

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

Chapter 4 — Initial Enrollment

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401 Initial Enrollment and Effective Dates

Immediately upon hire, employers must provide newly eligible employees with the current *It's Your Choice Decision and Reference Guides* (ET-2107d and ET-2107r, respectively) and the *Health Insurance Application/Change Form* (ET-2301). All eligible employees must either enroll online via myETF Benefits or submit a completed application/change form, including those who do not wish to enroll and are choosing to waive/decline coverage (refer to subchapter 402).

Employees can enroll online via myETF Benefits or by downloading and submitting a *Health Insurance Application/Change Form*:

- Within 30 days of the employee's date of hire. Coverage is effective the first of the month on or following receipt of the application by the employing state agency. New WRS employees will be responsible for paying the full premium until employer contributions begin.
- On or before becoming eligible for the employer contribution. Eligibility for employer contribution follows completion of two months of state service under the WRS for permanent/project employees, six months of state service for limited term employees or 1,000 hours of service for Beyond Visison (aka WISCRAFT) employees. Coverage is effective the first of the month on or after the employer's receipt of the application. This does not apply to UW unclassified faculty/academic staff.
- UW unclassified faculty/academic staff: A teacher who is a participating employee and who is employed by the University of Wisconsin for an expected duration of not fewer than six months with at least a one-third full time appointment (UW Faculty). UW Faculty members are eligible for the State premium contribution beginning on the date coverage begins.
- Graduate Assistants: If eligible, may enroll for single or family coverage in any of the available non-high deductible health plans. Their benefits/payroll/personnel office must receive the application within 30 days of the date of first eligible appointment. Health insurance coverage will be effective the first day of the month on or after the employer's receipt of the application. If this is not the grad assistant's first eligible appointment, they may still be eligible for the initial 30-day enrollment period if there was a 30-day employment break between appointments.

Note: If currently an active WRS participant, grad assistant positions are **not** eligible for coverage under the graduate assistant program.

Employees who chose coverage beginning as soon as possible have the option of changing health plans and/or coverage levels effective on the first of the month that the state premium contribution begins. Employees cancelling coverage prior to the date that the state premium contribution begins may re-enroll with the coverage becoming effective on the first of the month that the employer contribution begins.

For initial enrollment, if the new employee's spouse/domestic partner is also an eligible state or participating WPE employee or annuitant, there are several options available.

- If their spouse is already enrolled with single coverage, the new employee may also elect single coverage or elect family coverage in which case the spouse would have to submit an application to cancel their single coverage in order to go onto the new employee's family coverage.
- If their spouse is already enrolled with family coverage, the new employee elects family coverage, in which case the spouse would have to submit an application to cancel their family coverage in order to be added onto the new employee's family coverage.
- If their domestic partner is already enrolled with either single or family coverage, the new enrollee can elect single coverage, or family coverage if they have additional dependents other than the domestic partner, or the domestic partner can submit an application to cancel their single or family coverage in order to go onto the new enrollee's coverage.

402 Declining (waiving) Coverage

An employee declining to enroll in the Group Health Insurance Program when initially eligible must complete (mark appropriate box declining coverage, sign, and date) a *Health Insurance Application/Change Form* (ET-2301) indicating coverage is being declined. Employees should be reminded that once declined, election of coverage at a later date is limited to the onset of qualifying events creating enrollment opportunities (refer to subchapter 403), or during the annual It's Your Choice Open Enrollment period for an effective date of January 1 of the following year.

403 Enrollment Opportunities for Employees who Previously Declined or Cancelled Coverage

Employees who have declined coverage during a designated enrollment period can elect coverage either during the next It's Your Choice Open Enrollment period for an effective date of January 1 of the following year or due to a qualifying event.

Under federal law and by contract, the following constitute qualifying events that permit employees who previously declined or cancelled coverage to enroll in any health plan without limitations:

A. Loss of Other Coverage: Employees who declined coverage under the Group Health Insurance Program due to the following circumstances:

- Coverage under another health insurance plan;
- Coverage under medical assistance (Medicaid);
- Coverage as a member of the US armed forces;

- Coverage as a citizen of a country with national/universal health-care coverage comparable to the Standard Plan options;

and who lose eligibility for the other coverage or the employer's premium contribution for the other coverage ceases, may take advantage of a 30-day enrollment period, beginning on the date the other health-insurance coverage terminates. This does not include voluntary cancellation of the other coverage. A *Health Insurance Application/Change Form* (ET-2301), or online application via myETF Benefits, and other information documenting the loss of coverage or employer premium contribution must be received by the employer within 30 days of the date the other coverage or the employer premium contribution ended.

