



Local Health Insurance

Employer Administration Manual

Wisconsin Department of Employee Trust Funds
801 W. Badger Road
Madison, WI 53702

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

TABLE OF CONTENTS

Preface

CHAPTER 1 - Background Information (Revised 10/2015)

- 101 Applicable Policies, Statutes and Legislation
- 102 Employer Agent Responsibilities
- 103 Employer Training and Support
- 104 myETF Benefits System (MEBS)
- 105 ETF Ombudsperson Services
- 106 Employer Services Section (ESS) Contacts

CHAPTER 2 - Health Plan and Program Information (Revised 10/2015)

- 201 Alternate Health Plans (HMOs and PPOs such as WEA Trust)
- 202 Standard Plan
- 203 State Maintenance Plan (SMP)
- 204 Three Tiering Health Insurance Premium Structure
- 205 Program Options (PO)
- 206 Pharmacy Benefit Manager (PBM)
- 207 Health Plan Contacts
- 208 Coordination of Benefits (COB)

CHAPTER 3 - Eligibility (Revised 10/2015)

- 301 Employee, Annuitant and Continuant Eligibility
- 302 Dependent Coverage Eligibility
- 303 Employer Premium Contribution Eligibility
- 304 Determining Effective Dates for the Employer Premium Contribution
- 305 WRS Previous Service Check

CHAPTER 4 - Initial Enrollment (Revised 10/2015)

- 401 Initial Enrollment and Effective Dates
- 402 Declining Coverage
- 403 Enrollment Opportunities for Employees who Previously Declined or Cancelled Coverage
- 404 Applying for Coverage
- 405 Insurance Cards

CHAPTER 5 - Changing Coverage (Revised 10/28/2015)

- 501 Status Changes
- 502 Changing Plans Due to a Residential Move
- 503 Changing from Single to Family Coverage
- 504 Changing from Family to Single Coverage
- 505 Adding Dependents
- 506 Removing Dependents

CHAPTER 6 - It's Your Choice Open Enrollment (Revised 10/2015)

- 601 It's Your Choice Open Enrollment Eligibility
- 602 Withdrawing/Rescinding It's Your Choice Enrollment Elections
- 603 When a Health Plan is Not Available at It's Your Choice
- 604 Late It's Your Choice Applications

CHAPTER 7 - Leave of Absence (Revised 10/2015)

- 701 Definition of a Leave of Absence
- 702 Coverage Does Not Lapse While on a Leave of Absence
- 703 Coverage Lapses While on a Leave of Absence
- 704 Coverage During Layoff
- 705 Coverage During Appeal of Discharge

CHAPTER 8 - Cancellation and Termination of Coverage (Revised 10/2015)

- 801 Ending Coverage
- 802 Changing From Active to Annuitant Coverage
- 803 Cancellation of Coverage

CHAPTER 9 - COBRA, Continuation and Conversion (Revised 10/2015)

- 901 Overview of COBRA, Continuation and Conversion
- 902 Persons Eligible for Continuation (Qualified Beneficiaries)
- 903 Employee Responsibilities
- 904 Qualified Beneficiary Responsibilities
- 905 Employer Responsibilities
- 906 Notice Requirement Illustration Chart
- 907 Continuation Coverage Information

CHAPTER 10 - Retirement, Disability or Long-Term Disability Insurance (Revised 10/2015)

- 1001 Coverage – Requirements to Continue
- 1002 Medicare Enrollment
- 1003 Premium Payment
- 1004 Completing *Employer Verification of Health Insurance Coverage* (ET-4814)

CHAPTER 11 - Rehired Annuitants (Revised 10/2015)

- 1101 Eligibility
- 1102 Coverage
- 1103 Disability Annuitants

CHAPTER 12 - Medicare (Revised 10/2015)

- 1201 Overview of Medicare

CHAPTER 13 - Employee Death (Revised 10/2015)

- 1301 How to Report an Employee Death
- 1302 Surviving Spouse/Domestic Partner and Dependents
- 1303 Surviving Spouse/Domestic Partner who is also an Employee Eligible for Coverage

CHAPTER 14 - Invoicing (Revised 10/2015)

- 1401 Viewing Your Invoice
- 1402 Reconciling Your Invoice
- 1403 Accepting and Paying Your Invoice - Automated Clearing House (ACH)
- 1404 Late Interest Charge
- 1405 Who to Contact for Assistance

Appendix A - Forms and Brochures (Revised 10/2015)

Appendix B - Codes (Revised 10/2015)

- B-1 Employee Type Codes
- B-2 Coverage Type Codes
- B-3 Individual Relationship Codes
- B-4 Enrollment Type Codes
- B-5 Program Option Codes
- B-6 Surcharge Codes
- B-7 Health Plan Codes

Appendix C - myETF Benefits (Revised 10/2015)

- C-1 How to Log in to myETF Benefits
- C-2 Add Coverage
- C-3 Add Dependent
- C-4 Remove Dependent
- C-5 Change Health Plans
- C-6 Termination of Coverage
- C-7 Pending Transactions
- C-8 Enrollment Inquiry
- C-9 Dependent Inquiry
- C-10 Address Inquiry

Department of Employee Trust Funds Local Health Insurance Administration Manual

Preface

The *Local Agency Health Insurance Administration Manual* (ET-1144) is a reference source intended to aid your administration of and participation in the Wisconsin Public Employer Group Health Insurance Program. Its contents are based on state statute, administrative code, and group health contract language and contain instruction relevant to the administrative and reporting practices of the Group Health Insurance Program. Wisconsin statutes, administrative code, and group health contract language are reviewed on an ongoing basis and may be revised after the printing of this manual.

The Department of Employee Trust Funds will make every effort to communicate changes to employers via *Employer Bulletins* and manual updates. This manual contains examples relevant to the administration of the Group Health Insurance Program but may not cover every eventuality. Specific program questions and situations will be considered with regard to current statute, administrative code, Terms and Conditions for Comprehensive Medical Plan Participation in the *State of Wisconsin Group Health Benefit Program and Uniform Benefits* (ET-1136), and/or case law by ETF.

Consult this manual as a first-step resource when you encounter Group Health Insurance Program-related questions or concerns. If questions remain, contact the Employer Services Section (ESS). ESS provides a single point of contact to resolve issues regarding eligibility, enrollment, coverage and invoicing for ETF benefit programs. A central voice mail system handles calls when all ESS staff member lines are busy. The voice mail system is monitored on a regular basis and all calls are returned within 24 business hours. The ESS telephone numbers are toll-free 1-877-533-5020, 1-608-266-3285 or e-mail at ETFHealthandIns@etf.wi.gov.

Your efforts to accurately administer the provisions of the Group Health Insurance Program are appreciated. If you have comments on this edition or suggestions for the next edition of this manual, please contact toll free at 1-877-533-5020 or 1-608-266-3285.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 1 — Background Information

- 101 Applicable Policies, Statutes and Legislation**
- 102 Employer Agent Responsibilities**
- 103 Employer Training and Support**
- 104 myETF Benefits System (MEBS)**
- 105 ETF Ombudsperson Services**
- 106 Employer Services Section (ESS) Contacts**

101 Applicable Policies, Statutes and Legislation

Wisconsin Statutory Authority: § 40.51

The Wisconsin Public Employers Group Health Insurance Program is authorized by Wis. Stat. § 40.51 and is administered under the authority of the State of Wisconsin Group Insurance Board. The program offers employees and retirees the opportunity to choose between two or more health plans.

Group Insurance Board

The Group Insurance Board (GIB) sets policy and oversees administration of the group health, life, and income continuation insurance programs for eligible state and local employees. The GIB can allow other types of insurers and third-party vendors to provide other insurance plans, if employees pay the entire premium.

Department of Employee Trust Funds Administrative Code

Chapter ETF 40 of the ETF administrative code provides guidelines and policies used to administer health care benefits.

Contract for a Health Plan to Participate Under the Group Health Insurance Program

The goals and objectives of the contract between the GIB and the health plans are to:

- Encourage the growth of alternate health benefit plans that can deliver quality health care benefits efficiently and economically.
- Offer employees a choice between two or more health plans.

Act 10 and Act 32

2011 Wisconsin Act 10 and 2011 Wisconsin Act 32 contain a number of provisions that

affect the Group Health Insurance Programs administered by ETF. For more information, please visit ETF's website at etf.wi.gov.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA was enacted by Congress in 1996. The primary goal of HIPAA is to implement national standards that simplify and streamline the health-care claims and payment process.

The three components of this effort are:

- **Electronic Data Transaction Standards** - Sets uniform methods for conducting electronic transactions.
- **Privacy** - Limits how health information can be used and disclosed.
- **Security** - Requires safeguards for health information maintained in electronic form.

ETF must comply with the following HIPAA regulations:

- When an employee does not apply for health insurance when first eligible, a new opportunity to apply occurs during the annual It's Your Choice Open Enrollment period. Coverage is then effective January 1 of the following year.
- Certain qualifying events such as loss of other group coverage, marriage/ establishment of a Chapter 40 domestic partnership, or the birth or adoption of a child, permit an enrollment opportunity without restriction. For more information, contact ETF's *Employer Communication Center* at 1-877-533-5020 (toll free) or 1-608-266-3285.

A Notice of Privacy Practices is posted on ETF's website (etf.wi.gov) and appears in the *It's Your Choice Reference Guide* (ET-2128r).

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, and will be fully implemented by 2018. The law offers choices for consumers and provides new ways to hold insurance companies accountable. The law offers several benefits relating to the following health-care issues:

- Rights and protections.
- Insurance choices.
- Full coverage for federally required preventive care services.

For more detailed information about ACA provisions, visit www.healthcare.gov and www.dol.gov/ebsa/healthreform/.

102 Employer Agent Responsibilities

Designate a health insurance representative to:

- Explain eligibility, cost, enrollment procedures and effective dates to employees.
- Provide *It's Your Choice Reference and Decision Guides* (ET-2128r and ET-2128d), either paper or electronically, to all new hires and current subscribers prior to the annual It's Your Choice Open Enrollment period and track when each employee received one.
- Provide information upon initial enrollment, during It's Your Choice Open Enrollment, continuation-conversion provisions, and when applicable, Medicare.
- Secure, audit and maintain health insurance applications, audit and approve online enrollments and arrange payroll deductions.
- Review, reconcile and pay monthly ETF invoices online by the 24th of each month. Refer to Chapter 15.
- Refer employees to the appropriate health plan contacts for claim or benefit questions.
- Refer annuitant health insurance questions to ETF Retiree Services Section.
- Refer questions regarding the contract to ETF (Refer to subchapter 106).
- Respond to health plan questions and audits in a timely manner.
- Maintain a supply of current ETF forms, available at etf.wi.gov, and update supply when forms are revised. (refer to Appendix A).

103 Employer Training and Support

Training

Training for employers administering benefits under the Group Health Insurance contract is provided via the ETF website and the help tab on myETF Benefits.

Technical Support

For technical support with or questions about myETF Benefits System, please call the Help Desk at 1-608-266-9466.

Group Health Plan Questions

Questions about group health plans or benefits should be directed to the Employer Services Section (ESS) at 1-877-533-5020 (toll-free) or 1-608-266-3285 (local) or etf-healthandins@etf.wi.gov

104 myETF Benefits System

myETF Benefits System is a self-service benefits management system. The system has two applications:

1. myETF Benefits Administrator application for Employers (via Online Network for Employers - ONE).
2. myETF Benefits application for Members (via Online Network for Members - ONM).

The myETF Benefits Administrator Application for Employers allows employers to:

- Initially enroll new employees.
- View and update individual member health insurance eligibility and demographic data.
- Complete mass employee terminations.
- View and update health insurance enrollment data.
- Approve employee submitted changes to health insurance and demographic data.

The myETF Benefits Application for Members allows members and employers to:

- Initially enroll in the health insurance if the employer allows and has set up the employee on the myMembers screen.
- View individual health insurance eligibility and demographic data.
- Update health insurance enrollment data.
- Update demographic information.

The administrator (employer) application can be found at the ONE site and is accessed using the employer's ONE login and password. Access to myETF Benefits is granted via the *Online Network for Employers Security Agreement* (ET-8928).

Members will need to set up a login and password to access the system through Wisconsin Access Management System (WAMS). Employers will need to gain access by submitting the *Online Network For Employers Security Agreement*.

Appendix C contains more detailed instructions for employers to use the myETF Benefits System.

105 ETF Ombudsperson Services

The ombudsperson is a confidential resource for WRS and insurance program members and acts as a neutral party to work for equity, fairness and compliance with program policies and insurance contracts.

ETF offers ombudsperson services to assist members who remain dissatisfied after first having contacted the health plan and/or the Employer Services Section regarding

a problem or complaint. Employers should direct employees in this situation to write or telephone ETF's ombudsperson at the following:

Department of Employee Trust Funds
P O Box 7931
Madison WI 53707-7931
Local (Madison) 608-261-7947
Toll Free 1-877-533-5020 ext. 17947
E-mail ombudsperson@etf.wi.gov

ETF ombudspersons advocate for members and attempt to resolve complaints and problems on their behalf. If unsuccessful, the ombudsperson advises the member of subsequent avenues of appeal. Complaints should be made in writing, using the *Insurance Complaint Form* (ET-2405) whenever possible. Additional information regarding ETF ombudsperson services can be found under the "Members" section at etf.wi.gov.

Note: For complaints pertaining to benefit determinations, members must complete at least the first level of the administrative review process through the health plan and/or Pharmacy Benefit Manager (PBM) prior to requesting assistance from the ETF ombudsperson.

106 Employer Services Section (ESS) Contacts

Employers can contact ESS for questions related to eligibility, enrollment, forms and other inquiries via the methods below.

Madison

Mailing Address	P O Box 7931 Madison WI 53707-7931
Shipping Address	Department of Employee Trust Funds 801 W Badger Road Madison WI 53713-2526
Telephone	1-877-533-5020 (toll free) 1-608-266-3285 (local Madison area)
TTY	1-608-267-0676
Fax	1-608-267-4549
Website	etf.wi.gov
E-mail	ETFHealthandIns@etf.wi.gov

Office Hours

7:45 a.m. to 4:30 p.m. Monday through Friday (except holidays)

Pharmacy Benefit Manager (PBM) Contact Information

Office Address	Navitus Health Solutions, LLC 1025 West Navitus Drive Appleton WI 54913
Mailing Address	Navitus Health Solutions, LLC P O Box 999 Appleton, WI 54912-0999
Telephone	1-866-333-2757 (toll free)
Website	https://www.navitus.com

Chapter 2 — Health Plan and Program Information

- 201 Alternate Health Plans (HMOs and PPOs such as WEA Trust)**
- 202 Standard PPO Plan**
- 203 State Maintenance Plan (SMP)**
- 204 Three Tiering Health Insurance Premium Structure**
- 205 Program Options (PO)**
- 206 Pharmacy Benefit Manager (PBM)**
- 207 Health Plan Contacts**
- 208 Coordination of Benefits (COB)**

The Wisconsin Public Employers Group Health Insurance Program offers three types of plans to participating employees and annuitants: alternate health plans, the Standard Plan, and the State Maintenance Plan. Effective January 1, 2015, there are four different Program Options to choose from, including a High Deductible Health Plan (HDHP) option.

201 Alternate Health Plans (HMOs and PPOs such as WEA Trust)

Alternate health plans are health maintenance organizations (HMOs) and preferred provider organizations (PPOs) that provide Uniform Benefits at a lower cost, with slightly different benefits, than the Standard PPO Plans. Most employees select an alternate health plan.

All alternate health plans participating in the Group Health Insurance Program offer the same level of coverage, called Uniform Benefits, with the exception of dental coverage that may be offered at the discretion of the health plan. If dental coverage is offered, it is Uniform Dental Benefits.

Uniform Benefits, as detailed in the *It's Your Choice Reference Guide*, are designed to ease employee health plan selection and assist ETF's efforts to negotiate quality care at the lowest possible cost. Uniform Benefits permit employees to select a health plan based on cost, quality of services, and access to specific physicians or other health care providers.

While Uniform Benefit coverage levels are the same for alternate health plans, plans differ in other ways, namely premium amount, provider network, benefit determinations and administrative requirements. Uniform Benefits and premium amounts change on an annual basis, so the latest *It's Your Choice Decision Guide* (ET-2128d) and *Reference Guide* (ET-2128r) are the most reliable resources for details.

Note: Benefits generally differ for annuitants and their dependents enrolled in Medicare.

202 Standard PPO Plan

The Standard PPO Plan is a comprehensive self-insured Preferred Provider Organization (PPO) that is currently administered by WPS Health Insurance (WPS). Participants enrolled in the Standard Plan can see a provider of their choice without the network restrictions associated with an HMO. In exchange for this freedom to select the provider of their choice, the participants have different benefit levels depending on whether the provider selected is in-network (higher benefit level) or out-of-network (lesser benefit level). Participants can review the *Standard PPO Plan* brochure for more details regarding the differences between the benefits under the Standard Plan and the Uniform Benefits offered under the alternate health plans.

Four different Standard PPOs are available, based upon the Program Option (PO) an employer selects (refer to subchapter 204). Detail about them is available as follows:

PO 2: <http://etf.wi.gov/publications/et2131.pdf>

PO 6: <http://etf.wi.gov/publications/et2160.pdf>

PO 4: <http://etf.wi.gov/publications/et2162.pdf>

PO 7: <http://etf.wi.gov/publications/et2170.pdf>

Members who choose this plan typically want the freedom of choice to see any provider, anywhere. They tend to be higher utilizers of care and thus the cost of this plan is typically greater than an alternate plan.

203 State Maintenance Plan (SMP)

The State Maintenance Plan (SMP) offers the same Uniform Benefits package as the alternate health plans, but is available only in those counties that do not have a qualified Tier 1 alternate health plan as noted in the current *It's Your Choice Decision Guide*. The SMP is administered by WPS.

204 Three Health Insurance Premium Contribution Structures Available

Employers may not provide payments to employees in lieu of coverage under the WPE Group Health Insurance Program. Employer contributions toward health insurance coverage are limited to those described in Wis. Stat. § 40.51 (7) and Wisconsin Administrative Code ETF 40.10.

Under the law, participating employers potentially have three structures available for

establishing employer contribution toward premium. The 88% Calculation Method, which must also align with the 105% calculation, the Three-Tiered Premium Structure and the 105% Formula Method that is only available to those groups identified in the law following passage of 2011 Wisconsin Act 10. Contributions can vary by employee groups. A group can be defined by start dates, full-time equivalency, coverage type (single or family), collective bargaining agreements and/or geographic location. Contact ETF with questions.

1. The 88% Calculation Method must align with the 105% calculation. The 88% and 105% rate tables ETF provides indicate the maximum employer share. If a health plan's premium is equal to or less than the employer's share, the employer pays the entire premium. The employer may adjust the employer contribution downward to require employees who select low-cost plans to pay some amount. The employer must apply the same adjusted contribution rate equally to all employees within the same group, regardless of the plan they select.

The criteria for a local employer using either the 88% Calculation Method or the 105% Formula Method are as follows:

- Participating employers are allowed to pay up to 88% of the average premium cost of the qualified Tier One health plans within the service area of the employer (i.e., the county).
 - The 105% of the low-cost qualified health plan contribution method still applies. This method allows the employer to contribute toward the premium for any eligible employee an amount between 50% and 105% of the least costly qualified health plan within the county of the employer.
 - The minimum employer premium contribution for all local employees cannot be less than 50% for employees who work 1,044 hours or more per year or less than 25% for employees who work fewer than 1,044 hours.
2. The Three-Tiered Premium Structure is also available for employers to use in establishing the maximum employee contribution toward premium. Each year the Group Insurance Board and its consulting actuaries rank and assign each of the available health plans to one of three "tier" categories. An employee's premium contribution is determined by the tier ranking of the health plan selected.

The criteria for a local employer to implement tiering is as follows:

- The employee portion of the monthly premium will increase for plans in higher tiers by at least \$20 for single coverage and \$50 for family coverage for each successively higher tier.
- The employee's single or family premium contribution must be the same for all plans in a given tier.
- A number of provisions affect the amount an employer may contribute toward the employee cost of health insurance. 2011 Wisconsin Act 10 also requires that participating local employers not pay more than 88% of the average premium

cost of the qualified tier one health plans. If a collective bargaining agreement is in effect, the terms of that agreement regarding group health insurance apply. In addition, Administrative Code ETF 40.10 prohibits the employer from paying more than 105% of the least costly qualified health plan within the employer's county.

- The employer must pay at least 50% of the premium for employees who work 1,044 hours or more per year and can pay no less than 25% of the premium for employees who work fewer than 1,044 hours per year.
3. All employees of participating local employers are subject to the 88% maximum contribution method except those listed below. For these, the 105% formula applies or a tiering structure that aligns with the 105% formula may be used:
- Represented employees who are subject to a collective bargaining agreement that was in place before June 28, 2011.
 - Non-represented managerial law enforcement or managerial fire-fighting employees initially hired by a local employer before July 1, 2011. These employees are paid at the same percentage as represented law enforcement or fire-fighting personnel hired before July 1, 2011.
 - Represented law enforcement or fire-fighting employees initially hired before July 1, 2011 and who on or after July 1, 2011 became a non-represented law enforcement or fire-fighting managerial employee. These employees are paid at the same percentage as represented law enforcement or fire-fighting personnel hired before July 1, 2011.

In these cases, the 105% of the low-cost qualified health plan contribution method still applies.

Health plans must have providers in the geographic area serving the majority of the employees in order to be considered in the employers' contribution formula; however, this does not limit the employee's choice of plans. Employees may select any plan offered by this program, as long as they are willing to receive health care from its respective network providers.

