYER (more than 50 employees in the Wisconsin Retirement System) may indefinitely retain a second plan, as described in (4) above, or temporarily retain a second plan for up to four years ~~waive the participation requirements~~ due to timing of collective bargaining or the merger or division of municipalities~~, as described in (2) above,~~ by executing the appropriate Resolution to Participate, provided the EMPLOYER also meets the 65% participation requirement as described in (2) above. The EMPLOYER may later enroll the EMPLOYEES in the collective bargaining unit that did not enroll during the EMPLOYER'S initial enrollment period due to the EMPLOYER retaining a second plan or due to the timing of collective bargaining. The EMPLOYER must notify the DEPARTMENT, in writing, of this enrollment at least 30 days prior to the EFFECTIVE DATE of coverage for these EMPLOYEES. These EMPLOYEES may elect any available plan if they enroll with no lapse of coverage when their coverage under the other plan terminates.

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(6) The EMPLOYER electing the deductible option coverage shall not pay the deductible on behalf of the EMPLOYEE/PARTICIPANT unless it is under Section 125 of the Internal Revenue Code.

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

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

(9) The EMPLOYER is responsible for notifying any CONTINUANTS of the prior group plan of the EMPLOYER'S change of coverage to or from this health insurance program. Notification and application should be sent to his/her last known address.

3.3 SELECTION OF COVERAGE

(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 under medical assistance (Medicaid),~~ or as a member of the US Armed Forces, or as a citizen of a country with national health care coverage comparable to the STANDARD PLAN as determined by the DEPARTMENT. If the EMPLOYEE or a DEPENDENT loses eligibility for that other coverage or the EMPLOYER'S contribution towards the other coverage ceases, ~~he/she~~ 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 another 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) As required by Federal law, an eligible EMPLOYEE may defer coverage if he/she is covered under medical assistance (Medicaid) or the Children's Health Insurance Program (CHIP). 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.

(~~b~~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, or marriage 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.

(~~c~~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.

3.4 DUAL-CHOICE ENROLLMENT PERIODS

(7) As required by Federal law, an insured EMPLOYEE or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, 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. ~~to~~ ANNUITANTS also have this enrollment opportunity, 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.

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3.9 REHIRED OR TRANSFERRED EMPLOYEE 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.

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3.12 COVERAGE DURING AN UNPAID LEAVE OF ABSENCE

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

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(4) 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 state 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 ~~resumes~~ within 9180 days ~~after release from active duty~~.

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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~~, if the DEPARTMENT receives an application for coverage from the surviving DEPENDENT within 90 days after the death of the insured EMPLOYEE or ANNUITANT or 30 days of the date the DEPARTMENT notifies the DEPENDENT of the right to continue, whichever is later~~. A DEPENDENT that regains eligibility and was previously insured under a contract of a deceased EMPLOYEE or ANNUITANT or a child of the EMPLOYEE or ANNUITANT who is born after the death of the EMPLOYEE or ANNUITANT will be eligible for coverage until such time that they are no longer eligible.

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

3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE

(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, or CONTINUANT who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.

(2) The reduction in PREMIUM shall be effective on the first day of the calendar month which begins on or after the date the Medicare hospital and medical insurance benefits (Parts A and B) become effective as the primary payor and coverage is provided under a non-employer group number.

(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.

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3.18 INDIVIDUAL TERMINATION OF COVERAGE

(1) A PARTICIPANT'S coverage shall terminate on the earliest of the following dates:

(a) The effective date of change to another HEALTH PLAN through the BOARD approved enrollment process.

(b) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due. Pursuant to federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the HEALTH PLAN'S requirement for the amount that must be paid. However, the HEALTH PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period. 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 expires, 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.

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(e) The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, 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 36 months for which the PARTICIPANT is allowed to continue under paragraph (4) as required by state and federal law.

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

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