Note: The employee should complete and submit an application even if they have not received the required documentation. The employer needs to receive the application within the 30-day window of loss. Many times the required documentation will be received outside of the 30-day enrollment window and the employee can secure the enrollment opportunity by submitting the application to the employer prior to receiving the required documentation.

Copies of the required documentation must be submitted to ETF for approval. Coverage is effective on the day following the last day of the other coverage. For example, if coverage ended on May 13th with the other plan, coverage under the state plan would begin on May 14th.

ETF requires documentation including the following items on letterhead from the previous insurer and/or the former employer where at least the insurer's document is dated and issued after termination of coverage. If separate parts of the information are provided from both the employer and the former insurer on different dates, for example, your employee who lost coverage through his spouse provides a COBRA form from his spouse's former employer stating why coverage ended that is dated prior to the termination date, and the former insurer issues a letter after the termination date stating that coverage terminated on a preceding date, that assortment of documentation is acceptable.

The documentation on letterhead must include:

1. Who was covered (must list the name of the member who is requesting this special, late enrollment)
2. Name of Health Insurer
3. Subscriber number (and name)
4. Date coverage was terminated
5. Reason for the cancellation (that is voluntary such as due to non-payment of premium vs. involuntary such as due to job loss)

Note: This enrollment period is not available if the employee and/or their dependents remain eligible for coverage under a health insurance plan that replaces the other plan without an interruption in coverage.

B. Marriage/Domestic Partnership/Birth/Adoption/National Medical Support Notice/

Paternity: Employees who declined coverage under the Group Health Insurance Program have an opportunity to enroll in family coverage if they have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption, a court ordered National Medical Support Notice, or paternity. If documentation is required and not readily

available, the employee should submit the application to the employer before receiving the required documentation to secure the effective date of the enrollment opportunity.

- For marriage or domestic partnership – coverage is effective on the date of marriage or the effective date of the domestic partnership if an application is received within 30 days of that event date.
- For birth, adoption, placement for adoption, paternity acknowledgement – coverage is effective on the date of birth, adoption or placement for adoption, if an application is received within 60 days of that event date.
- For National Medical Support Notice – coverage is effective on the first of the month following the receipt of the application by the employer or the date specified on the Medical Support Notice. The application should be received within 30 days of the court ordered support notice.

C. Increase in hours for LTEs and less than half-time employees: LTEs and less than half-time employees who initially decline health insurance coverage have a new enrollment opportunity each time their hours increase to half-time or more. These employees may enroll in any plan without restriction and have 30 days from the date the employer contribution increases to file online via myETF Benefits or submit a *Health Insurance Application/Change Form* with the employer. Coverage is effective the first of the month following the employer’s receipt of the application.

Example: An employee in a WRS-covered position appointed to work fewer than 1,044 hours is eligible for less than half-time employer premium contributions and elects not to participate in health insurance coverage. The employee later receives an appointment, effective October 1, for 1,044 hours or 50% time. (Refer to note regarding number of hours in subchapter 303 B). The employee now has an additional enrollment opportunity due to this increase in hours. The employee can file an application on October 1 for coverage effective on October 1, or the employee can file the application with the employer on or before October 30, (30 days from being hired into the new appointment) for coverage effective on November 1.

Employees who fail to enroll during this additional enrollment opportunity will only be eligible to elect health insurance coverage either during the next It’s Your Choice Open Enrollment period or if an enrollment opportunity arises (e.g., marriage/domestic partnership, birth, adoption, etc.).

Note: A full month’s premium is due for the month if coverage or change in coverage level is effective before the 16th of the month. Otherwise the new premium rate goes into effect the following month.

D. Preserve Sick Leave: If an employee who deferred coverage wants to preserve sick leave credits for later use, they must enroll in the Standard Plan 30 days prior to retirement.