Note: The State Maintenance Plan (SMP) will be designated as the low-cost qualified health plan in those counties where other plans do not meet the minimum provider qualification requirements. In those counties, the 88% formula is based on SMP rates.

For health plan premium rates, refer to the *It's Your Choice Decision Guide* (ET-2128d) or applicable addendums for the *Coinsurance* (ET-2168), *Deductible* (ET-2158) or *High Deductible Health Plan* (ET-2169) program options.

Premiums change annually on January 1.

205 Program Options (PO)

Local government employers have flexibility in choosing cost-sharing plan options under the WPE Group Health Insurance Program. Employers may offer up to four program options (POs) to different classes of employees (that is, collective bargaining units). Individual employees cannot choose between POs. Following the bulleted descriptions below, a grid briefly illustrates the differences between the POs.

Local employers may change POs or enroll under additional program options once a year, by submitting an *Existing Employer Option Selection Resolution* (etf.wi.gov/publications/et1152.docx) with ETF before October 1. It must be signed by your governing body. Employers having questions about changing, adding, or deleting program options may call the Employer Services Section at 1-877-533-5020 or 608-266-3285.

PO 2: Traditional or HMO-Standard PPO. Under this program option, subscribers select from:

- Traditional (no coinsurance or deductible) Uniform Benefits offered by the Alternate Health Plans (refer to subchapter 201).
- Standard PPO that allows participants to see their choice of provider with higher out-of-pocket costs for out-of-network providers. Detail is provided in the *It's Your Choice Guides*.

PO 6: Coinsurance HMO-Standard PPO. Subscribers select a health plan that offers Coinsurance Uniform Benefits or the Standard PPO. This program option offers Uniform Benefits premium rates that are approximately 5% lower than PO 2 rates.

- Coinsurance Uniform Benefits' offered by the Alternate Health Plans, includes a member coinsurance of 10% up to a maximum of \$500 individual/\$1000 family except for federally required preventive care. Such care is 100% covered. This program option mirrors the Uniform Benefits offered to state employees. Over time, if changes are made to the state Uniform Benefits plan, this plan will mirror those changes.
- The Standard PPO allows participants to see their choice of provider, with higher out-of-pocket costs for out-of-network providers. This program has larger deductible and coinsurance costs than the PO 2 Standard PPO allowing for greater premium savings.
- More detail is provided in the addendum at: <http://etf.wi.gov/members/IYC2015/et2168.pdf>.

PO 4: Deductible HMO--Standard PPO. Subscribers select a health plan that offers Deductible Uniform Benefits or the Standard PPO. Uniform Benefit premium rates in PO 4 are approximately 10% lower than PO 2 rates.

- Deductible Uniform Benefits, offered by the Alternate Health Plans, contains an up-front deductible on all medical services except for federally-required preventive

care. Such care is 100% covered. The deductible is \$500 individual/\$1000 family per calendar year. Once the deductible is met, benefits are administered generally without coinsurance.

- The Standard PPO allows participants to see their choice of providers, with higher out-of-pocket costs for out-of-network providers. This program has larger deductible and coinsurance costs than the Standard PPOs of PO 2 and PO 6 allowing for greater premium savings.
- More detail is provided in the addendum at: <http://etf.wi.gov/members/IYC2015/et2158.pdf>.

PO 7: High Deductible Health Plan (HDHP) HMO-Standard HDHP PPO. Subscribers select a health plan that offers an HDHP Uniform Benefits or the Standard PPO. This option will be compliant with Health Savings Accounts or Health Reimbursement Accounts. The employer may set up such plans as they wish.

- HDHP Uniform Benefits, offered by the Alternate Health Plans, contains a deductible of \$1,500 single, \$3,000 family except for federally required preventive care. Such care is covered at 100%. In a family plan, the entire \$3,000 deductible must be met before the coinsurance coverage begins. This deductible applies to all services (including prescription drugs and offered Uniform Dental). After the deductible, medical services are subject to a 10% member coinsurance and pharmacy benefits apply to the listed copays up to an overall out-of-pocket limit of \$2,500 individual, \$5,000 family. This program option mirrors the HDHP Uniform Benefits offered to state employees. If changes are made to the state HDHP, this plan will mirror those changes.
- The Standard HDHP PPO allows participants to see their choice of providers, with higher out-of-pocket costs for out-of-network providers.
- More detail is provided in the addendum at: <http://etf.wi.gov/members/IYC2015/et2169.pdf>.

Note: Please refer to the Non-Medicare Benefits - Program Options Table on the following page.

**Wisconsin Public Employees
 Non-Medicare Benefits
 Program Options Effective January 1, 2015**

NON-MEDICARE BENEFITS		Program Option 2	Program Option 4	Program Option 6	Program Option 7
		'Traditional'	'Deductible'	'Coinsurance'	'High Deductible - HDHP'
UNIFORM BENEFITS	(For HMOs and some PPOs: benefits described for services at plan providers only)	Traditional Uniform Benefits (No deductible or coinsurance.)	\$500 Single / \$1,000 Family deductible except as required by federal law. After deductible is met, Uniform Benefits apply	90%/10% coinsurance to \$500 Single / \$1,000 Family out-of-pocket limit, except as required by federal law. After coinsurance is met, Uniform Benefits apply	\$1,500 Single / \$3,000 Family deductible and 90%/10% coinsurance (most services) to \$2,500 Single / \$5,000 Family out-of-pocket limit, applies to allowable medical, prescription drug and applicable dental services except as required by federal law. After coinsurance is met, Uniform Benefits apply.
	Freedom of Choice type Benefit:	Standard PPO	Standard PPO	Standard PPO	Standard PPO HDHP
STANDARD PPO BENEFITS	Deductible (Unless otherwise noted, it is an overall deductible)	<i>In-Network:</i> \$100 Single / \$200 Family <i>Out-of-Network:</i> \$500 Single / \$1,000 Family	<i>In-Network:</i> \$500 Single / \$1000 Family <i>Out-of-Network:</i> \$1,000 Single / \$2,000 Family	<i>In-Network:</i> \$250 Single / \$500 Family <i>Out-of-Network:</i> \$500 Single / \$1,000 Family	<i>For allowable medical, dental (if available) and prescription drug claims:</i> <i>In-Network:</i> \$1,700 Single / \$3,400 Family <i>Out-of-Network:</i> \$2,000 Single / \$4,000 Family
	Coinsurance	<i>In-Network:</i> 100% / 0% <i>Out-of-Network:</i> 80% / 20%	<i>In-Network:</i> 80% / 20% <i>Out-of-Network:</i> 70% / 30%	<i>In-Network:</i> 90% / 10% <i>Out-of-Network:</i> 70% / 30%	<i>In-Network:</i> 90% / 10% <i>Out-of-Network:</i> 70% / 30%
	Annual out-of-pocket limit (Includes deductible & coinsurance)	<i>In-Network:</i> \$100 Single / \$200 Family <i>Out-of-Network:</i> \$2,000 Single / \$4,000 Family	<i>In-Network:</i> \$2,000 Single / \$4,000 Family <i>Out-of-Network:</i> \$4,000 Single / \$8,000 Family	<i>In-Network:</i> \$1,000 Single / \$2,000 Family <i>Out-of-Network:</i> \$2,000 Single / \$4,000 Family	<i>For allowable medical, dental (if available) and prescription drug claims:</i> <i>In-Network:</i> \$3,500 Single / \$7,000 Family <i>Out-of-Network:</i> \$3,800 Single / \$7,600 Family

The WPE Group Health Insurance Program provides two different plan options:

- **Uniform Benefits** option (denoted in green in the chart).
- **Standard PPO Benefits** option (denoted in orange in the chart).

Note: Most employees opt for the Uniform Benefit option (denoted in green in the chart).

206 Pharmacy Benefit Manager (PBM) - Navitus

A pharmacy benefit manager (PBM) is the third party administrator of the prescription drug program and is primarily responsible for processing and paying prescription drug claims. All participants in the Group Health Insurance Program receive their pharmacy benefits through the PBM, Navitus Health Solutions, regardless of the health plan they have chosen.

Medicare eligible retirees enrolled in the Group Health Insurance Program will be automatically enrolled in the Navitus MedicareRx (PDP) plan, which is underwritten by Dean Health Insurance Inc., a federally-qualified Medicare Part D prescription drug plan. In addition, these retirees will also have supplemental “Wrap” coverage that pays secondary to the Navitus MedicareRx (PDP) plan.

Retirees may choose to be enrolled in another Medicare Part D plan, but it is neither recommended nor required. Retirees who choose to enroll in another Medicare Part D plan will be disenrolled from the Navitus MedicareRx (PDP) plan. However, they will still maintain the supplemental “Wrap” coverage, which will be secondary to the other Medicare Part D plan. There is no partial premium refund for enrolling in another Medicare Part D plan.

Pharmacy ID Cards

Subscribers receive separate ID cards from Navitus and must present that ID card to their pharmacist when filling a prescription. Please contact Navitus (refer to subchapter 106) for questions pertaining to the pharmacy benefit. In addition, retirees who maintain their enrollment in the Navitus MedicareRx (PDP) plan will receive a separate ID card specifically for the Navitus MedicareRx (PDP) plan.

207 Health Plan Contacts

Health plan addresses and phone numbers are listed on the inside back cover of the *It's Your Choice: Decision Guide* (ET-2128d). Your employees are encouraged to contact health plans using the resources listed on this page with specific questions regarding such topics as referral policies, benefits, filing of claims and/or provider networks.

Refer to <http://etf.wi.gov/publications/et1728.pdf>, which can be found under the Employer Forms and Brochures sections. Employers may use the contacts on this form to get answers to questions on membership, claims, grievances, supplies (and other information) etc. This form should not be shared with employees.

208 Coordination of Benefits (COB)

For a variety of reasons, some individuals are covered under more than one group health insurance plan. When this occurs, insurance regulations are used to “coordinate” or determine the order in which the benefits are paid. The plan that pays first is called the “primary plan” and the plan that pays next is the “secondary plan.” The insurance regulations for determining the order in which plans will pay benefits are described in the Uniform Benefits section of the *It’s Your Choice Reference Guide* (ET-2128r).

Questions regarding COB should be directed to the health plans.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 3 — Eligibility

- 301 Employee, Annuitant and Continuant Eligibility**
- 302 Dependent Coverage Eligibility**
- 303 Employer Premium Contribution Eligibility**
- 304 Determining Effective Dates for the Employer Premium Contribution**
- 305 WRS Previous Service Check**

301 Employee, Annuitant and Continuant Eligibility

All Wisconsin Retirement System (WRS) eligible employees, including part-time employees, are eligible for group health insurance and must be offered coverage if the employer elects to provide coverage under the Wisconsin Public Employers Group Health Insurance Program. This includes:

- Active WRS participating employees.
- Retired employees receiving a WRS annuity (including a lump sum or disability annuity) who were participants in the employer's preceding group health insurance plan.
- Insured employees terminating employment after age 55 (age 50 for protective category employees) having 20 years of WRS creditable service who defer the annuity. Insured employees who terminate employment (for reasons other than gross misconduct) and fail to meet the above age and service requirements, must be offered continuation coverage (refer to Chapter 7).
- Rehired WRS annuitants who elect to return to active WRS coverage.

No employer contribution is required for retirees. Premiums are billed to retirees through the Department of Employee Trust Funds (ETF) and are not the responsibility of individual employers. Employers may choose to contribute toward retirees' premium (employer paid annuitant). Employers participating in the WPE Group Health Insurance Program are responsible for notifying retired employees of the type and availability of coverage. Retired employees may remain covered as long as their former employer participates in the WPE Group Health Insurance Program and they pay the applicable premium.

Former employees on COBRA continuation may remain covered until their eligibility for COBRA ends, they cease to pay the premium or their former employer withdraws from the WPE Health Insurance Program, whichever occurs first. In addition, any retired or covered dependent eligible for Medicare must enroll when first eligible and must notify ETF.

If you have questions about whether an employee or group of employees are eligible for health insurance coverage, contact the Employer Communication Center toll free at 1-877-533-5020 or locally at 608-266-3285.

Employers may not provide payments to employees in lieu of coverage under the WPE Group Health Insurance Program.

Employers may decide whether married employees who work for the same employer may each select single or family coverage or if they are eligible only for family coverage through one of the spouses.

302 Dependent Coverage Eligibility

Single contracts cover only the eligible employee. Family contracts cover all eligible, listed dependents. A subscriber/employee cannot choose to exclude any eligible dependent from family coverage. Eligible dependents for family coverage include:

- Spouse (must be legally recognized in the State of Wisconsin).
- Domestic Partner, if elected.
- Children who include:
 - Natural children.
 - Stepchildren or children of the domestic partner's insured on the contract/policy.
 - Adopted children and pre-adoption placements. Coverage will be effective on the date that a court makes a final order granting adoption by the subscriber or covered domestic partner) or on the date the child is placed in the custody of the subscriber, whichever occurs first. These dates are defined by Wis. Stat. § 632.896. If the adoption of a child is not finalized, the insurer may terminate coverage of the child when the adoptive placement ends.
 - Legal wards that become the subscriber's permanent ward before age 19. Coverage will be effective on the date that a court awards permanent guardianship to either the subscriber/employee or spouse/domestic partner.
 - Grandchild if the parent is a dependent child and under the age of 18. The grandchild ceases to be a dependent at the end of the month in which the dependent child (parent) turns 18.

Note: Children, stepchildren, and legal wards may be covered until the end of the month in which they attain age 26. Their spouse and/or dependents are not eligible. Upon the child's loss of eligibility, the child may be eligible for COBRA Continuation.

Note: Pertaining to divorce - if a court orders the subscriber/employee to insure an ex-spouse, the order does not create eligibility for the ex-spouse to remain insured under the subscriber/employee. Ex-spouse eligibility is under COBRA Continuation (refer to Chapter 9). Contact ETF for review of individual situations.

303 Employer Premium Contribution Eligibility

Employer contributions must begin no later than the first of the month following the employee's completion of six months of qualified employment with the present employer or at an earlier date, if mutually agreed upon by the employer and employee. Employer premium contributions must be in line with one of the three health insurance premium contribution structures described in Chapter 2 (subchapter 204) of this manual.

As of January 1, 2014, in order to avoid penalties that may be assessed if coverage is found to be 'unaffordable' under federal health care reform, you may want employer contributions to begin no later than the first of the month preceding the employee's completion of 90 days of qualified employment.

304 Determining Effective Dates for the Employer Premium Contribution

Employees wishing immediate coverage upon becoming WRS eligible may submit a *Health Insurance Application/Change Form* (ET-2301) within 30 days of their hire date. Coverage is effective the first of the month following receipt of the application and the employee is responsible for the entire premium amount until such time as they are determined to be eligible for the employer contribution. Employer share of premium must commence no later than 6 months after hire. However, as of January 1, 2014, in order to avoid penalties that may be assessed if coverage is found to be 'unaffordable' under federal health care reform, you may want employer contributions to begin no later than the first of the month preceding the employee's completion of 90 days of qualified employment.

Employees wishing to wait until they are eligible for the employer contribution toward the health insurance premium must submit a *Health Insurance Application/Change Form*, or apply online, prior to the date they become eligible for the employer contribution. Coverage will be effective the first of the month on or following the date the employee becomes eligible for the employer contribution toward the premium.

Coverage effective dates for teachers (employment category 40) are based on the date WRS employment begins and the date a completed *Health Insurance Application/Change Form* is received by the employer. Health insurance coverage is effective the first of the month in which WRS employment begins if the application is received on, or prior to, the first of that month. For applications received after the first of the month in which WRS employment begins, coverage is effective the first of the following month as long as the application is submitted within 30 days of WRS eligibility.

Example: A teacher is hired (signs a contract) on June 27 and begins employment on August 29 (WRS begin date). In the event the employer receives the completed *Health Insurance Application/Change Form* on or prior to August 1, the coverage effective date is August 1. Should the employer receive the completed *Health*

Insurance Application/Change Form after August 1 and on or prior to September 1, the coverage effective date is September 1.

Note: Employees failing to enroll when first eligible must wait until the next annual It's Your Choice enrollment period to enroll unless they experience a HIPAA qualifying event prior to that period. (Refer to Chapter 5 for other enrollment opportunities.)

Employers have the option, when both spouses are employed by the same employer and both are eligible for coverage, of offering the following:

- Both employees may elect single coverage.
- One employee may elect family coverage.
- One employee may elect family coverage while the spouse elects single coverage, if permitted by the employer.
- Both employees may elect family coverage, if permitted by the employer.

305 WRS Previous Service Check

A WRS previous service check must be performed for each employee applying for health insurance to determine the appropriate employer premium contribution and effective date of the employer premium contribution.

ETF provides two methods for employers to use in determining whether an employee has previous WPE, state, and/or University of Wisconsin service:

- Access the Previous Service Benefit Inquiry application on ETF's Online Network for Employers (ONE) site at: <http://etfonline.wi.gov/etf/internet/employer/one.html>.

Note: This is a password-protected site. To obtain access refer to Chapter 8, subchapter 801, of the *WRS Administration Manual* (ET-1127).

- Call the Employer Communication Center toll-free at 1-877-533-5020 or 1-608-266-3285 and request a previous service check.

Chapter 4 — Initial Enrollment

- 401 Initial Enrollment and Effective Dates**
- 402 Declining Coverage**
- 403 Enrollment Opportunities for Employees who Previously Declined or Cancelled Coverage**
- 404 Applying for Coverage**
- 405 Insurance Cards**

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-2128d and ET-2127r, 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 participating employer. New WRS employees will be responsible for paying the full premium until employer contributions begin.
- On or before becoming eligible for the employer contribution. Coverage is effective the first of the month on or after the employer's receipt of the application. The effective date of the employer contribution shall not be later than the first of the month following the completion of six months service with the employer under the WRS. As of January 1, 2014, in order to avoid penalties that may be assessed if coverage is found to be 'unaffordable' under federal health care reform, you may want employer contributions to begin no later than the first of the month preceding the employee's completion of 90 days of qualified employment.

Employees cancelling coverage prior to the date that the premium contribution begins may re-enroll with the coverage becoming effective on the first of the month that the employer contribution begins, provided the application is received prior to the

contribution date.

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

- If both spouses are employees of WPE covered employers, both spouses can maintain single and/or family coverage simultaneously.
- If their spouse is already enrolled with single coverage, the new employee can 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 they both worked for the same WPE and that WPE does not allow dual 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 they both worked for the same WPE and that WPE does not allow dual coverage.
- If their domestic partner is already enrolled with either single or family coverage, the new enrollee can also 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 if they both worked for the same WPE and that WPE allows dual coverage.
- If non-state WPE spouses or annuitants have their own (family or single) coverage they can have contracts simultaneous with the members.

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 entire 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 WPE plan would begin on May 14th. When coverage is effective prior to the 16th of the month, a whole month of premiums is owed.

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 their spouse provides a COBRA form from the 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.

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* (ET-2128d) and *Reference Guides* (ET-2128r) and the *Health Insurance Application/Change Form* (ET-2301) and/or show them where to locate both these documents on ETF's 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 within the same timeframe.

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.

- A. If employees are enrolling using the paper *Health Insurance Application/Change Form*, direct employees to the ETF website at etf.wi.gov for the form.
- 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. If the employee does not already have a Wisconsin Account Management System (WAMS) ID, they will need to obtain one prior to using myETF Benefits.

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. The employer can edit the member's transaction if there is a problem or deny the transaction and ask the employee to complete the enrollment again.
- B. If submitted via *Health Application/Change Form*, the employer will have to process the enrollment in the myETF Benefits System for the member. 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 local employers (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 – 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 Appointment Began or Hire Date – The month, day and year the employee began WRS 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-2128d) or online at etf.wi.gov.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 5 — Changing Coverage

- 501 Status Changes**
- 502 Changing Plans Due to a Residential Move**
- 503 Changing from Single to Family Coverage**
- 504 Changing from Family to Single Coverage**
- 505 Adding Dependents**
- 506 Removing Dependents**

501 Status Changes

There may be opportunities during the course of a year which allow employees to change coverage outside the initial enrollment opportunity. If there is a status change within the limitations imposed by the contract and statute, the employee can change health plans, add dependents, remove dependents, or change from single to family coverage or family to single coverage.

Status changes include:

- Move from service area (change health plan or cancel coverage only).
- Birth, adoption or placement for adoption.
- Marriage (opposite or same sex) or a domestic partnership.
- Establishment of a permanent legal guardianship.
- National Medical Support Notice (NMSN) or paternity acknowledgment.
- Loss of other coverage for employee or dependents.
- Divorce or termination of a domestic partnership.
- Death of a dependent.
- Spouse to spouse transfer.
- Transfer from one employer to another.
- Disability of dependent.
- It's Your Choice Open Enrollment period.

These status changes are explained and their limitations clarified in the following sections.

502 Changing Plans Due to a Residential Move

When an employee moves to another county or out of state for a minimum of three months they have an enrollment opportunity to change health plans, even if their current plan remains available in the county to which the employee moved. (A move from one medical facility to another medical facility is not considered a residential move.) The relocating employee must go online to myETF Benefits and submit a request to change health plans or submit a *Health Insurance Application/Change Form* (ET-2301) to their employer within 30 days after the move. The new plan selected must have in-network providers in the county the employee moved to as shown in the annual It's Your Choice materials (refer to Service Areas and Provider Directory information). If the employee moved out of state they will be limited to the Standard Plan. Coverage will be effective with the new plan the first of the month on or after either the submission of the electronic change by the employee in myETF Benefits or the receipt of the *Health Insurance Application/Change Form* by the employer.

If the application to change plans is not received within 30 days following the move, the employee cannot change health plans until the annual It's Your Choice Open Enrollment period or until they experience another qualifying event as outlined later in this Chapter.

