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2.3 CLERICAL AND ADMINISTRATIVE ERROR

(4) Except in cases of fraud, material misrepresentation, resolution of BOARD appeal, or when required by Medicare, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to no more than six months of PREMIUMS paid. In cases where Medicare is the primary payer, retroactive adjustments to PREMIUM or claims for coverage not validly in force shall correspond with the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed six months and in accordance with § 3.16 (3).~~, and 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.~~ No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. In situations where coverage is validly in force, the EMPLOYER has not paid PREMIUM, and the EMPLOYEE does not have a required contribution, retroactive PREMIUM will be made for the entire period of coverage, regardless of the discovery date. The HEALTH PLAN is responsible for resolving discrepancies in claims payment for all Medicare data match inquiries.

(5) In the event that an EMPLOYER determines an EFFECTIVE DATE under Wis. Stat. § 40.51 (2) based on information obtained from the DEPARTMENT available at the time the application is filed, such application shall not be invalidated solely as a result of an administrative error in determining the proper effective date of EMPLOYER contribution. No such error will result in providing coverage for which the EMPLOYEE would otherwise not be entitled, except as required by law.

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2.10 GRIEVANCE PROCEDURE

(1) Any dispute about health insurance BENEFITS or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through the HEALTH PLAN'S and/or PBM's internal grievance process and may then, if necessary and appropriate, be submitted to the DEPARTMENT. The PARTICIPANT may file a complaint for review with an Ombudsperson at the DEPARTMENT. The PARTICIPANT may also request a departmental determination. The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. § 40.03 (6) (i) and Wis. Adm. Code § ETF 11.01 (3). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12). However, the Department will not issue a determination regarding denials of coverage by a HEALTH PLAN and/or PBM based on medical necessity, appropriateness, health care setting, level of care, effectiveness of of a covered benefit, experimental treatment, pre-existing condition, or the rescission of a policy or certificate that can be resolved through the independent review process under Wis. Stat. § 632.835 and Wis Adm. Code § INS 18.11.

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(2) The PARTICIPANT may also request an independent review as provided under Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, the DEPARTMENT must be notified by the HEALTH PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.

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(11) A SUBSCRIBER who does not request coverage for a DOMESTIC PARTNER, or an adult child when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling the DOMESTIC PARTNER or child when the DOMESTIC PARTNER or child become newly eligible due to the loss of eligibility for other coverage or the loss of employer contribution for the other coverage. The SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days after the event and coverage for the DEPENDENT will be effective on the event date. This paragraph does not prevent a SUBSCRIBER from adding the eligible DEPENDENT during the DUAL-CHOICE enrollment period for coverage effective the following January 1.

Coverage for the DEPENDENT eligible under this section remains in effect until the DEPENDENT is no longer eligible, the family coverage is terminated, the SUBSCRIBER requests to terminate coverage for the adult dependent within 30 days of the DEPENDENT'S eligibility and enrollment in other health insurance coverage, or the SUBSCRIBER requests to terminate the coverage for the DEPENDENT during Open 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.

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(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).

3.11 COVERAGE OF SPOUSE OR DOMESTIC PARTNER

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

(2) If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one DOMESTIC PARTNER elects family coverage, the other eligible DOMESTIC PARTNER may be covered as a DEPENDENT but may not have any other coverage except if necessary to avoid imputed income. If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual 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.

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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.

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(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.

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

In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV., A., 12., b. In such cases, the HEALTH PLAN will make claims adjustments prospectively.

3.20 ADMINISTRATION OF BENEFIT MAXIMUMS UNDER UNIFORM BENEFITS

(1) If a PARTICIPANT changes HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the effective date of coverage with the new HEALTH PLAN with the exception of the prescription annual out-of-pocket maximum.

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

(3) The HEALTH PLAN shall provide the PARTCIPANT 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.

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