404 Applying for Coverage

Verify the employee’s eligibility for group health insurance coverage (refer to subchapter 301). Provide the employee with the *It’s Your Choice Decision and Reference Guides* and the *Health Insurance Application/Change Form* (ET-2301) and/or show them where to locate

both on the ETF website at etf.wi.gov. Inform the employee of the deadline for submitting the application. Employees may also submit their application online via myETF Benefits. Employees should complete the application following the instructions included with the *Health Insurance Application/Change Form*. Each eligible employee must submit an application (paper or online) to the employer even if declining coverage (currently must submit paper form if declining coverage). It is important that there is written documentation indicating the employee declined coverage; employers should retain such documentation. UW staff using ebenefits to decline coverage need not complete this step.

- a. If employees are enrolling using the paper *Health Insurance Application/Change Form*, direct employees to the ETF website at etf.wi.gov.
- b. If employees are enrolling online via myETF Benefits, direct employees to the ETF website at etf.wi.gov and click on the *Members* tab. Under the title *Insurance*, click on the bullet titled *myETF Benefits for Members*. Under the heading *Applications*, first click on *Instructions*. After the employee reviews and/or prints the instructions, then hit the back button. Next, click on *myETF Benefits*. The employee will need to have their Member ID (which the employer will need to share with the employee) and follow the steps outlined in the Instructions.

Note: Instructions for using myETF Benefits can be found in the *It's Your Choice Decision Guide*.

After the employee submits their application (paper or online via myETF Benefits) the employer will review:

- a. If submitted via myETF Benefits, the employer will go to myETF Benefits, myMembers/myMembers Requests, review and approve the update(s) submitted by the employee under Request Status: Pending.
- b. If submitted via *Health Application/Change Form*, the employer must review the completed form before approving the application by completing the Employer Section. **Note: the employee must sign the application. Failure to provide a signature is an incomplete application and will be rejected.**
 1. Employer Identification Number (EIN) – The EIN given to employers, beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-0001-101).
 2. Name of Employer
 3. Payroll Representative E-mail
 4. Five-digit Group Number – The five digit number assigned to state agencies (e.g., 84535)
 5. Employee Type – Enter the appropriate code (refer to Appendix B).
 6. Coverage Type Code – Coverage code identifying single or family coverage (refer to Appendix B).
 7. Health Plan Name or Suffix – The full name or two-digit code identifying the health plan.

8. Employment Status – Is the employee full-time, part-time, or LTE.
 9. Employee Deductions – Are the employee's health insurance premiums deducted pre-tax or post-tax.
 10. Previous Service – Complete Information – Check the appropriate response for each question.
 11. Date WRS Eligible Employment or Graduate Assistant Appointment Began or Hire Date – The month, day and year the employee began WRS (or grad assistant) employment with the employer. For rehired employees, enter the rehire date.
 12. Employer Received Date – The date the employer received the completed application. It is important that this date be accurate in order to determine if the application was received timely.
 13. Event Date – The date the event took place (e.g., marriage date, birth date, loss of coverage date, etc.).
 14. Prospective Date of Coverage – The month, day and year the coverage should be effective.
 15. Payroll Representative Signature/Phone Number – The signature acknowledges the date the employer received the application and that an audit of the application has been completed and the phone number of that representative.
- c. Upon completion of the Employer Section, make copies of the application:
1. Employer Copy – retain original for your records.
 2. Employee Copy – return a copy to the employee.
 3. ETF Copy – if requested, submit with copies of any required documentation (e.g., contract in “Waiting for ETF Approval” status).

405 Insurance Cards

Subscribers will receive an ID card from the health plan for use in obtaining medical services and a separate ID card from the pharmacy benefit manager (PBM) for use in filling prescriptions. (Refer to subchapter 206 for further information about the PBM). Member identification numbers are different on each card. The eight digit ID number appearing on the pharmacy ID card is the employee's myETF Benefits member ID.

Applications should be submitted/entered at least one month prior to the coverage effective date, whenever possible, to allow sufficient time for the health plan and Navitus to issue the ID cards to the subscriber prior to the effective date.

Subscribers can contact the health plan and the PBM directly to request additional ID cards. Phone numbers for the health plans and the PBM are listed on the inside back cover of the *It's Your Choice Decision Guide* (ET-2107d) or online at etf.wi.gov.