An employee not wishing to change plans due to the move to another county may continue with their current plan. They should be aware they may have to drive to the former location in order to have providers that are in-network. The employee should still go online to myETF Benefits and update their address or submit a *Health Insurance Application/Change Form* to their employer within 30 days of the move.

503 Changing from Single to Family Coverage

An employee can change from single to family coverage in several situations outside of the annual It's Your Choice Open Enrollment period. The following are generally qualifying Health Insurance Portability and Accountability Care Act (HIPAA) events:

- Birth.
- Adoption.
- Placement for adoption.
- Marriage/domestic partnership.
- Receives a National Medical Support Notice or paternity acknowledgment.
- Establishes a permanent legal guardianship.
- Loss of other coverage.
- Loss of entire employer contribution for other coverage.
- Has a dependent older than age 26 who is newly disabled.

The employee must either go online to myETF Benefits and add the new dependent(s) for the appropriate reason from the drop-down listing or submit a *Health Insurance Application/Change Form* (ET-2301) to the employer.

The following guidelines describe the restrictions placed on the enrollment for these events and the conditions under which they may be restricted:

- **Marriage or Domestic Partner:** Online enrollment or application must be submitted within 30 days from the event date. An employee with single coverage may change to family coverage provided the application is received within 30 days of the marriage or receipt of the *Affidavit of Domestic Partner* (ET-2371) by ETF.

Note: Employers have the option, when both spouses are employed by the same employer and both are eligible for coverage, of offering the following:

- Both employees may elect single coverage.
- One employee may elect family coverage.
- One employee may carry family coverage while the spouse has single coverage, if permitted by the employer.
- Both employees may carry family coverage with the employer, if permitted by the employer.

Cancellation of single coverage and the change to family coverage can be coordinated provided one of the applications is received timely. If the application to cancel the single coverage and/or the application to change to family coverage is not received timely, the change to family can only occur during the annual It's Your Choice Open Enrollment period.

Documentation supporting a Domestic Partnership is required as outlined in the *Health Insurance Application/Change Form*. The employee also has the opportunity to change health plans within 30 days of the marriage or domestic partnership, provided their application is submitted within those 30 days. The change in health plan will be effective the first of the month on or after receipt of the application to change health plans or the electronic submission of the request to change health plans.

- **Birth, Adoption or Placement for Adoption, or Establishment of Permanent Legal Guardianship:** An application or online enrollment must be submitted within 60 days after the event.

An employee with single coverage must submit the application to add a dependent and change to family coverage within a 60 day time frame to be effective on the event date. If an application is not submitted within this time frame, the employee cannot change to family coverage until the annual It's Your Choice Open Enrollment period unless another qualifying event occurs in the interim.

- **Note:** An application or online enrollment must be completed in a timely manner.

Documentation supporting the adoption, placement for adoption or the establishment of permanent legal guardianship is required as outlined in the *Health Insurance Application/Change Form*. The employee has the opportunity to change health plans within 30 days of birth, adoption or placement for adoption (not establishment of permanent legal guardianship), provided the application to do so is submitted within the 30 day time frame. The change in health plan will be effective the first of the month on or after receipt of the application or electronic submission of the request to change health plans.

- **Loss of Coverage or Complete Loss of Employer Contribution for other coverage:** Application must be received within 30 days before or after a dependent has a loss of coverage or employer contribution. If the employee's dependent(s) lost other coverage or the employee lost the entire employer contribution toward their coverage, the employee may change from single to family coverage within the specified time frame.

Documentation supporting the loss of coverage or employer contribution is required as outlined in the *Health Insurance Application/Change Form*. 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)
- **Paternity Acknowledgment:** When an acknowledgment of paternity is filed within 60 days of the birth, and an application is received or online enrollment performed within the 60 day time frame, family coverage is effective on the date of birth. Beyond the 60 day time frame, coverage is effective the first of the month on or after receipt of the application.

Documentation supporting the paternity acknowledgment is required as outlined in

- **National Medical Support Notice (NMSN):** NMSN occurs when a court orders the parent in question to provide coverage for their child(ren). Coverage is effective the first of the month on or after receipt of the application **or** the date specified on the NMSN, if one is specified.

The employee is required to provide the coverage through your ETF administered plan provided the aggregate cost of the child support amount and health insurance premium does not exceed the percent you are allowed to withhold from the employee's paycheck under the Consumer Credit Protection Act..

Documentation supporting the NMSN is required as outlined in the *Health Insurance Application/Change Form* if the employee elects to cover the child(ren) through ETF.

- **Disabled Dependent (child age 26 or older):** Coverage is effective the date the health plan approves the dependent's disabled status.

Submit an application or MEBS electronic request which ETF will forward to the health plan to have them complete their disability review process. When the health plan has reviewed the child's disability status, ETF will update the coverage accordingly.

Documentation to support the disability is required as outlined in the *Health Insurance Application/Change Form*.

504 Changing from Family to Single Coverage

An employee can change from family to single coverage in several situations outside of the annual It's Your Choice Open Enrollment period, provided they have experienced a family status change/event that allows the change under the plan or they have experienced a HIPAA qualifying event. An employee can change from family to single coverage if they experience a HIPAA qualifying event or a status change such as a divorce or termination of domestic partnership, their last dependent becomes ineligible for the coverage, all dependents become eligible for and enroll in other coverage, or their last eligible dependent becomes eligible for and enrolls in other coverage.

The employee must either go online to myETF Benefits to remove their dependent(s) using the "change family to single coverage" reason from the drop-down listing or submit a *Health Insurance Application/Change Form* (ET-2301) to their employer. If an employee's premiums are deducted post-tax or they are an annuitant, they may change to single coverage at any time.

The following guidelines describe the restrictions placed on the enrollment for these various events and the conditions under which they may be restricted:

the *Health Insurance Application/Change Form*.

- **Divorce or Termination of Domestic Partnership (DP):** The application must be submitted within 30 days of the divorce or termination of DP and single coverage is effective the first of the month on or after receipt of the application.

An employee in a domestic partnership who is only covering their domestic partner or their domestic partner and their domestic partner's dependents may change to single coverage at any time without termination of the partnership in response to the added costs of imputed income which is applied post-tax. No documentation is required for this type of change to single coverage.

In the event of a Divorce or Termination of DP in conjunction with a change to single coverage, ETF does not require the submission of a *Continuation/Conversion Notice* (ET-2311), but one must be provided to the ex-spouse or domestic partner and any stepchildren or dependents.

Documentation to support the termination of domestic partner may be required as outlined in the *Health Insurance Application/Change Form*. The employee, as well as the ex-spouse/DP, has the opportunity to change health plans within 30 days of divorce/termination of DP provided their application is submitted within the 30 day time frame. The change in health plan will be effective the first of the month on or after receipt of the application to change health plans or the electronic submission of the request to change health plans.

Note: If an employee would like to enroll a new spouse or domestic partner that is different from the previous spouse or domestic partner, the new spouse/domestic partner must wait six months before being eligible for coverage.

Note: If an employee marries a domestic partner, coverage is continuous. Please notify ETF to change the relationship in myETF Benefits.

- **Last Dependent Becomes Ineligible for Coverage:** Occurs when the last covered dependent reaches age 26, if not disabled. The employee must notify the employer within 60 days of the dependent losing eligibility.

If the employee does not notify the employer of the dependent's loss of eligibility within 60 days, or the employer does not utilize the 'Dependent Inquiry' available under 'Enrollment Reports' to track aging out dependents, there are invoice consequences. The employer will be limited to two months of premium refund paid prior to the current month of coverage for the difference between family and single coverage (refer to section 2.3 (3) of the contract).

Example: Dependent ages out February 23; employer is not notified until July 14; employer invoice can be refunded for May, June, and July. The change to single coverage will be retroactive to the end of the month the last dependent lost eligibility. In the example, single coverage will be effective March 1.

Under federal law, if notification of the loss of eligibility is not reported to the employer within 60 days of the event that caused the loss of eligibility, or the date the coverage ended, the right to Continuation Conversion Coverage (COBRA) is lost.

- **All Dependents or Last Eligible Dependent Become(s) Eligible for and Enroll(s) in Other Coverage:** Occurs when the employee's dependents all enroll in other group coverage, such as insurance through a spouse's employer. The application to change to single coverage must be submitted within 30 days of the date the dependent(s) enrolled in other coverage. If the application is not received within 30 days, the employee is limited to the annual It's Your Choice Open Enrollment period to remove these dependents.

Documentation to support the eligibility for the other coverage is required as outlined in the *Health Insurance Application/Change Form*.

505 Adding Dependents

Dependents can be added to an existing family contract outside the annual It's Your Choice Open Enrollment period for the following reasons:

- **Marriage or Domestic Partner (DP):** When family coverage is already in place, the application to add a spouse and dependent children or a DP and dependent children must be received within 30 days of the date of marriage or the date ETF receives the *Affidavit of Domestic Partnership* (ET-2371); coverage for the new dependents will be effective on the event date. If the application was not received within 30 days and the marriage or DP was not reported, but family coverage was in place, the spouse or DP and any minor children may not be added to coverage until the It's Your Choice Open Enrollment, unless another qualifying event occurs in the interim. Refer to "Eligible Dependent Left Off Original Application" below for exceptions, but this does not apply to DPs, dependents of DPs, or adult dependents.

Documentation supporting the Domestic Partnership is required as outlined in the *Health Insurance Application/Change Form* (ET-2301). The employee also has the opportunity to change health plans within 30 days of the marriage or domestic partnership, provided the application to do so is submitted within the 30 day time frame. The change in health plan will be effective the first of the month on or after receipt of the application or electronic submission of the request to change health plans.

- **Birth or Adoption/Placement for Adoption or Establishment of Permanent Legal Guardianship:** If family coverage is already in place, the application to add the child(ren) or ward(s) must be received within 60 days after the event. Coverage will be effective the date of the event. If an application is not submitted within this time frame, the employee cannot change to family coverage until the

annual It's Your Choice Open Enrollment period unless they have another qualifying event occur before then and submit the application or online enrollment in a timely manner. Refer to "Eligible Dependent Left Off Original Application" below for exceptions, but this does not apply to DPs, dependents of DPs, or adult dependents.

Documentation to support the adoption or placement for adoption or the establishment of permanent legal guardianship is required as outlined in the *Health Insurance Application/Change Form*. The employee also has the opportunity to change health plans within 30 days of birth, adoption, or placement for adoption (not establishment of legal guardianship), provided the application to do so is submitted within those 30 days. The change in health plan will be effective the first of the month on or after receipt of the application to change health plans or the electronic submission of the request to change health plans.

- **Dependent Loss of Other Coverage or Complete Loss of Employer**

Contribution: If family coverage is in place, an application must be received within 30 days before or after a dependent has a loss of other coverage or an employee completely loses employer contribution for the other coverage. Because an employee's dependent(s) lost other coverage or the employee lost the entire employer contribution toward coverage, the employee may add their dependent to the existing family coverage within the specified time frame.

If an application is not submitted within this time frame, the employee cannot change to family coverage until the annual It's Your Choice Open Enrollment period unless another qualifying event occurs in the interim. Refer to "Eligible Dependent Left Off Original Application" below for exceptions, but this does not apply to DPs, dependents of DPs, or adult dependents.

Documentation supporting the loss of coverage or employer contribution is required as outlined in *Health Insurance Application/Change Form*. 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). If loss of employer premium contributions, letter from employer indicating they no longer contribute towards their employee's premium.
- **Paternity Acknowledgment:** If family coverage is already in place, coverage for the dependent(s) will be effective on the date of birth if an acknowledgment of paternity is filed and an application is received or online enrollment performed within 60 days of the birth. If more than 60 days have elapsed, coverage will be effective on the first of the month on or after receipt of the application.

Documentation supporting the paternity acknowledgment is required as outlined in the *Health Insurance Application/Change Form*.

- **National Medical Support Notice (NMSN):** NMSN occurs when a court orders the parent in question to provide coverage for their child(ren). If family coverage is already in place, coverage for the new dependent(s) is effective the first of the month on or after receipt of the application **or** the date specified on the NMSN, if one is specified.

The employee is required to provide the coverage through your ETF administered plan provided the aggregate cost of the child support amount and health insurance premium does not exceed the percent you are allowed to withhold from the employee's paycheck under the Consumer Credit Protection Act.

Documentation supporting the NMSN is required as outlined in the *Health Insurance Application/Change Form* if the employee elects to cover the child(ren) through ETF.

- **Disabled Dependent (child age 26 or older):** If family coverage is already in place, coverage is effective the date the health plan approves the dependent's disabled status.

Submit an application or MEBS electronic request which ETF will forward to the health plan to have them complete their disability review process. When the health plan has reviewed the child's disability status, ETF will update the coverage accordingly.

- **Eligible Dependent Left Off Original Application:** If family coverage is already in place, dependents who were left off the original application can be added to coverage prospectively if the following requirements are fulfilled in compliance with the contract and statute.

The relevant contract and statute provisions follow:

Contract Article 1.7 (6): Any **dependent** eligible for **benefits** who is not listed on an

application for coverage will be provided **benefits** based on the date of notification with coverage effective the first of the month following receipt of the subsequent application by the **employer**, except as required under Wis. Stat. § § 632.895 (5) and 632.896 and as specified in Article 3.3 (11).

In summary, if there is a prior application adding dependents based on a qualifying event that excluded an eligible dependent, that dependent can be added prospectively under this provision. This does not apply to DPs, dependents of DPs, or adult dependents.

- **Coverage Beyond Age 26 and Not Disabled:** A dependent who was a full-time, post-secondary student younger than age 26 at the time they were called to active duty with the military, can continue health coverage provided they apply to an institution of higher education as a full-time student within 12 months of the date they are discharged from active duty.

Documentation to support this status is required and would include a copy of the class schedule prior to deployment, a copy of their discharge papers (DD-214), and a copy of their current class schedule.

506 Removing Dependents

Dependents can be removed from family coverage for a limited number of reasons outside the annual It's Your Choice Open Enrollment period. These include the following reasons:

- **Divorce:** Upon divorce, either a *Health Insurance Application/Change Form* (ET-2301) or a MEBS request must be processed before the ex-spouse or any stepchildren can be removed from coverage. Ideally this should be submitted within 30 days of the entry of judgment of divorce.

In the event the employee reports the divorce beyond 30 days of it being finalized, the ex-spouse will be removed prospectively. Coverage for the ex-spouse and any stepchildren will not end until the end of the month of the divorce **or** the end of the month the COBRA *Continuation-Conversion Notice* (ET-2311) was provided to the former dependents, whichever is later.

Documentation to support the coverage end date due to divorce may be required as outlined in the *Health Insurance Application/Change Form*.

- **Termination of Domestic Partnership:** When a Domestic Partnership is terminated, an application must be submitted by the employee within 30 days of the date ETF receives the *Affidavit of Termination of Domestic Partnership* (ET-2372). Coverage for the DP and any dependents of the DP ends at the end of the month

ETF receives the *Affidavit of Termination of Domestic Partnership*.

- In the event the employee does not submit an application to remove their DP due to termination of domestic partnership in a timely manner, coverage will still terminate at the end of the month in which ETF received the *Affidavit of Termination of Domestic Partnership* when they do submit the *Health Insurance Application/Change Form* to remove the DP.

If the employee is terminating the domestic partnership due to marrying their DP, they must submit a *Health Insurance Application/Change Form* but do not need to submit an *Affidavit of Termination of Domestic Partnership* as the marriage supersedes the domestic partnership. In this situation, the domestic partner and any dependents of the domestic partner are not terminated, but their relationship codes do need to be changed in myETF Benefits.

Documentation supporting the termination of domestic partnership may be required as outlined in the *Health Insurance Application/Change Form*.

- **Death of Dependent:** In the event of a dependent death, a *Health Insurance Application/Change Form* or report of the death online through myETF Benefits must be submitted. There is no limitation on how long the employee has to report the death of a dependent; however, if the death results in the coverage level changing to single, premiums for the difference in premium cost between family and single coverage will only be refunded to the employer for a maximum of six months.

Covered stepchildren can remain covered at the discretion of the surviving spouse in the event of the employee's death.

- **Dependent No Longer Qualifies as Disabled:** For disabled adult dependents who no longer meet the health plan requirements to be considered disabled, coverage ends at the end of the month in which the health plan makes that determination.

The qualifications to determine disability include a medical review and the employee or their spouse providing at least 50% of the child's support and maintenance. If the dependent no longer meets these qualifications, they must be sent a *Continuation Conversion Notice* by the employer.

- **Grandchild's Parent Turns 18:** The employer can pull an enrollment report monthly from myETF Benefits (Dependent Inquiry) to determine if any employee's grandchild(ren)'s parent turns 18 years old at the end of the month. The employee must submit an application or go online to myETF Benefits and report that the grandchild is losing eligibility.

The employee must be sent a *Continuation Conversion Notice* for the grandchild within five days of the date coverage ends.

- **Minor Dependent No Longer a Permanent Legal Ward:** When a court terminates the permanent guardianship of a minor child or replaces the guardian with a new party, coverage for the legal ward who is no longer dependent on the employee or their spouse will end at the end of the month of the order terminating the permanent guardianship. Expiration of legal guardianship due to the ward attaining age 18 does not necessitate the removal of the ward from coverage.

Documentation supporting the termination of the permanent guardianship is required as outlined in the *Health Insurance Application/Change Form*. A *Continuation Conversion Notice* for the ward must be sent.

Under Federal law, if notification of the loss of eligibility is not reported to the employer within 60 days of the event that caused the loss of eligibility or the date the coverage ended, then the right to Continuation Conversion Coverage (COBRA) is lost.

- **Adult Dependent Child Eligible for Other Coverage:** A dependent child over the age of 19 who becomes eligible for, and elects, other coverage requires that an application to remove this dependent be submitted within 30 days of the event (enrollment in other coverage). Coverage will terminate at the end of the month following receipt of the electronic request or paper application. If not received within 30 days, the employee will not be able to remove their dependent until the annual It's Your Choice Open Enrollment period, even if this would result in the employee dropping to single coverage as they are their last eligible dependent.

Documentation to support the eligibility for the other coverage is required as outlined in the *Health Insurance Application/Change Form*.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 6 — It's Your Choice Open Enrollment

- 601 It's Your Choice Open Enrollment Eligibility**
- 602 Withdrawing/Rescinding It's Your Choice Enrollment Elections**
- 603 When a Health Plan is not Available at It's Your Choice**
- 604 Late It's Your Choice Applications**

601 It's Your Choice Open Enrollment Eligibility

It's Your Choice Open Enrollment provides an annual opportunity for **uninsured employees** to apply for new health insurance coverage and currently **insured subscribers** to change from one health plan to another, drop or add an adult dependent (age 19 or older) or a dependent who does not qualify as a tax dependent, transfer the coverage from one spouse to the other or one domestic partner to the other, or change from single-to-family or family-to-single coverage without limitations.

A. It's Your Choice Open Enrollment Period:

The Group Insurance Board sets the It's Your Choice Open Enrollment period, normally a four-week period in October. Changes in coverage take effect January 1 of the following year.

B. Participation in the It's Your Choice Open Enrollment Period:

Two requirements must be met to make a change or enroll during It's Your Choice:

1. To enroll, the employee must be eligible for and be enrolled in the WRS or be an employee of a non-WRS employer enrolled in the Wisconsin Public Employers' Group Health Insurance Program for Non-WRS Employers. To make a change, the employee must be currently insured in the WPE Group Health Insurance Program; **and**
2. The employee must enter the change request online into the myETF Benefits system or provide the *Health Insurance Application/Change Form* (ET-2301) to the employer within the designated It's Your Choice Open Enrollment period.

C. Distribution of *It's Your Choice Reference and Decision Guide*:

The *It's Your Choice Reference and Decision Guides* (ET-2128r and ET-2128d) provides information on important changes, health insurance rates, uniform benefits,

coordination of benefits and plan availability for the plan year. The guides are forwarded to local employers that participate in the WPE Group Health Insurance Program prior to the It's Your Choice Open Enrollment period for distribution to all eligible employees, insured and uninsured (including those on leave of absence and layoff). There is a limited supply of paper *It's Your Choice Guides* available; employers are encouraged to direct employees to the electronic version found on ETF's website at: <http://etf.wi.gov/publications/insurance.htm>. The *It's Your Choice Guides* must be distributed in a timely manner.

D. Employees Initially Eligible for Coverage on November 1 or December 1:

Employees initially eligible for coverage on November 1 or December 1, who wish to change to a different health plan or coverage type effective January 1, **must file two Health Insurance Application/Change Forms** during their regular enrollment period. The first application will cover the period from the date of initial coverage through December 31. The second application will change to whatever health plan or coverage type is selected effective January 1, and must have the It's Your Choice box checked as the reason for submitting the application.

E. Employee's employment and/or health coverage ends after submitting an It's Your Choice election:

- If coverage ends on or prior to December 31, list the health plan that coverage is with as of the coverage end date on the *Continuation - Conversion Notice* (ET-2311).
- List *It's Your Choice* elected health plan on *Continuation - Conversion Notice* if current coverage ends after December 31.

602 Withdrawing/Rescinding *It's Your Choice* Enrollment Elections

Entry of an employee's request to withdraw/rescind an It's Your Choice election in MEBS must be completed by ETF. Employees may withdraw/rescind an It's Your Choice election by notifying their employer in writing (letter or e-mail) prior to the January 1 effective date.

A. If the employee submitted their It's Your Choice election on a *Health Insurance Application/Change Form* (ET-2301), upon receipt of the written request to withdraw/rescind:

1. Employer makes two photocopies of the *Health Insurance Application/Change Form* that was initially submitted by the employee and writes "Rescind" across each copy.
2. Forward one copy of the application along with a copy of the employee's written request to withdraw/rescind the application to ETF.

3. Retain the second copy of the application for the employer's records.
 4. ETF will update myETF Benefits by deleting the initial It's Your Choice request and reinstating the employee's coverage that was to end on December 31.
- B. If the employee entered their It's Your Choice change online and now wishes to withdraw/rescind their requested online change, the employee must notify their employer in writing (letter or e-mail) prior to the January 1 effective date. On receipt of the employee's written request to withdraw/rescind their online change:
1. Employer will make a copy of the employee's letter and forward the copy to ETF while retaining the original copy for the employer's records.
 2. ETF will update MEBS by deleting the initial It's Your Choice request and reinstating the employee's coverage that was to end on December 31.

Note: No application or on-line request for coverage may be withdrawn/rescinded on or after the effective date of coverage. After the coverage effective date, the subscriber can only cancel coverage prospectively *if* premiums are paid with post-tax dollars (refer to subchapter 803) or through the late It's Your Choice process, also prospectively (refer to subchapter 604).

603 When a Health Plan is not Available at *It's Your Choice*

When a plan is no longer available for the upcoming year, subscribers enrolled in that plan **must** make an It's Your Choice change online **or** submit a *Health Insurance Application/Change Form* (ET-2301) during the It's Your Choice Open Enrollment period to enroll in a new plan. Subscribers are notified by letter from the departing plan at the onset of It's Your Choice. Information on plans no longer available will also be included in the "Important Changes" section in the *It's Your Choice Decision Guide*.

Note: In some instances, such as a health plan service area merger, applications are not required and subscribers are switched automatically to a new plan. In the event a new application is not required, annual It's Your Choice *Employer Bulletins*, e-mail updates, and the *It's Your Choice Guides* will include instructions.

Subscribers whose plan will no longer be available and who fail to submit an application selecting an available plan during the It's Your Choice Open Enrollment period are deemed to have cancelled coverage and must apply through the late It's Your Choice application process to select a new health plan to continue coverage. Coverage is effective the first day of the calendar month on or after the date ETF receives the application.

604 Late It's Your Choice Applications

Subscribers may request a review by ETF if they believe they were not offered an It's Your Choice enrollment opportunity and they feel that their *Health Insurance Application/Change Form* (ET-2301) should be accepted after the designated It's Your Choice Open Enrollment period. Please note that a late It's Your Choice application does not guarantee approval. The steps included in this process are as follows:

1. Employee submits application after the end of the It's Your Choice Open Enrollment period.
2. Employer rejects and returns late application to employee with instructions on requesting a review. A sample letter informing an employee of this process is found in subchapter 605.
3. Employee submits a written request (letter or e-mail) for ETF to review to the employer no later than January 31 following the It's Your Choice Open Enrollment period.
4. Employee includes in the letter or e-mail the facts or circumstances regarding the reason(s) their application is being filed late and the remedy being sought.
5. Employer develops a cover memo, letter or e-mail addressed to ETF detailing the process used to distribute It's Your Choice materials and information to employees, the date of receipt of the employee's It's Your Choice application, and any pertinent facts that either supports or does not support the employee's request.
6. Employer sends a copy of the employee's late It's Your Choice *Health Insurance Application/Change Form*, the original employee's letter or e-mail requesting a review, and the employer cover memo, letter or email to:

EMPLOYER SERVICES SECTION
DEPT OF EMPLOYEE TRUST FUNDS
P O BOX 7931
MADISON WI 53707-7931

These materials and information can also be scanned and e-mailed to:
etfhealthandins@etf.wi.gov.

E-mails must be sent encrypted to comply with HIPAA standards; if you cannot send encrypted e-mail, please mail or fax only. The subject line should be titled "Late It's Your Choice Application".

7. ETF reviews the materials submitted and issues a letter within 30-60 days to the employee, copying the employer, that the request was either approved or denied.

605 Late It's Your Choice Review Sample Letter

Below is a sample letter from the employer informing an employee of the review process for a Late *It's Your Choice* application.

(DATE)

(EMPLOYER NAME AND ADDRESS IF NOT ON THE LETTERHEAD)

Dear (EMPLOYEE NAME):

Your It's Your Choice health insurance application is being returned to you by our office because it was not received timely. You may request a review of your late application by the Department of Employee Trust Funds (ETF) through the following process:

- Prepare a written request detailing the circumstances and facts surrounding the reason for your late application and the remedy you are seeking.
- **Submit your written request and your application to our office at the address noted above by January 31.** Do **not** submit your request directly to ETF.
- We will review your request for completeness and attach any pertinent documentation.
- We will submit your request, your health insurance application, and other documentation to ETF for review.
- ETF will review the materials and issue you a letter either approving or denying your request.

If you have questions, please contact (NAME) at (TELEPHONE NUMBER).

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 7 — Leave of Absence

- 701 Definition of a Leave of Absence**
- 702 Coverage Does Not Lapse While on a Leave of Absence**
- 703 Coverage Lapses While on a Leave of Absence**
- 704 Coverage During Layoff**
- 705 Coverage During Appeal of Discharge**

701 Definition of a Leave of Absence

Wis. Stat. § 40.02 (40) “Leave of absence” means any period during which an employee has ceased to render services for a participating employer and receive earnings and there has been no formal termination of the employer–employee relationship.

A return from a leave of absence under Wis. Stat. § 40.02 (40) is deemed to be the first day the employee returns to work if the employee resumes active performance of duty for 30 consecutive calendar days for at least 50% of the employee’s normal work time. If the employee does not complete 30 consecutive calendar days of duty, the employee is not deemed to have returned from leave and coverage will continue as an employee on leave of absence.

702 Coverage Does Not Lapse While on a Leave of Absence

Insured employees on an unpaid leave of absence (LOA) choose whether to continue health insurance coverage during their LOA. Employee coverage remains active as long as premiums are paid when due.

The following applies to employees continuing their coverage during an approved LOA:

- The maximum length of time coverage can be continued for an employee on LOA is 36 months. After 36 months or upon termination, whichever occurs first, the employee may continue coverage under continuation coverage (COBRA) regulations. (Refer to Chapter 9 for information on COBRA.)
- Employer contributions made toward premium payment while an employee is on a LOA is at the discretion of the employer.
- Regardless if the employee is paying the entire premium or an employee share, premiums must be paid in advance of the coverage month. This can be done by either a deduction from the last payroll check or by direct payment to the employer,

e.g., personal check. Again, the employer must receive premium payments in advance of the coverage month.

- Employees on a LOA remain active on the employers invoice. Employers will be billed the premiums on their monthly invoice for each respective coverage month the employee remains on a LOA. Payments received from an employee on a LOA are to be made payable to the employer.
- Employers must provide It's Your Choice information to employees on a LOA prior to the beginning of the designated It's Your Choice Open Enrollment period.
 - An employee on a union-service leave may continue coverage beyond 36 months until termination of the leave or the date that service with that labor organization ceases, whichever occurs first.
 - Employees continuing coverage while on LOA are not required to complete a *Health Insurance Application/Change Form (ET-2301)* upon return to work.

703 Coverage Lapses While on a Leave of Absence

Insured employees on an unpaid leave of absence (LOA) can choose to allow their health insurance coverage to lapse during their LOA. An employee may choose to allow their coverage to lapse by not paying the premium when due. If the employee files an application to cancel coverage they are not eligible to enroll upon return to work; the coverage must lapse, not be terminated voluntarily.

Employee allowed their health insurance coverage to lapse while on an approved LOA. The following applies upon returning to work and the employee chooses to reinstate coverage:

- Employee must complete and submit an application to their employer within 30 days after returning to work to enroll in coverage. Coverage is effective the first of the month following the employer's receipt of the completed application.
- The employee is limited to the same health plan and level of coverage they were enrolled in prior to their LOA. See the three bullet points that follow for exceptions to this requirement.
 - Employee may change coverage level if a qualifying event occurred during their LOA (e.g. marriage, birth, etc.). Refer to Chapter 4, subchapter 403 for information about other enrollment opportunities.
 - Employee who moved while on a LOA may change health plans upon return to work.
 - Employee who returns from a LOA that encompassed the entire previous It's Your Choice Open Enrollment period and files an application within 30 days of returning to work, may make changes to the coverage they had prior to their LOA.
- Employee who did not file an application within 30 days of returning to work cannot

re-enroll in coverage until the next It's Your Choice Open Enrollment period or when a qualifying event occurs (e.g. marriage, birth, etc.), whichever occurs first. Refer to Chapter 4, subchapter 403 other enrollment opportunities.

- The coverage effective date for employees returning from military leave or Family Medical Leave of Absence (FMLA) is the date the employee returns to work provided an application is filed with the employer within 30 days of returning to work. A full month's premium is due for that month if coverage is effective before the 16th of the month. If coverage is effective on the 16th or later, the entire premium is waived for that month.

704 Coverage During Layoff

A. The following apply to employees on layoff status who do not allow health insurance coverage to lapse. Coverage may be continued during layoff with the following conditions:

- Employer contributions toward premium payment during layoff are at the discretion of the employer.
- Coverage may be continued for up to 36 months while an employee is on layoff status.
- Premiums, whether the entire monthly premium or the employee share, must be paid by the employee in advance of the coverage month. Premium payment can be either by deduction from the last payroll check or by direct payment to the employer, e.g., by personal check.
- Employees on layoff are included on the employer's monthly invoice along with active employees and employees on LOA. Any payments received from employees on layoff should be made payable to the employer and included in your monthly premium remittance to ETF.
- Employees on layoff during an entire It's Your Choice Open Enrollment period must be given an It's Your Choice opportunity. It's Your Choice information should be sent to those employees who are on layoff prior to the beginning of the designated It's Your Choice Open Enrollment period.
- Employees who do not allow their coverage to lapse while on layoff status are not required to complete a *Health Insurance Application/Change Form* (ET-2301) upon their return to work.

B. The following apply to employees on layoff status who allow health insurance coverage to lapse and choose to reinstate coverage upon return to work:

- The employee must submit a *Health Insurance Application/Change Form* and is limited to the same health plan and level of coverage as before the layoff. The application must be received within 30 days of the employee's return to work. Coverage is effective the first of the month following the employer's receipt of the

completed *Health Insurance Application/Change Form*. After 30 days, enrollment is limited to the It's Your Choice Open Enrollment period or if there is another qualifying event that occurs (e.g., marriage, birth, etc.).

- The employee may change level of coverage only if a special enrollment opportunity (e.g., marriage, birth, etc.) occurs during the layoff. (Refer to Chapter 4, subchapter 403 for information about special enrollment opportunities.)
- Employees moving to a different health plan service area during a layoff may change health plans.
- An employee who returns from a layoff that encompassed the entire previous It's Your Choice Open Enrollment period will be allowed an open enrollment opportunity provided an application is filed with the employer within 30 days of the employee's return to work.

705 Coverage During Appeal of Discharge

An insured employee appealing an employment discharge may continue to be insured from the date of the contested discharge until a final decision is made. The following apply:

- The employer must receive the first premium payment within 30 days of discharge.
- Future premium payments must be made through the employer and must be received in advance of the coverage month.
- The employee must pay both the employee and employer share of premium due each month until the appeal is resolved.
- The employee must continue to be reported along with active employees on the employer's monthly invoice. Any payments received from employees appealing a discharge should be made payable to the employer and included in the employer's monthly premium remittance to ETF.

In the event the appeal is decided in favor of the employee and the employee is made whole (as if the discharge did not occur), the employer must reimburse the employee for all employer shares of premiums paid by the employee during the course of the appeals process. The employer is not required to return the employer share in cases where the employee is not made whole but returns to work under the terms of the final agreement.

In the event an appeal reinstates an employee who allowed coverage to lapse during the appeal, the employee may reinstate coverage provided the employee re-applies for coverage within 30 days of the return to work.

If the final decision is adverse to the employee, the date of termination shall, for purposes of health care coverage, be the end of the month in which the decision becomes final.

If the discharge is for reasons other than gross misconduct, the employee is eligible to continue health insurance for the balance of 18 months from the original termination date (the balance of the continuation period). If the discharge is for gross misconduct, the employee is eligible for conversion coverage and should contact the health plan for information on benefits, rates and policy provisions. (Refer to Chapter 9 for information about continuation and conversion.) In either case, a *Continuation-Conversion Notice* (ET-2311) must be provided to the employee using the original discharge date.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

CHAPTER 8 — Cancellation and Termination of Coverage

801 Ending Coverage

802 Changing From Active to Annuitant Coverage

803 Cancellation of Coverage

801 Ending Coverage

The coverage end date for the employee is entered by the employer in myETF Benefits. After logging into myETF Benefits, from the Health tab select the *Termination of Coverage* option.

Active coverage may be ended for an employee based upon an employee's request to complete a spouse-to-spouse transfer, death of the subscriber, disability approval (non-ICI), termination of employment or employee's request to cancel coverage. Refer to the chart below for specific limitations and requirements surrounding these termination scenarios.

The ending of an employee's coverage will be reported on the Monthly Employer Invoice. (Refer to Chapter 15 regarding instructions and information on the Monthly Employer Invoice.)

Reason	Coverage End Date	Comments
Cancel Coverage	Refer to subchapter 803	Employee is voluntarily ending coverage. Refer to subchapter 803 regarding Internal Revenue Code (IRC) Section 125 pre-tax and post-tax requirements. If employee does not pay required premiums while out on a leave of absence (LOA), this is a cancellation, voluntarily ending coverage.
Termination of Employment	End of the calendar month in which the employee terminates employment.	Employee's coverage is an involuntary loss of coverage. If employee is terminating employment because they are retiring (refer to Chapter 11), going on an unpaid LOA or on permanent layoff and are starting an immediate annuity.

Reason	Coverage End Date	Comments
Cancel Spouse-To-Spouse Employment	Refer to subchapter 803	Employee voluntarily ending coverage. Cannot complete a cancellation mid-year without an allowable status change under the plan language (contract) or HIPAA qualifying event if premiums are deducted pre-tax.
Disability Approval (Non-ICI)	Coverage is continued as an annuitant without lapse upon approval of a disability benefit.	This is an employer entry in myETF Benefits. No application to end coverage is required from employee. ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs. Refer to subchapter 802.
Death of Subscriber with Single Coverage	End of the calendar month in which the death occurred.	Refund any premiums paid in advance for coverage beyond the end of the month in which death occurred.
Death of Subscriber with Family Coverage	Coverage under the employee's contract continues through the last day of the month for which the premium has already been deducted.	Do not refund any premiums unless authorized by ETF.

802 Changing from Active to Annuitant Coverage

Retiring insured employees are eligible to continue health coverage under any of the following conditions: (Refer to Chapter 10)

- Employee receives an immediate annuity upon retirement (monthly or lump sum benefit), WRS disability, or Long-Term Disability Insurance benefit.
- Employee terminates after age 55 (50 for protective category employees) with at least 20 years of creditable WRS service, but does not take an immediate retirement annuity.

When an employee retires, the employer must end their coverage in myETF Benefits. When a retiring employee qualifies for health insurance coverage and the employer continues to pay all or part of the monthly health insurance premium, for example, through conversion of unused sick leave or some similar employee benefit agreement, the retiring employee is considered an Employer-Paid Annuitant. (Refer to Chapter 11)

Employees on an unpaid leave of absence immediately prior to retirement whose coverage lapsed due to non-payment of premiums can reinstate coverage if an immediate WRS annuity is taken and a health insurance application is filed with ETF by the date of their first annuity payment.

In all cases, they must also complete the Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report (ET-4814).

803 Cancellation of Coverage

When an employee wishes to cancel coverage for any of the voluntary reasons listed in subchapter 801, they cannot complete their request mid-year without an eligible status change that is allowed under the plan language (contract) or under HIPAA if the employee premium is being deducted on a pre-tax basis under Internal Revenue Code (IRC) Section 125.

If the employee premium is being deducted post-tax, coverage can be cancelled at any time throughout the calendar year. If an event has occurred that is not listed in the following table, contact ETF for review and guidance.

Event	Eligibility Requirements	Coverage End Dates	Comments
Move from Service Area	<i>Health Insurance Application</i> (ET-2301) or myETF Benefits request must be submitted within 30 days of the move from the service area date.	End of the month following receipt of the application/myETF Benefits request or the event date, whichever is later.	The coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.
Pre-Tax Employee Terminating Employment	<i>Health Insurance Application</i> or myETF Benefits request must be submitted no later than the month employment terminates. The event date is the date employee terminates employment.	End of the month following receipt of the application/myETF Benefits request or the event date, whichever is later.	The coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.

Event	Eligibility Requirements	Coverage End Dates	Comments
<p>Pre-Tax Employee Going on an Unpaid LOA</p>	<p><i>Health Insurance Application</i> or myETF Benefits request must be submitted no later than the month employee goes on a LOA.</p> <p>The event date is the date employee begins a LOA.</p> <p>An affirmative choice to cancel coverage by submitting an application invalidates the right to re-enroll at the end of the LOA.</p> <p>To retain re-enrollment rights the employee should allow coverage to lapse due to non-payment. At the time the employee ceases paying their contribution or the entire premium while on unpaid LOA, the employer must terminate their coverage in myETF Benefits. No application is required and none should be requested for a lapse.</p>	<p>End of the month following receipt of the application/myETF Benefits request or the event date, whichever is later.</p> <p>For lapses, coverage termination should be entered at the time payment is not received from the employee.</p> <p>Coverage ends the end of the month for which payment was received.</p>	<p>An employee who continued coverage during a LOA is eligible to receive the employer share of the monthly premium for the one coverage month premiums were pre-paid plus three additional months. Once the employee is paying the employer share of the premium or the entire premium post-tax, coverage can be canceled at the end of any month following receipt of an application/request.</p> <p>Coverage end date for a cancellation request is always the end of a month.</p> <p>Retroactive cancellations are not allowed.</p>

Event	Eligibility Requirements	Coverage End Dates	Comments
<p>Pre-Tax Family Status Change (e.g., spouse to spouse, DP to DP)</p>	<p>An allowed family status change under the plan language (contract) or under HIPAA must occur to allow cancellation to enroll under spouse/ DP's coverage as an employee.</p> <p><i>Health Insurance Application/Change Form</i> or myETF Benefits request must be submitted within 30 days of the IRC Section 125 status change, the event.</p>	<p>End of the month following receipt of an application/myETF Benefits request or the event date, whichever is later.</p>	<p>Refer to Chapter 5 for status changes allowed under the plan language (contract) and HIPAA.</p> <p>Documentation may be required.</p> <p>If an allowed family status change has not occurred, an employee can submit an application in October, November or December requesting coverage to be canceled effective December 31.</p> <p>Coverage end date for a cancellation request is always the end of a month.</p> <p>Retroactive cancellations are not allowed.</p>

Event	Eligibility Requirements	Coverage End Dates	Comments
<p>Pre-Tax Employee Premium Contribution Has Increased Significantly</p>	<p><i>Health Insurance Application</i> or myETF Benefits request must be submitted within 30 days of the date premiums significantly increased, the event date.</p>	<p>End of the month following receipt of an application/myETF Benefits request or the event date, whichever is later.</p>	<p>When the employer share of the premium contribution decreases by at least 5% and the employee share increases, this is considered a significant increase in the employee premium contribution. Coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.</p>
<p>Pre-Tax Employee (and all dependents, if applicable) Became Eligible for and Enrolled in Other Group Coverage</p>	<p><i>Health Insurance Application</i> or myETF Benefits request must be submitted within 30 days of the date the other coverage becomes effective.</p>	<p>End of the month following receipt of an application/myETF Benefits request or the event date, whichever is later.</p>	<p>Documentation is required: proof of enrollment in other group insurance that displays the date coverage began such as a copy of an insurance ID card or enrollment acknowledgment. Coverage end date for a cancellation request is always the end of a month. Retroactive cancellation are not allowed.</p>
<p>Pre-Tax Annual It's Your Choice Open Enrollment Period</p>	<p><i>Health Insurance Application</i> or myETF Benefits request must be submitted during the It's Your Choice Open Enrollment Period.</p>	<p>Coverage end date is December 31.</p>	<p>Based on plan language (contract), coverage can be cancelled at the end of a calendar year regardless if employee premiums are deducted pre-tax or post-tax.</p>

Event	Eligibility Requirements	Coverage End Dates	Comments
<p>Premiums Deducted Post Tax</p>	<p><i>Health Insurance Application</i> or myETF Benefits request must be submitted.</p>	<p>Coverage end date is the end of the month following the application received date or the myETF Benefits request date, whichever is later. If the application received date or the myETF Benefits request date is the last day of a month, coverage ends on the receipt/request date.</p>	<p>An application can be submitted requesting a future cancellation date other than the end of the month following receipt of the application. Coverage can be canceled mid-year. Coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.</p>

Chapter 9 – COBRA, Continuation and Conversion

- 901 Overview of COBRA, Continuation and Conversion**
- 902 Persons Eligible for Continuation (Qualified Beneficiaries)**
- 903 Employee Responsibilities**
- 904 Qualified Beneficiary Responsibilities**
- 905 Employer Responsibilities**
- 906 Notice Requirement Illustration Chart**
- 907 Continuation Coverage Information**

901 Overview of COBRA, Continuation and Conversion

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), participants and their eligible dependents covered under the Wisconsin Public Employers Group Health Insurance Program have options available to them for the continuation or conversion of health insurance coverage in the event eligibility for group coverage ends. COBRA requires that the WPE Group Health Insurance Program offer subscribers (employees/members) and their covered dependents (qualified beneficiaries) temporary extension of identical coverage at the group rate for a maximum of 18 months (36 months under certain circumstances) following specific events, referred to as “qualifying events” (refer to subchapter 902). The following provides an overview of Continuation and Conversion.

Continuation:

Wisconsin statutes (Wis. Stat. § 40.51 (3-4), § 632.897) incorporate and extend the federal COBRA benefit noted above. Under this subsection, authority is given to the Wisconsin Group Insurance Board (GIB) to reinforce and broaden continuation rights under certain circumstances (e.g., to include domestic partners).

Note: Where Federal (COBRA) and State (continuation) laws differ, the law most favorable to the participant will apply. When used in this Chapter, “COBRA continuation” refers to the State or Federal legislation resulting in the most favorable outcome to the participant, unless otherwise specified.

Note: One commonly encountered distinction between federal and state law occurs in late-reported divorce. Under federal law, divorcees are entitled to 36 months of COBRA following the divorce event. (For example, a divorce reported on month 34 after the event would only leave the ex-spouse with a balance of 2 months.) However, state law guarantees a minimum of 18 months’ continuation regardless of event date. As a result, state law rules are followed and the ex-spouse would be entitled to continuation for

months 34 through 51.

Conversion:

Conversion coverage is available to participants who have been covered under the WPE Group Health Insurance Program under terms negotiated with the health plan. Participants may elect to convert to individual (non-group) coverage upon loss of eligibility for group coverage, i.e., when they reach the maximum length of continuation of group coverage or in lieu of continuation coverage. Participants electing conversion coverage do not need to provide evidence of insurability but must apply directly with the health plan through the process established by the health plan. The benefits and rates for conversion coverage are different than the benefits and rates for continuation coverage.

902 Persons Eligible for Continuation (Qualified Beneficiaries)

Under federal and state laws, when group health insurance coverage would otherwise end because of a life event known as a “qualifying event,” employees and their covered dependents become “qualified beneficiaries” and must be offered continuation coverage (refer to subchapter 905 for employer responsibilities).

- A. Employees must be offered continuation coverage in the event coverage is lost due to either of the following events:
- Termination of employment (for reasons other than gross misconduct), including retirement. The exception is when an employee retires and elects to take an immediate annuity and to continue health insurance. (Refer to Chapters 10, 11, and 12).
 - Completion of the maximum prepayment periods of 36 months while on a leave of absence or layoff. (Refer to Chapter 7).
- B. The spouse/domestic partner of an employee with family coverage in the WPE Group Health Insurance Program becomes a qualified beneficiary as a result of any of the following qualifying events:
- Death of spouse/domestic partner (employee). (Refer to Chapter 14 on Employee Death.)
 - Divorce. Coverage as a dependent spouse continues until the later of:
 - The end of the month in which the employer provides notification of continuation rights (*Continuation - Conversion Notice* [ET-2311]). (Refer to subchapter 903.)
 - or**
 - The end of the month in which the divorce is entered/final.

- Termination of domestic partnership. Coverage as a domestic partner ends at the end of the month the partnership is terminated.
 - Spouse/domestic partner (employee) loses coverage for reasons listed above under section A.
- C. Each eligible dependent child of an employee with family coverage in the WPE Group Health Insurance Program becomes a qualified beneficiary as a result of any of the following qualifying events:
- Death of parent/stepparent or parent's/stepparent's domestic partner (employee; refer to Chapter 14 on Employee Death).
 - Dependent eligibility status ceases under the WPE Group Health Insurance Program (Refer to the chart in subchapter 906 for examples).
 - Parents become divorced resulting in loss of eligibility.
 - Parent/step-parent and their domestic partner end a domestic partnership resulting in loss of eligibility.
 - Parent (employee) loses coverage for reasons listed above in A.
- D. An eligible dependent of a minor dependent of an employee with family coverage in the WPE Group Health Insurance Program becomes a qualified beneficiary when losing eligibility as a result of the minor dependent (parent) turning age 18. Coverage for the dependent of a minor dependent terminates at the end of the month in which the dependent child turns 18.
- E. An eligible disabled dependent, over age 26, of an employee with family coverage in the WPE Group Health Insurance Program becomes a qualified beneficiary upon loss of disabled status. Coverage terminates at the end of the month in which it is determined the disabled status ceases.

Note: When a voluntary change in coverage from a family plan to a single plan is done in anticipation of a divorce, the spouse and dependent children are eligible for continuation coverage when the divorce is final. The effective date for continuation coverage in this case is the date of the entry of the judgment of divorce. This is usually when the judge signs the divorce papers and the Clerk of Courts date-stamps them. In all other cases, voluntary cancellation does not create a continuation enrollment opportunity.

903 Employee Responsibilities

Employees and/or the qualified beneficiaries (refer to subchapter 902) are responsible for informing the employer of a qualifying event in which an employee and/or dependent loses eligibility for coverage under the WPE Group Health Insurance Program.

Under Federal COBRA law, if the employer is not notified within 60 days of the:

- event that caused the loss of coverage, or
- end of the period of coverage, whichever is later,

the right to continuation coverage is lost. Under state continuation law, separate requirements may allow notification after the 60-day period in limited divorce circumstances.

In the event of a divorce, if an employee does not notify their employer of their divorce, coverage for the ex-spouse and any stepchildren continues if the family premium continues to be paid. The ex-spouse must then be given the right to continue coverage even if notice is given beyond 60 days following the divorce.

Should the employee fail to advise the employer of divorce within 60 days of the event, the employer must provide notice to stepchildren that they are ineligible to continue coverage as a qualified beneficiary of the employee as soon as possible. Coverage terminates the end of the month in which the employer provides the notice of the right to continue coverage (*Continuation - Conversion Notice* (ET-2311)) to the ex-spouse and any stepchildren or children of minor stepchildren. In this situation, employers must check with ETF on the length of continuation coverage that is available.

Note: The ex-spouse is eligible to continue coverage under a single contract or a family contract with eligible dependents. The stepchildren or children of minor stepchildren are not eligible to continue coverage under a single contract of their own because notice of the divorce was not given to the employer within 60 days of the divorce. If the stepchildren meet the criteria of being an eligible dependent and the ex-spouse applies for family coverage as a continuant, the stepchildren can be included as covered dependents on the ex-spouse's family contract.

Note on terminations of domestic partnerships: Former DPs are also eligible to elect a single contract or a family contract with eligible dependents also losing coverage. Dependents of DPs are treated like stepchildren (or their dependents' children if that dependent is a minor) in the same way as indicated in the paragraph above. Coverage of former DPs (and dependents) will only extend through the end of the month the partnership terminates; the employer notification date will not affect the end date of coverage. DPs lose continuation rights if notice of termination is not received within 60 days.

904 Qualified Beneficiary Responsibilities

When electing continuation or conversion coverage, qualified beneficiaries are responsible for the following:

- Submitting the *Continuation - Conversion Notice* (ET-2311) and the *Health Insurance*

Application/Change Form (ET-2301) to ETF. Both forms (an employee need only submit a *Continuation - Conversion Notice* unless requesting a change in coverage) must be sent to ETF (that is, postmarked) no later than 60 days from the termination of their coverage or within 60 days of the date they were notified by their employer, whichever is later. If qualified beneficiaries do not elect continuation coverage within the 60-day period, they lose eligibility to enroll under continuation.

- Paying premium to the health plan when billed by the health plan.
- Reporting any changes affecting coverage, for example, address change, birth or adoption. If continuation coverage is elected, changes must be reported to ETF; if conversion coverage is elected, changes must be reported to the health plan.
- Subscribers and their insured dependents continuing coverage must enroll in Medicare Parts A and B when initially eligible. A copy of the Medicare card must be submitted to ETF. If a qualified beneficiary is eligible for Medicare:
 - **prior to** or on the effective date of COBRA coverage, they are eligible for Medicare reduced rates.
 - **after** COBRA coverage begins, COBRA coverage ends when the subscriber or dependents enroll in Medicare Parts A and B.
 - Qualified beneficiaries not eligible for Medicare remain eligible for COBRA coverage.
 - If Part B becomes effective after the continuation begins, the continuation period ends at the end of the month prior to when Medicare Part B becomes effective.

905 Employer Responsibilities

Within five days of being notified of the “qualifying event,” the employer is responsible for notifying qualified beneficiaries of their right to continue group coverage or convert to individual coverage by providing them with the following documents:

- *Continuation - Conversion Notice* (ET-2311), with the employer sections completed.
- *Health Insurance Application/Change Form* (ET-2301). This form is needed to enroll in continuation or conversion. The employee does not need to complete the application if continuing the coverage already in effect. The employee must still complete and return the *Continuation - Conversion Notice*. The employer should not complete any information on this form.

Note: A continuation notice must be provided within the five-day period even when it is determined the qualified beneficiary is not entitled to continuation coverage, for example, notice of the qualifying event was not provided to the employer within the required time period (refer to subchapter 906 for information on providing notice). The employer must indicate on the continuation notice that the qualified beneficiary is not eligible for COBRA by marking the correct fields.

The employer is responsible for informing qualified beneficiaries of the following:

- If electing continuation coverage, the completed *Continuation - Conversion Notice* and *Health Insurance Application* forms must be sent to ETF (i.e., postmarked) no later than 60 days after the date of the notice or 60 days after coverage ends, whichever is later.
- If electing continuation coverage, the health plan will bill the continuant(s) directly.
- If electing continuation coverage and the continuants are moving or will move to a different county for more than three months, they are eligible to change to another health plan without restrictions, provided the application is received within 30 days after the move. The application must be returned to the employer if the change would be effective before the termination of coverage paid through the employer; otherwise, the application must be returned to ETF. If the qualified beneficiary lives in a county different from that of the subscriber, they are also eligible to change plans at the time they begin continuation coverage.

Note: When entering a coverage end date in myETF Benefits for the employee's coverage or the end date for any specific dependent on the employee's contract through 'Remove Dependent', enter an end date that is the end of the month following the event. There is an exception to this when removing the subscriber's spouse due to divorce (refer to subchapter 903).

906 Notice Requirement Illustration Chart

The following chart illustrates a sample timetable for providing notices related to continuation coverage for common scenarios:

Event	Occurs	Coverage Continues Until	Employee or Beneficiary Must Notify Employer By	Employer Must Provide Continuation Notice By	To Elect Continuation, Application Must Be Submitted To ETF By
Child (or stepchild, DP's dependent) turns 26 and is not disabled.	3/15	3/31	05/31	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.
Dependent of Minor Dependent Eligibility Ends as Dependent turns 18	03/15	03/31	05/31	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.

Event	Occurs	Coverage Continues Until	Employee or Beneficiary Must Notify Employer By	Employer Must Provide Continuation Notice By	To Elect Continuation, Application Must Be Submitted To ETF By
Disability Status Terminates for >26 Year Old Dependent	03/15	03/31	05/31	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.
Divorce Decree is Entered	03/15	End of the month in which continuation notice is given	05/31 But, if continuation notice is given late, check with ETF.	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.
Domestic Partnership is terminated	03/15	03/31	05/31 If continuation notice is given late, check with ETF.	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.
Employee Terminates Employment	03/15	03/31	05/31	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.

907 Continuation Coverage Information

The benefits and limitations of coverage under continuation are identical to those provided to active employees. Participants enrolled in continuation coverage (continuants) must select the health plan already in effect at the time of termination of active coverage. Should the qualified beneficiary not reside in the same county as the subscriber, the qualified beneficiary may elect a health plan in their county of residence when enrolling in continuation coverage, even if the subscribers health plan is available in the qualified beneficiary's county. Continuants are allowed to change health plans during the annual It's Your Choice Open Enrollment period or following a residential move out of the county.

Continuation coverage may be in effect for up to 18 (sometimes 36) months. However, continuation coverage may be terminated early for any of the following reasons:

- The premium for continuation coverage is not paid when due.
- The subscriber becomes covered under another group health plan; a subscriber who refuses health insurance offered by another employer will not be affected.

- A spouse is divorced from a covered employee and subsequently remarries and is covered through the new spouse's group health plan.
- Qualified beneficiary voluntarily cancels continuation coverage.

If COBRA coverage is terminated early for any reason, it may not be reinstated.

Continuants may elect to convert to individual coverage (conversion at non-group rates) upon reaching the maximum continuation coverage period. Continuants are responsible for knowing when group continuation coverage ends and must contact their health plan directly to make application for conversion coverage as provided by the health plan.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 10 — Retirement, Disability or Long-Term Disability Insurance

1001 Coverage – Requirements to Continue

1002 Medicare Enrollment

1003 Premium Payment

1004 Completing *Employer Verification of Health Insurance Coverage (ET-4814)*

1001 Coverage – Requirements to Continue

Coverage under the State Group Health Insurance Program may be continued when an employee is eligible for a retirement benefit or applies for a Wisconsin Retirement System disability or Long-Term Disability Insurance (LTDI) benefit upon termination of employment. In addition, subscribers and their insured dependents who are continuing coverage must enroll in Medicare Parts A and B when first eligible. This is required by state statute, as the State Group Health Insurance Program is designed to integrate with, rather than duplicate, Medicare benefits. The group health insurance coverage will be converted to a plan that is integrated with Medicare effective on the first of the month in which the member is required to be enrolled in Medicare. The amount of the monthly premium will be reduced accordingly. Retrospective adjustments to premiums are limited to the shortest retroactive enrollment limit set by Medicare (90 days), in accordance with the WPE Group Health Insurance Program contract.

Note: Active employees (non-annuitants) reported on the monthly invoices are not required to enroll in Medicare when first eligible and do not receive the Medicare reduced premium rate in the event they do enroll in Medicare.

- **Retirement Benefit**

Group health insurance coverage will automatically be continued if the employee retires on an *immediate annuity*. An immediate annuity is defined as a benefit that begins within 30 days after the employee terminates employment. This benefit can be a monthly benefit or a lump sum annuity.

Health insurance coverage automatically continues for covered employees upon retirement. If the retiring employee does not wish to continue health insurance coverage after retirement and wants to cancel coverage, ***ETF must receive that notification in writing with the member's signature PRIOR to their active employee coverage ending.*** A *Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report (ET-4814)* must be submitted to ETF, signed by both employer and employee, indicating whether the employee elects to continue or cancel health coverage.

- **Disability or LTDI Benefit**

Insured employees applying for a WRS disability or LTDI benefits must pre-pay premiums through their employers until their WRS disability or LTDI benefit is approved by ETF, or else coverage will lapse.

Employees who are on an unpaid leave of absence immediately prior to termination, and whose coverage has lapsed due to non-payment of premiums, can reinstate coverage if an immediate WRS disability or LTDI benefit is taken. Once the WRS disability or LTDI benefit is approved, ETF will send the employee a letter and a *Health Insurance Application/Change Form* (ET-2301) offering lifetime coverage under the State Group Health Insurance Program. The *Health Insurance Application/Change Form* must be received by the deadline provided in the letter (30 days from the date of the letter). ETF will notify the employer when a disability or LTDI benefit is approved. The employer will then need to terminate the employee from active coverage. (Refer to Chapter 8.)

- **Termination with 20 Years of WRS Service; Not Taking Immediate Annuity**

Group coverage can be continued when terminating after age 55 (50 for protective category employees) when the employee has at least 20 years of WRS creditable service, even if an immediate retirement annuity is not taken. The employee completes and submits a *Continuation – Conversion Notice* (ET-2311) to ETF at the time of the employee's termination. (Refer to Chapter 9.) The employee will be billed by the health plan for their coverage.

1002 Medicare Enrollment

Active employees and their insured dependents eligible for coverage under the Federal Medicare program may defer enrollment under Medicare Part A (hospital) and Part B (medical) until the employee terminates employment or health insurance coverage as an active employee ceases.

Annuitants and insured dependents who are eligible for coverage under the Federal Medicare program must enroll in Parts A and B when first eligible due to age or disability per Wis. Stats. § 40.51(7) and 40.52(2). Annuitants and insured dependents failing to enroll in Medicare will be held responsible for the portion of claims that Medicare would have covered, had they been enrolled in Medicare. Failure to enroll in Medicare at the next enrollment opportunity may result in termination of coverage in the WPE Group Health Insurance program.

A *Medicare Eligibility Statement* (ET-4307) is used to inform ETF of the Medicare effective dates. ETF will mail the Medicare Eligibility Statement to the retiree for completion. A sample of the Medicare Eligibility Statement appears at the end of this subchapter. Please provide ETF with a copy of the retiree's Medicare card, when available.

Medicare Eligibility Statement (ET-4307)



Medicare Eligibility Statement

Wis. Stat. §§ 40.51 (7) and 40.52 (2)

Wisconsin Department
 of Employee Trust Funds
 801 W Badger Road
 PO Box 7931
 Madison WI 53707-7931

1-877-533-5020 (toll free)
 Fax 608-267-4549
 etf.wi.gov

Make a copy for your records and return the original by mail or fax to ETF.

Subscriber Information <i>Please print clearly</i>	
Subscriber name – Policy holder (first, middle, last)	Member ID or SSN
Mailing address (Street or PO Box, city, state, ZIP code)	<input type="checkbox"/> Check this box if this is a change of address.
Indicate the reason you are now eligible for Medicare: <input type="checkbox"/> Age 65 and over <input type="checkbox"/> Receipt of Social Security disability payments for 24 months <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> Lou Gehrig's Disease (ALS)	

Prescription Drug Coverage
Prescription drug coverage in this program is provided by Navitus MedicareRX (PDP), a Medicare Part D Employer Group Waiver Plan.
Do you have other prescription drug coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, plan name: _____
Since you may only have one Part D plan, please select which plan you want to use: <input type="checkbox"/> Navitus MedicareRX (PDP) <input type="checkbox"/> Your current Part D plan
Attach a copy of your Medicare card or documentation from Medicare that clearly states your Medicare claim numbers and effective dates. If you have not yet received your card reflecting your Parts A and B coverage, contact the Social Security Administration to obtain your information, and return this completed form to ETF as soon as possible. Send a copy of your card to ETF once you receive it.

Persons Insured Under Your Group Health Insurance Policy				
Complete the table with the names and birth dates of all persons on your group health insurance policy. List effective dates and claim numbers or write "not eligible" if not eligible for Medicare. Include yourself as the subscriber, as well as spouse or domestic partner, and any dependents. See Page 2 for how to read your Medicare card.				
Names	Birth date	Medicare claim number	Medicare effective dates as shown on card	
			Hospital (Part A)	Medical (Part B)

By signing this statement, I attest that I have read and understand the Important Medicare Information on Page 2 , the information I provided above is true and correct to the best of my knowledge and I authorize the Department of Employee Trust Funds to verify information regarding eligibility for effective dates of coverage under Medicare Parts A, B and D.		
Date (MM/DD/CCYY)	Subscriber signature (Required)	Telephone ()



1003 Premium Payment

Annuitant premium payments are made through one of the following methods:

Employer Paid Annuitant - Premiums are paid to ETF by the employer when the employer pays any portion of the premium for the annuitant.

Annuity Deduction - Premiums are paid from a monthly retirement or disability annuity if the annuity is sufficient to cover the entire premium.

Direct Pay - When the annuity is not sufficient to cover the entire premium, the health plan will directly bill the annuitant, and the annuitant will pay premiums directly to the health plan.

Group Life Insurance Conversion - This program, governed by Wis. Stat. § 40.72 (4r) and Wis. Admin. Code ETF 60.60, allows eligible employees to convert their group life insurance to pay health insurance premiums. For more information, refer to the *Converting Your Group Life Insurance to Pay Health or Long-Term Care Insurance Premiums* brochure (ET-2325).

1004 Completing Employer Verification of Health Insurance Coverage

An *Employer Verification of Health Insurance Coverage* (ET-4814) must be submitted to ETF for each employee regardless of whether the employee plans to continue health coverage after retirement. The form is required, even when the employer is paying all or part of an annuitant's monthly health premium. An insured employee receives the form with the retirement application from ETF. The form is also required for a surviving spouse/dependent of a deceased insured employee or employer-paid annuitant. The employee or survivor completes the top portion of the form and submits to the employer.

Employer Instructions - Complete the Employer Section of the form reflecting the coverage as of the date employment terminates:

1. Check the appropriate box for coverage verification:
 - a. Coverage verified is in effect; or
 - b. Coverage verified is not yet in effect but employee has submitted a health insurance application to change coverage. (Advise employee to submit a *Health Insurance Application/Change Form* (ET-2301) with the *Employer Verification of Health Insurance Coverage* form if coverage will change when coverage as an active employee ceases.)
2. Plan - The name of the health plan.
3. Five-digit Group Number - The first digit of the group number is 7, followed by the four-digits preceding the "-000" in your EIN (e.g., 79999).

4. Coverage Type - Indicate Single **or** Family coverage.
5. Monthly Premium Rate - Enter the full monthly premium rate – TOTAL OF EMPLOYEE AND EMPLOYER CONTRIBUTIONS. Refer to the current *It's Your Choice booklet* (ET-2128).
6. Enter the month, day (the last day of the month) and year through which health insurance coverage is paid as an active employee.
7. Indicate whether premiums will be paid by the employer after termination: "Yes" **or** "No."
8. Name of Employer.
9. Employer Number - The number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-9999-000).
10. Date - Enter the current date.
11. Signature of Employer Representative - Signature of the employer representative completing the form.
12. Telephone Number - The telephone number of the employer representative who completed the form.

Return the top two plies to the employee. Keep the bottom ply for your records. The employee must submit the form to ETF after completing the employee portion. A sample of the Employer Verification of Health Insurance Coverage form appears at the end of this subchapter.



Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report

Wisconsin Department of Employee Trust Funds
 801 W. Badger Road
 Madison, WI 53707-7931
 1-877-533-5020 (toll-free)
 Fax: 608-267-4549
etf.wi.gov

See Instructions on Page 2 for assistance. Please print.			
Part A: Employer Verification of Health Insurance Coverage			
Health plan:			
Monthly premium: \$	Coverage type: <input type="checkbox"/> Single <input type="checkbox"/> Family		
Coverage as an <i>active employee</i> ends on? (mm/dd/ccyy) _____			
Will premiums be paid by the <i>employer</i> after termination/retirement?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes , employer must complete and submit Section C of this form at least two months prior to the date when the employer contribution for premiums will end.			
Note: To qualify as a local employer paid annuitant, the employer <i>must</i> pay a portion of the total premium due.			
Employer number: 69-036-	Employer name:		
Signature of employer representative:		Date: (mm/dd/ccyy)	Phone number:
Part B: Employee Information			
I wish to continue my health insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No (If no , please note that currently there are no re-enrollment opportunities for the Wisconsin Public Employer's Group Health Insurance Program.)			
Employee name:		Employee SSN: _____	
		DOB: (mm/dd/ccyy) _____	
Address: Street No.	City	State	ZIP Code
Spouse/domestic partner/dependent/survivor name (last, first, MI)		SSN: _____	
		DOB (mm/dd/ccyy) _____	
Signature of employee:		Date: (mm/dd/ccyy)	
Part C: Transfer Report (Local paid annuitant no longer receiving employer contributions.)			
Employee name: _____		SSN/Member ID: _____	
DOB: _____ (mm/dd/ccyy) Gender: ____ Health plan: _____			
Date coverage ends (employer contributions to premiums cease): _____ (mm/dd/ccyy)			

Employer: Keep a copy of this form for your records and make a copy for your employee.



**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 11 — Rehired Annuitants

1101 Eligibility

1102 Coverage

1103 Disability Annuitants

1101 Eligibility

A Wisconsin Retirement System annuitant's return to **non-eligible WRS** employment does not affect their WRS annuity or ETF administered annuitant health insurance benefits. Eligibility, under this Chapter, means the annuitant has met the requirements of a minimum break-in-service, as explained in Chapter 15 of the *WRS Administration Manual* (ET-1127), and returns to an **eligible WRS** position, either as an employee or an independent contractor.

Note: A WRS annuitant returning to their former employer, ***without meeting the required minimum break-in-service***, would be considered returning to a WRS eligible position regardless of the number of hours or duration of employment; therefore, their WRS annuity and ETF administered annuitant insurance benefits would be void.

Under the provisions of Wis. Stat. § 40.26 (1), a WRS annuitant returning to WRS eligible employment may elect to terminate the annuity and return to active WRS participation or will be required to return to active WRS participation and have their WRS annuity suspended, depending on the WRS annuitant's final WRS termination date. (Refer to Chapter 15 of the *WRS Administration Manual*.) In both scenarios, the WRS annuitant must complete a *Rehired Annuitant Form* (ET-2319).

Annuitants returning to active WRS participation are immediately eligible to apply for any ETF administered insurance program the employer participates in and their annuity and annuitant benefits are suspended under the following conditions:

- If their last termination date was ***prior to July 2, 2013***, the annuity is suspended, if the annuitant elects to participate in the WRS, effective the first of the month following ETF's receipt of the *Rehired Annuitant Form*. If the annuitant does not elect WRS participation, their WRS annuitant status continues uninterrupted.
- If their last termination date was ***on or after July 2, 2013***, the annuity is suspended effective the first of the month following their rehire date.
- If the minimum break in service has not been met, the annuity is invalid and considered a benefit paid in error; the annuitant would be re-enrolled in the WRS

with no break.

The annuitant remains enrolled in the WRS until they again retire and reapply for an annuity and annuitant benefits they are eligible for as a result of their most recent position worked.

Note: WRS annuitants returning to WRS eligible employment as independent contractors will have their WRS annuity suspended effective the first of the month following their hire date, but will not be WRS eligible for their active employment, nor will they be eligible for active ETF-administered insurances.

A rehired annuitant returning to active WRS participation is only eligible for health insurance coverage through the active employer. There is no option to continue the group health insurance coverage they held as a WRS annuitant. An annuitant rehired by a WRS participating employer not offering health insurance to its employees will lose group health insurance coverage as an annuitant. In other words, regardless of whether an employer participates in the WPE Group Health Insurance Program or not, an annuitant returning to active WRS coverage is no longer eligible for annuitant health coverage.

Eligibility for annuitant health coverage under the WPE Group Health Insurance Program is retained only when a rehired annuitant does not elect to return to active WRS participation or the position is not expected to require two-thirds of full-time hours (880 hours for teachers and school district educational support personnel; 1,200 hours for all others) and last at least one year, i.e., their WRS annuity is not suspended due to returning to work.

1102 Coverage

Upon receipt of the *Rehired Annuitant Form* (ET-2319), ETF will determine both the WRS participation begin date and the WRS annuity suspension date; notification will be sent to both the annuitant and employer. For an employee who was insured as an annuitant, WPE health insurance coverage, if any, becomes effective the day after their coverage as an annuitant lapses.

Note: WRS annuitants returning to WRS eligible employment as an independent contractor will have both their WRS annuity and annuitant health insurance coverage suspended, but are not eligible for WRS coverage for their work as independent contractors, nor are they eligible for active ETF-administered health insurance coverage.

As premiums paid through the annuity are deducted one month in advance, insurance is paid for one month beyond the annuity suspension date. ETF will assist the employer in determining the date the rehired annuitant should be added to active coverage. A *Health Insurance Application/Change Form* (ET-2301), or online enrollment through myETF, electing coverage must be received by the employer within 30 days following

the WRS participation begin date. When the employee retires again, refer to Chapter 12 for instructions on continuation of health insurance coverage, as the former annuitant is now considered an active employee.

A rehired annuitant electing to return, or statutorily required to return, to active WRS participation, but not electing to enroll in health insurance through the active employer ceases to be eligible for annuitant health coverage. However, ETF's continuation provisions allow an employee to continue coverage for a maximum of 36 months by paying the entire premium. ETF will notify the rehired annuitant of the right to continue prior coverage under COBRA law. Continuation coverage does not make the employee eligible to return to the prior annuitant group coverage when they again terminate employment and retire.

1103 Disability Annuitants

A WRS participant receiving a disability annuity cannot actively participate in the WRS until they are no longer eligible for the disability annuity (i.e., the participant is medically certified as no longer disabled). However, a WRS re-employed disability annuitant who has not reached normal retirement age (65, or age 53-54 for protective category employees [53 for those with 25 or more years of creditable service; 54 for those with fewer than 25 years]) will have the disability annuity suspended if the individual earns more than a set "earnings limit" during a calendar year of employment. Eligibility for annuitant health and/or life insurance coverage continues during the period of annuity suspension.

A disability annuity will be terminated if it is determined that the re-employed individual has recovered from their disability and is able to be gainfully employed. Following termination of the disability annuity, annuitant health insurance coverage ceases and, if in a WRS eligible position, the employee is immediately eligible for health insurance offered by their employer.

ETF notifies both the employee and the employer of the WRS coverage begin date, defined as the first of the month after the disability termination date. Employers are notified of their obligation to provide the employee with a *Health Insurance Application/Change Form* (ET-2301). ETF will coordinate between ending annuitant coverage and beginning active coverage if the individual elects coverage. New applications must be filed with the employer within 30 days after the date the employee resumes active status under WRS.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 12 - Medicare

1201 Overview of Medicare

Employer responsibility:

When an employee is planning to retire and is age 64 and 9 months or older, the employer should inform the employee to begin contacting Medicare to enroll in Medicare Part B three months before the employee retires.

Note: Employees age 65 and older are automatically enrolled in Medicare Part A coverage, in most cases.

myETF Benefits:

On the covered individual screen, you and your employees may see whether or not ETF has Medicare eligibility information for them and their dependents (see below). For active employees, ETF collects this information for coordination of benefits with Medicare. Please ask employees older than age 65 to provide the information.

Either the employer or the employee can enter the information into myETF Benefits. If entered by the employer, please have the employee provide a *Health Insurance Application/Change Form* (ET-2301). Medicare eligibility information may also be provided to ETF by the Centers for Medicare & Medicaid Services (CMS) through Voluntary Data Sharing Agreement (VDSA) between ETF and CMS, ETF, or the health plan. If your employees have concerns about the accuracy of the data, first carefully verify all fields with them, including expiration dates, then contact ETF.

Medicare: NO		
Medicare Eligibility Reason:	Medicare A Effective Date:	Medicare B Effective Date:
Health Insurance Claim Number:	Medicare A Expiration Date:	Medicare B Expiration Date:

Additional Medicare Info:		
Medicare C Effective Date:	Medicare D Effective Date:	ESRD Start Date:
Medicare C Expiration Date:	Medicare D Expiration Date:	ESRD End Date:
Medicare C Contract No:	Medicare D Contract No:	

Premium Rates:

Active employees (non-annuitants) and their dependents are not required to enroll in Medicare Part B when first eligible and do not receive the Medicare reduced premium rate in the event that they do enroll in Medicare. However, if your employee insures a

Domestic Partner, the DP may be subject to Medicare late enrollment penalties if they do not enroll in Part B when first eligible. Questions should be directed to the DP's local Social Security Administration office or 1-800-772-1213.

The coverage types of Medicare Single, Medicare Family - 1 and Medicare Family - 2 are not listed for active employees because they are not eligible for the Medicare reduced rates, as the WPE Group Health Insurance Program pays primary on claims for these employees.

Employees age 65 and older are automatically enrolled in Medicare Part A coverage, in most cases. Upon retirement they and/or their Medicare eligible dependents must immediately enroll in Medicare Part B. At that time, their annuitant premiums will be reduced and Medicare will become the primary payer for their claims. If they do not enroll in Part B, they will be responsible for paying the portion of the claims Medicare would have paid if they had enrolled Part B. For example, Medicare pays 80% for Part B services like allowable durable medical equipment and our program pays the remaining 20%. Without Part B coverage, the annuitant would pay the 80% portion of the claim.

Medicare due to disability:

If you have an employee who is eligible for Medicare due to disability, such as End Stage Renal Disease (ESRD), we recommend they speak with their local Social Security Administration office or call 1-800-772-1213. They should discuss their enrollment options and any potential late enrollment penalties.

Annuitants:

Annuitants and their insured dependents eligible for coverage under Medicare must enroll in Parts A and B when first eligible due to age or disability per Wis. Stat. § § 40.51 (7) and 40.52 (2). Annuitants and their insured dependents failing to enroll in Medicare will be held responsible for the portion of claims that Medicare would have covered, had they been enrolled in Medicare, and must enroll in Medicare at the next available opportunity. A *Medicare Eligibility Statement* (ET-4307) and a copy of the Medicare card is used to inform ETF of the Medicare effective dates. ETF will mail the *Medicare Eligibility Statement* to the retiree for completion. Please provide ETF with a copy of the retiree's Medicare card, when available.

U.S. residents, retired employees and their spouses, domestic partners and/or dependents participating in the WPE Group Health Insurance Program who are Medicare enrolled, will be automatically enrolled in the Navitus MedicareRx (PDP) plan, which is offered by Navitus Health Solutions and underwritten by Dean Health Insurance Inc., a federally qualified Medicare contracting prescription drug plan.

The prescription drug coverage under this program is Medicare Part D coverage. In addition, supplemental "Wrap" coverage, which pays secondary to the Medicare Part D plan, is also provided. A retiree's monthly health insurance premium includes a portion that applies to this program's coverage. Retirees may choose to enroll in another

Medicare Part D plan, but it is not recommended or required. Retirees who choose to enroll in another Medicare Part D plan will be dis-enrolled from the Navitus MedicareRX (PDP) plan. However, they will still maintain the supplemental “Wrap” coverage, which will be secondary to the other Medicare Part D plan. There is no partial premium refund for enrolling in another Medicare Part D plan.

A copy of the *Medicare Eligibility Statement* is available in Appendix A.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 13 — Employee Death

1301 How to Report an Employee Death

1302 Surviving Spouse/Domestic Partner and Dependents

1303 Surviving Spouse/Domestic Partner who is also an Employee Eligible for Coverage

1301 Report an Employee Death to ETF Immediately

In the event that an employee dies, please contact the Department of Employee Trust Funds immediately to report the death. Contact ETF via phone at 1-877-533-5020 or by visiting ETF's website at <http://etf.wi.gov> and using the 'Contact ETF' function.

The employer is responsible for entering the health insurance coverage end date in myETF Benefits. Please use the termination reason "Death of Subscriber" when entering this end date and enter the date of death as the event date. For single coverage, the end date is the end of the month of the employee's death (a payroll refund may be required). For family coverage, it is the end of the month through which premiums have been paid (no payroll refund will be required).

1302 Surviving Spouse and Dependents

In the event an employee or annuitant with family health coverage dies, the surviving spouse/domestic partner and/or eligible dependents will continue coverage. The surviving spouse/domestic partner may continue coverage indefinitely; dependent children (as defined under the WPE Group Health Insurance Program) may continue coverage as long as they remain eligible under the program.

Employers must submit a *Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report* (ET-4814) to ETF before processing the continuation of health insurance for eligible survivors. There will be no required employer contribution towards the monthly premium, although the employer has the option of offering to cover the survivor as a local paid annuitant if they would have done so for the employee or were doing so for the annuitant..

If the surviving spouse/domestic partner and dependents **do not** wish to continue coverage, ETF must receive a signed written request. Should the surviving spouse/domestic partner (or annuitant) and dependent(s) not elect to continue coverage, coverage will end the last day of the month for which premiums have been paid.

Upon notification of the death of an employee or annuitant who has family coverage, ETF will send the surviving spouse and dependents information about continuation rights. Premiums are due no later than the first of the month following the last month through which the decedent's premiums are paid. Premiums will be deducted from any WRS annuity the dependent may be receiving or, if employer paid, the employer will indicate this on the *Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report*. If there is no WRS annuity, or the annuity is insufficient to allow for the deduction of the premium, the survivor must pay the premium directly to the health plan.

Survivors may not add persons to the policy who were not covered at the time of death, unless the individual was previously insured under the contract of the deceased employee and regains eligibility or is a child born within 9 months of the death of the employee or annuitant.

1303 Surviving Spouse who is also a State Employee Eligible for Coverage

When an employee with family coverage dies, and the surviving spouse/domestic partner is also an eligible employee, the insured surviving spouse has two options:

1. Enroll as an employee and receive the employer contribution share toward premium. This allows the surviving spouse/dependents the right to lifetime coverage even if the spouse does not meet the retirement eligibility requirements.
2. Enroll as the surviving spouse/domestic partner and retain coverage indefinitely as indicated in subchapter 1302. Premiums may be paid through the employer as local employer-paid, through a WRS annuity or directly by the surviving spouse/domestic partner to the health plan.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Chapter 14 — Invoicing

1401 Viewing Your Invoice

1402 Reconciling Your Invoice

1403 Accepting and Paying Your Invoice - Automated Clearing House (ACH)

1404 Late Interest Charge

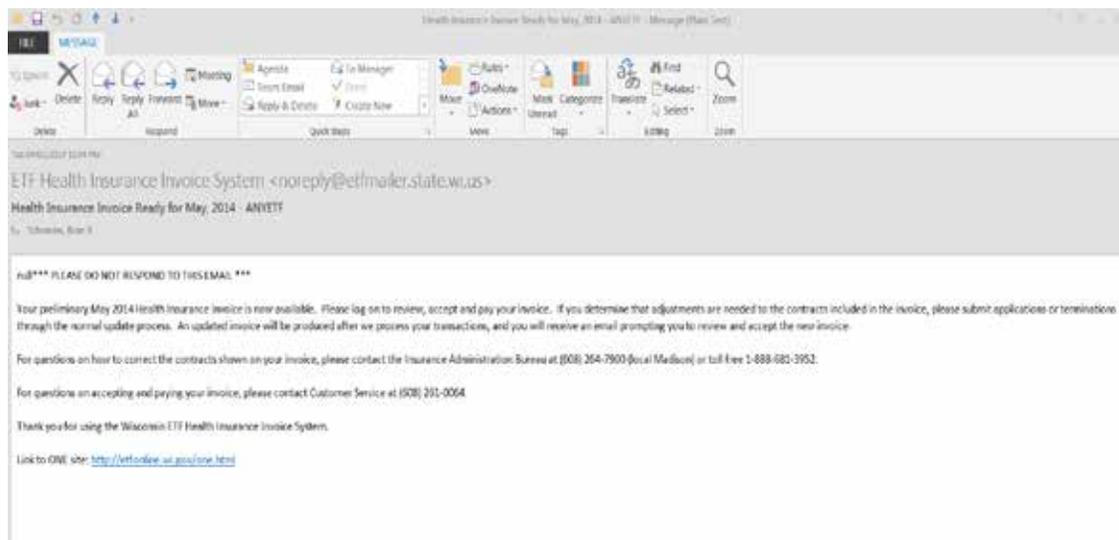
1405 Who to Contact for Assistance

1401 Viewing Your Invoice

Each month, ETF invoices employers for coverage one month in advance based on all active health insurance contracts in the myETF Benefits system. myETF Benefits is the system of record for health insurance eligibility, premium invoicing to employers, premium payment to ETF by employers and premium payment to health plans and the program's pharmacy benefits manager (Navitus) by ETF. Employers view their monthly invoice in the myETF Benefits system. Access to the myETF Benefits System is through the On Line Network for Employers (ONE).

A. Invoice Generation

During the evening on the first day of every month, the myETF Benefits system initially generates an invoice for health insurance premiums for all local employers. An e-mail is sent to all authorized employer agents and insurance contacts to alert them that an invoice is available for their review. An example of such an e-mail is below:



The e-mail address used is the one provided on the *Online Network for Employers Security Agreement (ET-8928)* when requesting access to the myETF Benefits system. The invoice charges premiums for the next calendar month on all health insurance contracts that will be active in that month.

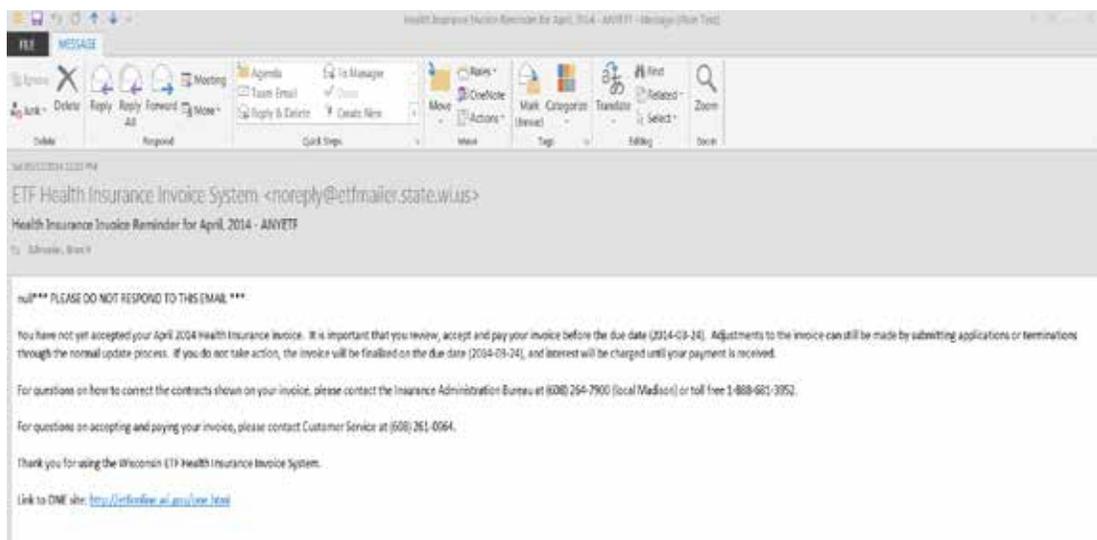
B. Invoice Regeneration and E-mail Notices

Each day, health insurance enrollments, terminations, changes in coverage level, or changes in health plans may be entered into myETF Benefits by the employee, the employer, or ETF. Whenever this is done, the invoice will regenerate to reflect what has been entered into the system. myETF Benefits will again send an e-mail to the authorized agent and insurance contacts to inform them the employer's invoice has been updated. An example of this e-mail is in Section A above. The system will go through this process each day that entries are made that change the previous days invoiced amount until the invoice is accepted by the employer. If no new entries are made that impact the previous day's invoice amount, the system will not regenerate the invoice and no additional e-mails will be sent.

Note: Changes to an employee's or dependent's personal information, physician or other insurance information will not cause the invoice to regenerate.

C. Deadlines for Accepting Monthly Invoices

Once an invoice is generated by the myETF Benefits system, an authorized employer representative can accept that invoice at any time. This is done by accessing the myETF Benefits system and going to the *Health* drop-down and selecting *Premium, Employer Invoice*. If the invoice has not been accepted, on the 15th of every month the myETF Benefits system will send an e-mail to the person authorized to accept the invoice to remind them that the employer invoice has not been accepted. An example of such an e-mail is below.



The latest date an employer must accept the invoice is the 24th of each month. If the employer invoice is not accepted by 5:45 p.m. on the 24th of each month, any unaccepted employer invoice will automatically be accepted by the myETF Benefits system. Refer to subchapter 1403 for more information on accepting and paying the monthly invoice and due dates.

D. Viewing the Employer Monthly Invoice

To access the monthly employer invoice, authorized users log into the myETF Benefits system. Once logged in, the first screen displayed to the user will be the myEmployer Info screen.

1. The user should then click on the 'Health' tab. From the drop-down, move the mouse to the 'Premium' button. Hover over the 'Premium' button to display the 'Employer Invoice' and 'Member Invoice' buttons. Hover your mouse over 'Employer Invoice' and click on that button. myETF Benefits will take the user to the next screen—*Employer E-mail Check*.



2. On this screen, the agent or authorized user can use this screen to view and update their individual e-mail contact information by clicking on the *employer e-mail address update* link. If the user is not updating their e-mail contact information, click the 'Continue' button to move to the Health Insurance Invoice Summary screen.



3. The *Health Insurance Invoice Summary* screen provides the user with the ability to search for the invoice by coverage month and year. Users can review the current coverage month's invoice or previous invoices. This screen also provides

employers with the invoice amount, invoice number, invoice date (last date the invoice generated or regenerated), accept date, accepted by, employee share field, initial payment late indicator, and interest amount. The employee share field is a field the employer will be required to complete once it is determined how much of the invoice amount is the employee share.

At the bottom of the Health Insurance Invoice Summary are the *'Invoice Detail'*, *'Contract Activity'* and *'Accept'* buttons. The *'Invoice Detail'* and *'Contract Activity'* applications can be used in conjunction with the Premium Report to reconcile the invoice; both are discussed in subchapter 1402. The *'Accept'* button is used once the invoice has been reconciled and the employer is ready to accept the invoice and pay the invoice amount. Refer to subchapter 1403 for more information and instructions on accepting and paying your invoice.



1402 Reconciling Your Invoice

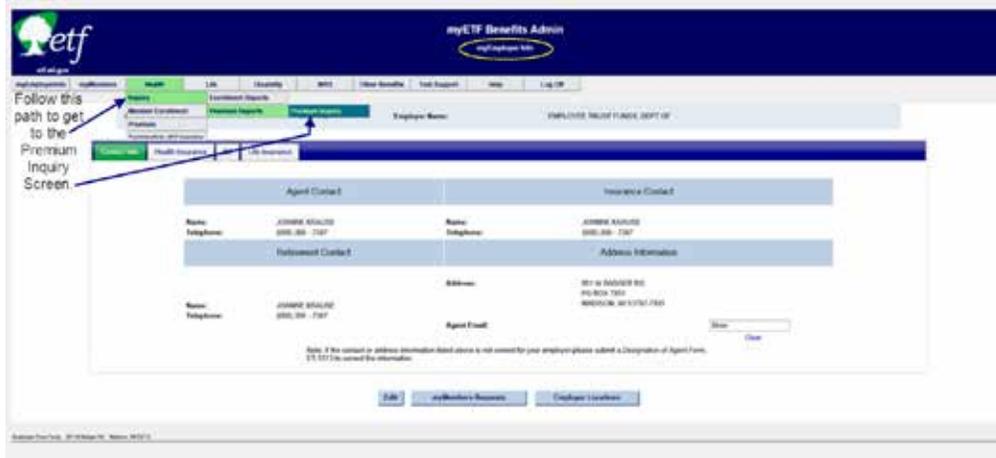
To ensure employers are accurately paying the premiums due for their employee's health insurance coverage, the invoice amount and invoice activity must be reconciled each month against the employer's payroll system. To reconcile the monthly invoice, employers have access to two reports, the 'Enrollment Report' and 'Premium Report'. In addition, employers have available to them the 'Invoice Detail' and 'Contract Activity' applications.

A. Premium Report - Employer Premium Inquiry

Under Premium Report, the Employer Premium Inquiry application is the best application available in myETF Benefits for employer use in reconciling the monthly invoice. It provides specific details on who an employer is paying for on an invoice for the coverage month being invoiced and any adjustments in previous months for the current calendar year or previous calendar year. Access to the Employer Premium Inquiry application is gained under the *'Health'* tab.

1. Upon logging in to myETF Benefits, hover over the *Health* tab. A drop-down

will appear with *'Inquiry'*, *'Member Enrollment'*, *'Premium'*, and *'Termination of Coverage'* visible. Hover over *Inquiry* which will make available the options of *Enrollment Reports* and *Premium Reports* in a drop-down to the right. With your mouse, hover over *Premium Reports*. The *'Premium Inquiry'* tab will now be available. Hover over *'Premium Inquiry'* and click on that tab.



2. When the *'Premium Inquiry'* application opens, you will get the following screen. The user must set the search filters for coverage month and year, health plan and coverage type.

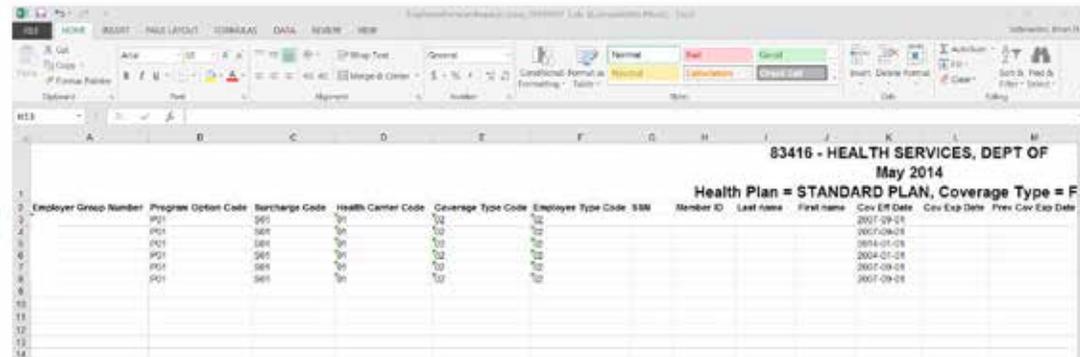
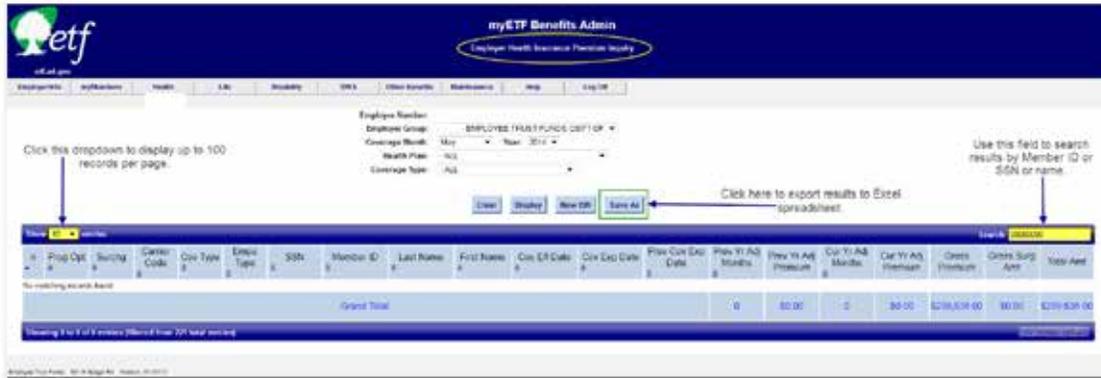


The following illustrates the results once the search filters are set and the user clicks *'Display'*. The results being displayed will provide the specific details of the employees for whom you are being billed or refunds are being generated on that coverage month's invoice by health plan and coverage type with the specific premium amount. A separate line will display for an adjustment that is refunding premiums to the employer for any month(s) in the current year or previous year and a separate line will display any adjustment that is charging premiums to the employer for any month(s) in the current year or previous year.

The user can click on *'Clear'* and set new filters from the drop-downs, then click

'Display'. The user can also go directly to the drop-downs, select new filters, then click 'Display' again without clearing the screen.

The 'Save As' button provides the user the ability to take the information being displayed and move it to an Excel spreadsheet. Using the Excel spreadsheet allows the user to sort however they wish and run it against their payroll system in their reconciliation effort.



In addition to the functionality of creating an Excel spreadsheet, employers have the ability to sort the data retrieved by each specific column without creating an Excel spreadsheet. This is accomplished by clicking on the arrow symbol (highlighted) just under each column name.

Program Code	Surcharge Code	Carrier Code	Coverage Type	Employee Type	SSN	Member ID	Last Name	First Name	Coverage Eff Date	Coverage Exp Date	Prev Cov Exp Date	Prev Yr Adj Months	Prev Yr Adj Premium	Cur Yr Adj Months	Cur Yr Adj Premium	Gross Premium	Gross Surg Amt	Total Amt
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B. Invoice Detail

Access to the Invoice Detail application is gained through the Health Insurance Invoice Summary screen. This is reached by clicking on Health, Premium, Employer Invoice as previously shown. Click on the 'Invoice Detail' button to open the application.



This application has limited use in the reconciliation process. It does not identify for the employer all the employees included in the invoice amount. It only identifies which specific employee is being added to coverage or terminated/deleted from coverage and the retroactive premium adjustments being calculated. Activity is displayed by health plan and lists employee type, coverage type, the activity (ADD, TERM, or DELETE), the date the activity was created, employee’s Social Security number, employee’s name, coverage effective date, coverage expiration date (if applicable), previous expiration date on a reinstatement, premium and adjustment for premium. The adjustment indicates the amount being charged or refunded. There is a current year adjustment and previous year adjustment field that will indicate the number of months for which premiums are being charged or refunded. The ‘Save As’ button provides the employer with the functionality to move this data to an Excel spreadsheet. From there, the data can be sorted however the employer wishes to in their reconciliation effort.



D. Enrollment Reports – Enrollment Inquiry, Dependent Inquiry and Address Inquiry

Under Enrollment Reports, the “Enrollment Inquiry” application, “Dependent Inquiry” application and “Address Inquiry” application are available. The three enrollment reports are described in this chapter. The Enrollment Inquiry is very similar to the Premium Inquiry. This report will tell you specifically which employee has active coverage under the employer’s group number on a specific coverage month. However, this application will not provide any information regarding previous months and previous year premium adjustments or current month premiums. The Premium

Inquiry application is the best application available in myETF Benefits for employer use in reconciling the monthly invoice.

1403 Accepting and Paying Your Invoice

Automated Clearing House (ACH)

Accepting the Invoice:

After viewing and reconciling the invoice, employers must accept the invoice:

1. Key in the Employee Share amount and then click the *'Accept'* button on the Invoice and Payment Summary screen.
2. On the next screen, review the invoice details and if everything is okay, click *'Confirm'*. Employers will then receive an e-mail acknowledging the acceptance of the invoice. Once an invoice has been accepted, no further changes can be made to it.

If an invoice has not been accepted by the due date, the system will automatically accept it on the employer's behalf that night. The employer will receive an e-mail letting them know that the system has accepted the invoice and they need to submit a payment.

Accepting and confirming the invoice does not mean a payment has been initiated.

Paying the Invoice:

ETF uses myETF Benefits as the system of record. The *invoice premium due* field is the amount owed to ETF. The invoice reflects what ETF will remit to the health plans on behalf of the employers.

Employers are set up to pay by Automated Clearing House (ACH).

Automated Clearing House (ACH):

For local employers, after confirming their invoice they will be automatically taken to the US Bank E-Payment Log In screen. They can Log In, Register, or Pay Without Registering.

Log In – User should select this option if they have already registered for an account. This is separate from ETF's Online Network for Employers (ONE) or myETF Benefits and uses a different User ID & Password.

Register – Simply follow the prompts to create an account. Registering allows users to save their contact and banking information. Registered users can also view their account information including prior and pending payments.

Pay Without Registering – This option allows a user to pay the invoice without having to log in to an account. The contact and banking information has to be keyed, but does not get saved for future use.

ABC Co. Make life simple

[Exit](#)

Welcome to the Electronic Payment System

Please enter your User ID and Password and click Log In.

User ID [Forgot Your User ID?](#)

Password [Forgot Your Password?](#)

Log In

[Register](#)

[Pay Without Registering](#)

powered by **usbank**

[Customer Service](#) | [Help](#) | [Privacy Policy](#) | [Security](#)

Next will be the **Make a Payment** screen.

ABC Co. Make life simple

Your last visit was Thu 10/03/2013 11:23 AM CDT

[Make a Payment](#) [My Account](#)

Make a Payment

[My Payment](#)

Payment for Your Organization

Amount Due \$45.00

Due Date 10/15/2013

Account Number

[Payment Information](#)

Frequency One Time

Payment Amount \$45.00

Payment Date Pay now Pay on a future date

[Payment Method](#)

Saved Payment Methods Select [Use a new payment account](#)

Email Address test.user@corp.com

Continue [Cancel](#)

This will have 3 sections.

1. My Payment – This will show the Amount Due and Due Date

2. Payment Information – This is where users will select their payment terms:
 - a. Frequency – Select One Time.
 - b. Payment Date – Select either Pay Now or Pay on a future date.
 - i. Selecting Pay on a future date allows the user to select the date the funds will be withdrawn. It can be any date in the future, but preferably on or before the due date.
 - c. If the user is not using a registered account, the user will get a Contact information Section to fill out.

Contact Information

First Name: Test
Last Name: User
Company: (Optional)
Address 1: 123 Street
Address 2:
City: 123 City
State: +21
Zip Code: 12345 (Optional)
Phone Number: 1231231234
Email Address: test.user@corp.com
[Become a Registered User](#)

3. Payment Method – If a user is registered this will be the saved banking account.
 - a. If a user is paying without registering, the user will need to fill in the banking information.

Payment Method: Checking or Savings

Sample Check
123 Main St.
Anytown, MO 12345
DATE: 1215
PAY TO THE ORDER OF: \$
DOLLARS
123456789 055 11111111 001215
Bank Routing Number Bank Account Number Check Number
Personal Check | [Business Check](#)
Bank Routing Number
Bank Account Number
Bank Account Type: Checking Savings
 This is a business account
 Save this payment account for future use
Email Address: test.user@corp.com

Once all 3 sections are complete, click 'Continue'.

The Review Payment screen will appear. Verify that it's correct. If okay, user can click 'Continue'.

Your last visit was Thu 09/19/2013 04:47 PM CDT

[Make a Payment](#) [My Account](#)

Review Payment

Please review the information below and select **Confirm** to process your payment. Select **Back** to return to the previous page to make changes to your payment.

Payment Details

Description	KR Corp Payment for Your Organization www.krcorp.com
Payment Amount	\$45.00
Payment Date	09/19/2013
Payment Due Date	09/30/2013

Payment Method

Account Nickname	visa
Payer Name	Test User
Card Number	*1111
Expiration Date	Jul-2015
Card Type	Visa
Confirmation Email	test.user@corp.com

Billing Address

Address 1	1234 S. Main
Address 2	Apt. 1234
City	1234
State	1234
Zip Code	12345

[Confirm](#) [Back](#)

powered by [Customer Service](#) | [Help](#) | [Privacy Policy](#) | [Security](#)

If successful, a printable Confirmation Page appears that will include a confirmation number. The user will also receive an e-mail with the confirmation number and payment details.

Your last visit was Thu 09/19/2013 04:47 PM CDT

[Make a Payment](#) [My Account](#)

Confirmation

Thank you for your payment.
Please keep a record of your Confirmation Number, or [print this page](#) for your records.
Confirmation Number: **KATABC000001543**

Payment Details

Description	KR Corp Payment for your organization www.krcorp.com
Payment Amount	\$45.00
Payment Date	09/19/2013
Payment Due Date	09/30/2013
Status	PROCESSED

Payment Method

Account Nickname	visa
Payer Name	Test User
Card Number	*1111
Card Type	Visa
Confirmation Email	test.user@corp.com

Billing Address

Address 1	123 Street
Address 2	
City	123 City
State	123 State
Zip Code	12345

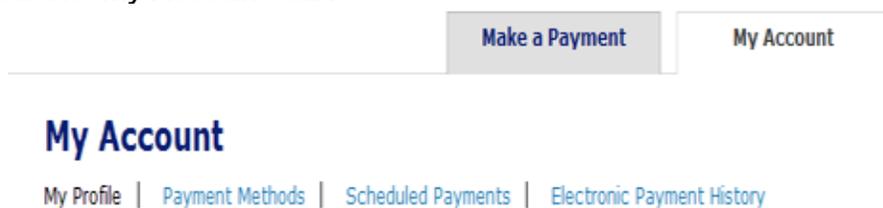
powered by [Customer Service](#) | [Help](#) | [Privacy Policy](#) | [Security](#)

Upon successful completion, the payment will post to the employer's invoice at 11:00 a.m. on the payment date selected.

There is no direct link to the U.S. Bank E-Payment Service so if an employer exits before scheduling a payment they will need to log back into myETF Benefits. Instead of the 'Accept' button, the employer will see a 'Pay' button. Click 'Pay' and then 'Confirm' on the next screen. The 'Pay' button is displayed until a payment has been posted to the invoice.

If a warning message displays stating that the invoice may have already been paid, employers should check their records. Here are four ways to check if payment has been previously made:

1. Check for print out of E-Payment Confirmation Page.
2. Check e-mails – Employers would have received an e-mail with the payment details and a confirmation number.
3. Call ETF using the phone number listed on the invoice – Staff will be able to look up any scheduled payments.
4. Continue on to the US Bank E-Payment Service and Log In if they are a registered user.
 - a. Click on the 'My Account' tab.



- b. Go to **Scheduled Payments** – This will list any pending payments. It will remain here as pending until the payment date.
 - i. If there is a pending payment, no further action is needed and the user can logout.
 - ii. If there is no pending payment, the user should select the 'Make a Payment' tab and complete the process to submit a payment.

1404 Late Interest Charge

Payment is due the 24th of every month, with exceptions being weekends and US Bank holidays. If a payment is received after the due date then a late payment interest charge will be applied to the employer's invoice based on the following calculation:

Interest Charge = Invoice Premium Due x Number of days late x 0.04%

The interest charge will be assessed after the payment has been submitted and should

be paid as soon as possible. Employers paying by ACH will have to log in to myETF Benefits and select the invoice month and year that received the interest charge. There should be an outstanding amount due. Just click on 'Pay' and it will take you through the normal ACH payment process via the US Bank E-Payment System.

Other Features - My Account:

Users have the ability to view other features in the 'My Account' tab.

1. **My Profile** – This is where a user's Contact Info and Log In Details are stored. Changes can be made here as needed.

The screenshot displays the 'My Account' web interface. At the top, there is a navigation bar with links for 'My Profile', 'Payment Methods', 'Scheduled Payments', and 'Electronic Payment History'. Below this, the 'My Contact Information' section contains several input fields: First Name (Test), Last Name (User), Company (Optional), Address 1 (123 Street), Address 2 (Apt. 123), City (123 City), State (123), Zip Code (12345) (Optional), Phone Number ((123)123-1234), and Email Address (test.user@corp.com). The 'Login Details' section below it includes fields for User ID (krtest1), Password (****) with a 'Change my Password' link, and three security questions with their respective answers: 'What was the name of your childhood best friend?' (Sue), 'What is your favorite sports team?' (Spartans), and 'What is your mother's maiden name?' (Lynn). At the bottom of the form, there are 'Save' and 'Cancel' buttons.

2. **Payment Methods** – This will list any saved banking accounts. If users need to update their banking information this is where they will need to go. They have the option to edit or delete an existing account and to add a new account by selecting Add a Payment Method.

My Account

[My Profile](#) | [Payment Methods](#) | [Scheduled Payments](#) | [Electronic Payment History](#)

Saved Payment Methods

[Add a Payment Method](#)

Nickname	Method	Type	Number	Actions
Test Visa	Credit	Visa	*1111	Edit Delete

- 3. Electronic Payment History** – This is where users can go to view past payments. Status will be marked as Processed. Data can be sorted by any of the columns and there is also a search filter.

My Account

[My Profile](#) | [Payment Methods](#) | [Scheduled Payments](#) | [Electronic Payment History](#)

Electronic Payment History

Show entries

Search Filter:

Confirmation Number	Payment Date	Amount	Payment Method	Status
	09/11/2013	\$45.00	*1111	PROCESSED
	08/27/2013	\$45.00	*1111	PROCESSED
	08/27/2013	\$60.20	*1111	PROCESSED
	08/19/2013	\$60.20	*1111	PROCESSED
	08/15/2013	\$45.00	*1111	PROCESSED

Showing 1 to 5 of 5 entries

[First](#) [Previous](#) [1](#) [Next](#) [Last](#)

1405 Who to Contact for Assistance

For help accepting an invoice, paying an invoice, or logging into the US Bank E-Payment System please contact:

- Laura Vang: 1-608 261-0064 or laura.vang@etf.wi.gov.
- Rolanda Franklin: 1-608-266-0781 or rolanda.franklin@etf.wi.gov.

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Appendix A — Forms and Brochures

Document name	Form number	Link
WRS Administration Manual	ET-1127	http://etf.wi.gov/publications/et1127.pdf
Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits (Health Insurance contract)	ET-1136	Contact ETF for a copy.
It's Your Choice Decision Guide	ET-2128d	http://etf.wi.gov/members/IYC2015/15et2128d.pdf
It's Your Choice Reference Guide	ET-2128r	http://etf.wi.gov/members/IYC2015/15et2128r.pdf
WPE Standard PPO Plan Program Option 2 Booklet	ET-2131	http://etf.wi.gov/publications/et2131.pdf
WPE Standard PPO Plan Program Option 4 Booklet	ET-2162	http://etf.wi.gov/publications/et2162.pdf
WPE Standard PPO Plan Program Option 6 Booklet	ET-2160	http://etf.wi.gov/publications/et2160.pdf
WPE Standard PPO Plan HDHP Program Option 7 Booklet	ET-2170	http://etf.wi.gov/publications/et2170.pdf
Medicare Plus Booklet	ET-4113	http://etf.wi.gov/publications/et4113.pdf
Health Insurance Application/Change	ET-2301	http://etf.wi.gov/publications/et2301.pdf
COBRA Continuation Conversion Notice	ET-2311	http://etf.wi.gov/publications/et2311.docx
Rehired Annuitant Form	ET-2319	http://etf.wi.gov/publications/et2319.pdf
Converting Your Group Life Insurance to Pay for Health Insurance or Long Term Care Insurance Premiums	ET-2325	http://etf.wi.gov/publications/et2325.pdf
Affidavit of Domestic Partnership	ET-2371	http://etf.wi.gov/publications/et2371.pdf
Affidavit of Termination of Domestic Partnership	ET-2372	http://etf.wi.gov/publications/et2372.pdf
Group Health Insurance	ET-4112	http://etf.wi.gov/publications/et4112.pdf
Medicare Eligibility Statement	ET-4307	http://etf.wi.gov/publications/et4307.pdf
Employer Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report	ET-4814	http://etf.wi.gov/publications/et4814.pdf

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Appendix B — Codes

- B-1 Employee Type Codes**
- B-2 Coverage Type Codes**
- B-3 Individual Relationship Codes**
- B-4 Program Option Codes**
- B-5 Surcharge Codes**
- B-6 Health Plan Codes**

B-1 Employee Type Codes

Code	Employee Coverage	Description
06	Local	Eligible local government employee.
07	WRS Annuitant	Retired employee eligible for health insurance.
15	Local Surviving Spouse/Dependent	Currently insured subscriber dies while carrying family health insurance coverage.
09	Local Paid Annuitant	WRS annuitant whose former employer pays all or part of the monthly health insurance premium.

B-2 Coverage Type Codes

Code	Type of Coverage	Description
01	Single	Coverage is for the subscriber (employee) only.
02	Family	Coverage is for the subscriber (employee) and eligible dependent(s).
05	Medicare - Single	Single coverage for annuitant or continuant subscriber with Medicare.
06	Medicare - Family 1	Family coverage for annuitant or continuant subscriber; one or more persons with Medicare.
07	Medicare - Family 2	Family coverage for annuitant or continuant subscriber, subscriber and all dependents with Medicare.

B-3 Individual Relationship Codes

Code	Definition
01	Spouse
03	Parent of Minor Dependent
15	Permanent Legal Ward
17	Stepchild
18	Self
19	Child
24	Dependent of a Minor Dependent
38	Dependent of Domestic Partner
53	Domestic Partner

B-4 Program Option Codes

Code	Definition
PO2	Full pay HMO option paired with the Standard PPO
PO4	Deductible HMO option paired with Standard PPO
PO6	Coinsurance HMO option paired with Standard PPO
PO7	High Deductible Health Plan HMO paired with Standard PPO

B-5 Surcharge Codes

The surcharge code can be found in the myETF Benefits System (MEBS) on the EmployerInfo screen under the 'Health Insurance' tab. It is the second item in the first line. The surcharge code can also be found under the 'Health' button, under 'Member Enrollment'. On the member screen, under 'Employer' you will see the employer name, then the Program Option/Surcharge Code.

The surcharge code is assigned after the employer submits information to underwriting when enrolling in the Wisconsin Public Employers' (WPE) Group Health Insurance Program. Underwriting compares the claims experience of the employer's employees over the last 2 to 3 years to the pool of currently insured employees in the WPE Group Health Insurance Program. If the claims experience (risk) is higher than the claims experience in the pool, the increased exposure is off-set by a surcharge of up to 80% of the average cost of the WPE health plans.

The code for no surcharge is S01. All other surcharge codes designate a certain amount of surcharge. The surcharge is added to the premium for the health plan; the employer and employee shares are apportioned. The surcharge for an employer joining the WPE Group Health Insurance Program on January first will run for one year. Beginning the second year, the surcharge reduces by about half. Beginning the third year of participation, the surcharge reduces to zero and will be designated as S01.

B-6 Health Plan Codes

Code	Health Plan Name
A1	STANDARD PLAN DANE
A2	STANDARD PLAN MILWAUKEE
A3	STANDARD PLAN WAUKESHA
A4	STANDARD PLAN WISCONSIN
A5	SMP
11	ANTHEM BLUE PREFERRED SOUTHEAST
14	ANTHEM BLUE PREFERRED NORTHEAST
15	DEAN HEALTH INSURANCE
17	DEAN HEALTH INSURANCE PREVEA360
21	HUMANA EASTERN
22	HUMANA WESTERN
30	GHC OF EAU CLAIRE
35	GHC OF SOUTH CENTRAL WISCONSIN
37	GUNDERSEN HEALTH PLAN
40	UNITY HEALTH INSURANCE COMMUNITY
47	ARISE HEALTH PLAN NORTHERN
48	ARISE HEALTH PLAN SOUTHEAST (eff. 01/01/2015)
55	HEALTH TRADITION HEALTH PLAN
63	MEDICAL ASSOCIATES HEALTH PLAN
64	MERCYCARE HEALTH PLANS
70	NETWORK HEALTH
71	SECURITY HEALTH PLAN
74	PHYSICIANS PLUS
84	WPS METRO CHOICE SOUTHEAST (withdrawn 12/31/2014)
85	HEALTHPARTNERS HEALTH PLAN
86	WEA TRUST EAST
87	WEA TRUST NORTHWEST CHIPPEWA VALLEY
88	WPS METRO CHOICE NORTHWEST (withdrawn 12/31/2014)
89	WEA TRUST SOUTHCENTRAL
90	WEA TRUST NORTHWEST MAYO CLINIC HEALTH SYSTEM (eff. 01/01/2015)
92	UNITY HEALTH INSURANCE UW HEALTH
94	UNITEDHEALTHCARE OF WISCONSIN
HA	ANTHEM BLUE PREFERRED SE HDHP
HB	ANTHEM BLUE PREFERRED NE HDHP
HC	DEAN HEALTH INSURANCE HDHP
HD	DEAN HEALTH INSURANCE PREVEA360 HDHP
HE	HUMANA EASTERN HDHP
HF	HUMANA WESTERN HDHP
HG	GHC OF EAU CLAIRE HDHP

Local Health Insurance Administration Manual
 Appendix B — Codes

Code	Health Plan Name
HH	GHC OF SOUTHCENTRAL WI HDHP
HI	GUNDERSON HEALTH PLAN HDHP
HJ	UNITY COMMUNITY HDHP
HK	ARISE HEALTH PLAN NORTHERN HDHP
HL	ARISE HEALTH PLAN SOUTHEAST HDHP
HM	HEALTH TRADITION HEALTH PLAN HDHP
HN	MEDICAL ASSOCIATES HEALTH PLAN HDHP
HO	MERCYCARE HEALTH PLAN HDHP
HP	NETWORK HEALTH HDHP
HQ	SECURITY HEALTH PLAN HDHP
HR	PHYSICIANS PLUS HDHP
HS	HEALTHPARTNERS HEALTH PLAN HDHP
HT	WEA TRUST EAST HDHP
HU	WEA TRUST NW CHIPPEWA VALLEY HDHP
HV	WEA TRUST SOUTHCENTRAL HDHP
HW	WEA TRUST NW MAYO CLINIC HLTH SYS HDHP
HX	UNITY HEALTH INSURANCE UW HEALTH HDHP
HY	UNITEDHEALTHCARE OF WI HDHP
H1	HDHP-STANDARD PLAN DANE (LOCAL)
H2	HDHP-STANDARD PLAN MILWAUKEE (LOCAL)
H3	HDHP-STANDARD WAUKESHA (LOCAL)
H4	HDHP-STANDARD WISCONSIN (LOCAL)
H5	HDHP-SMP (LOCAL)
H6	STANDARD PLAN HDHP
H7	SMP HDHP

**Department of Employee Trust Funds
Local Health Insurance Administration Manual**

Appendix C — myETF Benefits

C-1 How to Log Into myETF Benefits

C-2 Add Coverage

C-3 Add Dependent

C-4 Remove Dependent

C-5 Change Health Plans

C-6 Termination of Coverage

C-7 Pending Transactions

C-8 Enrollment Inquiry

C-9 Dependent Inquiry

C-10 Address Inquiry

C-1. How to Log into myETF Benefits

To get started in myETF Benefits you must first obtain access to the system by completing and submitting an *Online Network for Employers Security Agreement* (ET-8928) to the Department of Employee Trust Funds, on which you request access to myETF Benefits for Administrators for the following areas:

- Health Eligibility Inquiry
- Health Eligibility Update
- Health Premium Inquiry
- Health Premium Payment

Once access has been granted, you will need to go on-line through the Online Network for Employers (ONE) Site to get to the myETF Benefits system.

1. Go to the ETF website at etf.wi.gov.
2. Click on the “Employers” tab at the top of the screen.
3. Click on “myETF Benefits for Administrators” in the gray menu.





4. Enter your User ID and Password.



5. Enter your employer number and click the 'Verify' button.

myETF Benefits Admin
Employer Info

EmployerInfo myMembers Health Life Disability WES Other Benefits Help Log Off

Employer Specific Function - Employer Number Required

Use this screen to specify the employer whose data you would like to access. You must provide the employer's seven digit employer number. You must have the authority to access this information.

Please enter the seven digit Employer Number and click Verify

Employer Number:

Verify

Employee Trust Funds 821 W Badger Rd Madison, WI 53713

6. You will be directed to the myEmployerInfo screen. From here, you can update your information as well as select functions from the drop-down menus.

myETF Benefits Admin
myEmployerInfo

EmployerInfo myMembers Health Life Disability WES Other Benefits Help Log Off

Employer Number: XXXX-XXXX Employer Name: EMPLOYER

Contact Us Health Insurance Life Insurance Disability Insurance

Agent Contact Insurance Contact

Name: AGENT NAME Telephone: 0000-XXX-XXXX

Name: AGENT NAME Telephone: 0000-XXX-XXXX

Retirement Contact Address Information

Name: AGENT NAME Telephone: 0000-XXX-XXXX

Address: AGENT ADDRESS CITY, ST ZIPCODE

Agent Email: An agent email available More Clear

myMembers Requests New EIN Employee Locations

Employee Trust Funds 821 W Badger Rd Madison, WI 53713

C-2. Add Coverage

A Health Insurance Application/Change Form (ET-2301) has been received for one of the “Add Coverage” reasons, all information has been verified, and the employer section completed. Refer to the sample form below:

ETF Use Only		State of Wisconsin Department of Employee Trust Funds (ETF) Health Insurance Application/Change Form						Employer Notes		
1. APPLICANT INFORMATION			ETF Member ID			SSN <u>XXX-XX-XXXX</u>				
Applicant Name – First <u>FIRST</u>	M.I. <u>M</u>	Last <u>LAST</u>	Previous Name		DOB MM/DD/CCYY	Gender M	Physician/Clinic PRAIRIE CLINIC			
Home Mailing Address—Street and No. <u>1234 STREET LANE</u>			City <u>CITY</u>	State <u>ST</u>	Zip Code <u>ZIPCODE</u>	<input type="checkbox"/> Check here if updating address phone, email, or marital status.				
Primary Telephone Number: (608) 555-1111			Country (if not USA)		Applicant E-mail:					
MARITAL OR DOMESTIC PARTNERSHIP STATUS: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership (DP) <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Date: <u>MM/DD/CCYY</u>										
Spouse/DP: SSN <u>XXX-XX-XXXX</u>			Name <u>FIRST NAME/LAST NAME</u>							
Previous Name <u>MAIDEN NAME</u>			Physician/Clinic <u>PRAIRIE CLINIC</u>							
DOB: <u>MM/DD/CCYY</u>			Gender: <u>F</u>			Tax Dep <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
ELIGIBILITY STATUS: <input checked="" type="checkbox"/> Employee <input type="checkbox"/> Graduate Assistant <input type="checkbox"/> Survivor <input type="checkbox"/> Continuant (COBRA) <input type="checkbox"/> Annuitant/Retiree				NEW HIRE — I WANT MY COVERAGE TO BE EFFECTIVE: <input checked="" type="checkbox"/> As soon as possible (Employee will pay entire monthly premium until eligible for contribution) <input type="checkbox"/> When employer contributes to premium						
Coverage Desired <input type="checkbox"/> Single <input checked="" type="checkbox"/> Family			Health Plan Selected: <u>Unity - Community</u>							
2. REASON FOR APPLICATION Reasons marked with an * require supporting documentation. See page 4 of this application for specific documentation requirements.										
A. Decline Coverage (Check one box below and go to Section 6 to sign and date your application.) <input type="checkbox"/> I do not wish to enroll at this time. <input type="checkbox"/> I do not wish to enroll at this time as I currently have other insurance coverage.										
B. Enrollment (Check a Reason and an Event below and indicate the date of event. Update Dependent Information below as appropriate) Note: Deletion of a Dependent due to loss of eligibility provides a COBRA enrollment opportunity. Notice must be provided to Employer within 60 days of event.										
Reason: <input checked="" type="checkbox"/> Add Coverage (Add Cvg) <input type="checkbox"/> Add Dependent (Add Dep) <input type="checkbox"/> Remove Dependent (Rem Dep)										
Event:										
<input checked="" type="checkbox"/> New Hire (Add Cvg)			<input type="checkbox"/> State Annuitant/Retiree Re-enroll Effective Date _____ (Add Cvg)							
<input type="checkbox"/> Spouse/DP to Spouse/DP Transfer (Add Cvg)			<input type="checkbox"/> Eligible Dependent Not Included on Initial Enrollment (Excludes DP and Adult Dependents)							
<input type="checkbox"/> Transfer from One Employer to Another Employer (Add Cvg)			<input type="checkbox"/> Loss of other Coverage/Employer Contributions* (Add Cvg, Add Dep)							
Name of Previous Employer _____			<input type="checkbox"/> Divorce*/DP Terminated* (Rem Dep)							
<input type="checkbox"/> Marriage/DP* (Add Cvg, Add Dep)			<input type="checkbox"/> Death of Dependent (Rem Dep)							
<input type="checkbox"/> Birth (Add Cvg, Add Dep)			<input type="checkbox"/> Disabled Dependent: Disability Ends or Dependent Marries or Support less than 50% (Rem Dep)							
<input type="checkbox"/> Adoption* (Add Cvg, Add Dep)			<input type="checkbox"/> Grandchild's Parent Turns 18 (Rem Dep)							
<input type="checkbox"/> National Medical Support Notice* (Add Dep)			<input type="checkbox"/> Adult Dependent Eligible for other coverage (Rem Dep)							
<input type="checkbox"/> Paternity Acknowledgment* (Add Dep)			<input type="checkbox"/> Annual It's Your Choice (Jan. 1) (Add Cvg, Add Dep, Rem Dep)							
<input type="checkbox"/> Legal Ward/Guardianship* (Add Dep)			<input type="checkbox"/> COBRA (Add Cvg)							
<input type="checkbox"/> Legal Ward/Guardianship Ends* (Rem Dep)			<input type="checkbox"/> Other: _____							
<input type="checkbox"/> Disabled, Age 26 or Older* (Add Dep)			Event Date: <u>09/19/2013</u> (required)							
<input type="checkbox"/> LTE New Hire - State Only (Add Cvg)										
DEPENDENT INFORMATION (excludes spouse/DP) — Complete all requested information.										
Social Security Number	First Name	M.I.	Last	Previous	Birth Date (mm/dd/ccyy)	Gender (M/F)	Rel. Code	Tax Dep? (Y/N)	Disabled? (Y/N)	Enter Physician/Clinic or Provide Dependent address for COBRA, if removing dependent.
<u>XXX-XX-XXXX</u>	<u>CHILD</u>	<u>M</u>	<u>LAST</u>		<u>MM/DD/CCYY</u>	<u>F</u>	<u>19</u>	<u>Y</u>	<u>N</u>	<u>PRAIRIE CLINIC</u>

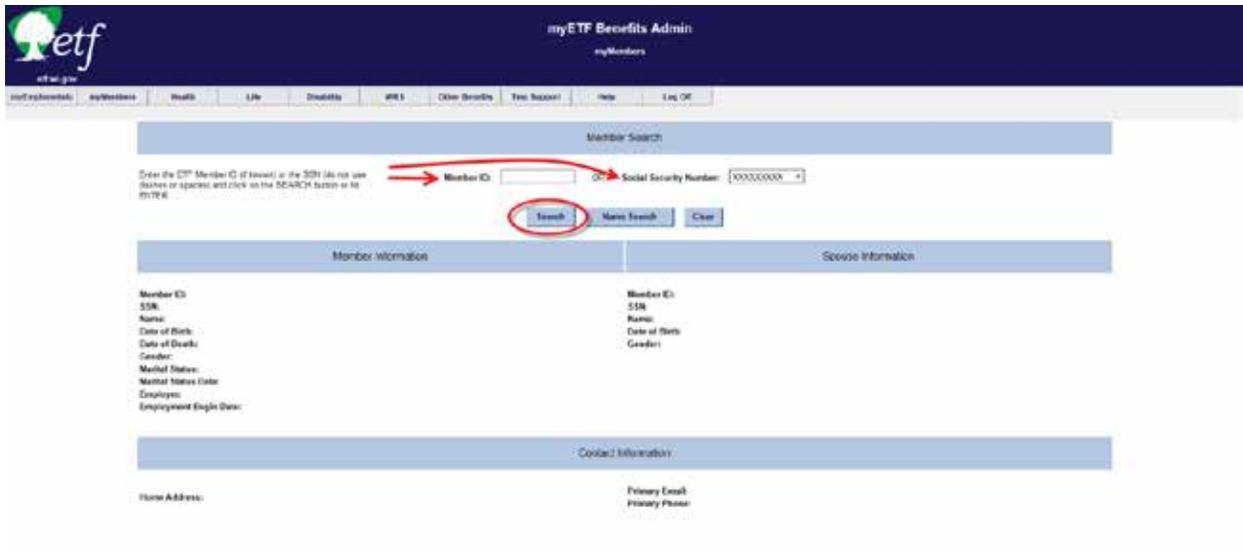


Applicant Name XXXXXXXX		ETF Member ID	SSN XXXXXXXXXX
2. REASON FOR APPLICATION (continued) Reasons marked with an * require supporting documentation. See page 4 of this application for specific documentation requirements.			
C. Change Health Plan (Check one box below, Indicate Current Health plan, Provide date of event, Update Section 1 or 2 if applicable) <input type="checkbox"/> Move from Service Area <input type="checkbox"/> Eligible Section 125 Status Change (see Instructions, Section 2(4))* <input type="checkbox"/> Annual It's Your Choice (Jan. 1) Current Health Plan: _____ Event Date: _____			
D. Spouse/DP/Dependent Personal Data Update/Correction <input type="checkbox"/> Update Name/SSN/DOB (Complete Section 1 or 2) Previous Name _____ Previous DOB _____ Previous SSN _____			
E. Cancel Coverage: <input type="checkbox"/> I wish to cancel coverage: Event Date _____ (Check a post-tax or pre-tax box below.) My Premiums are Deducted: <input type="checkbox"/> Post-tax, Coverage may be cancelled at any time <input type="checkbox"/> Pre-tax (If pre-tax check a box below.) <input type="checkbox"/> I am terminating employment. <input type="checkbox"/> My employee premium contribution has increased significantly.* <input type="checkbox"/> I am going on unpaid leave of absence. <input type="checkbox"/> I (and all dependents if applicable) became eligible for and enrolled in other group coverage.* <input type="checkbox"/> Cancel current family coverage to perform a spouse to spouse transfer. <input type="checkbox"/> Eligible Section 125 Status Change* (see Instructions, Section 2(4))* <input type="checkbox"/> Annual It's Your Choice Enrollment (Jan. 1). Event: _____			
Note: If pre-tax, coverage may only be cancelled due to a qualifying event or during the annual It's Your Choice period.			
F. Family to Single Coverage: If your employee premium share is taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage. My employee-required premium contribution is deducted (Check one box below, indicate event date, and update Section 1): <input type="checkbox"/> Pre-tax and my employee premium contribution has increased significantly <input type="checkbox"/> Pre-tax and my last dependent has become ineligible for this coverage. <input type="checkbox"/> Pre-tax and all dependents became eligible for and enrolled in other group coverage.* <input type="checkbox"/> Pre-tax, eligible Section 125 Status Change (see Instructions, Section 2(4))* Event: _____ <input type="checkbox"/> Pre-tax, change to single during annual It's Your Choice (Jan. 1). Event Date: _____ <input type="checkbox"/> Post-tax, midyear changes to coverage level can be made at any time.			
3. ADDITIONAL INFORMATION Are any of the dependents listed under Dependent Information your or your spouse/DP's grandchild? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of parent _____			
4. MEDICARE INFORMATION/UPDATE MEDICARE INFORMATION Are you or any insured dependent covered under Medicare? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If yes, list names of insured and Medicare dates. Name: _____ Dates: Part A _____ Part B _____ HIC # _____ Name: _____ Dates: Part A _____ Part B _____ HIC # _____			
5. OTHER HEALTH INSURANCE COVERAGE/UPDATE OTHER HEALTH INSURANCE (If yes, complete requested information) Other coverage? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Name of Company _____ Policy #: _____ Group #: _____ Name(s) of Insured: _____			
6. SIGNATURE (Read the TERMS AND CONDITIONS on page 7 and sign the application.) By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and I have read and agree to the TERMS AND CONDITIONS. A copy of this application is to be considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. §943.395. Additional documentation may be required by ETF at any time to verify eligibility.			
SIGN HERE & Return to Employer 		Signature Date Signed (mm/dd/yy) 09/23/13	
7. EMPLOYER COMPLETES (Coding instructions are in the Employer Health Insurance Administration Manual)			
Employer Number 69-036-XXXX-XXX		Name of Employer NAME OF EMPLOYER	
Payroll Representative E-mail			
Group Number XXXX	Employee Type 02	Coverage Type Code 02	Health Plan Name or Suffix UNITY COMMUNITY/40
EMPLOYMENT STATUS: <input checked="" type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> LTE		Employee Deductions: <input checked="" type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax	
Previous Service - Complete Information 1. Are you a WRS participating employer? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If Yes, answer questions 2, 3, and 4. 2. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. Previous service check completed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 4. Source of previous service check: <input checked="" type="checkbox"/> Online Network for Employers (ONE) <input type="checkbox"/> ETF		Date WRS Eligible Employment or Graduate Assistant Appointment Began or Hire Date 09/19/13	Employer Received Date 09/23/13
Payroll Representative Signature/Phone Number (XXX) XXX-XXXX		Event Date	Prospective Date of Coverage
Agent Name		09/19/13	10/01/13

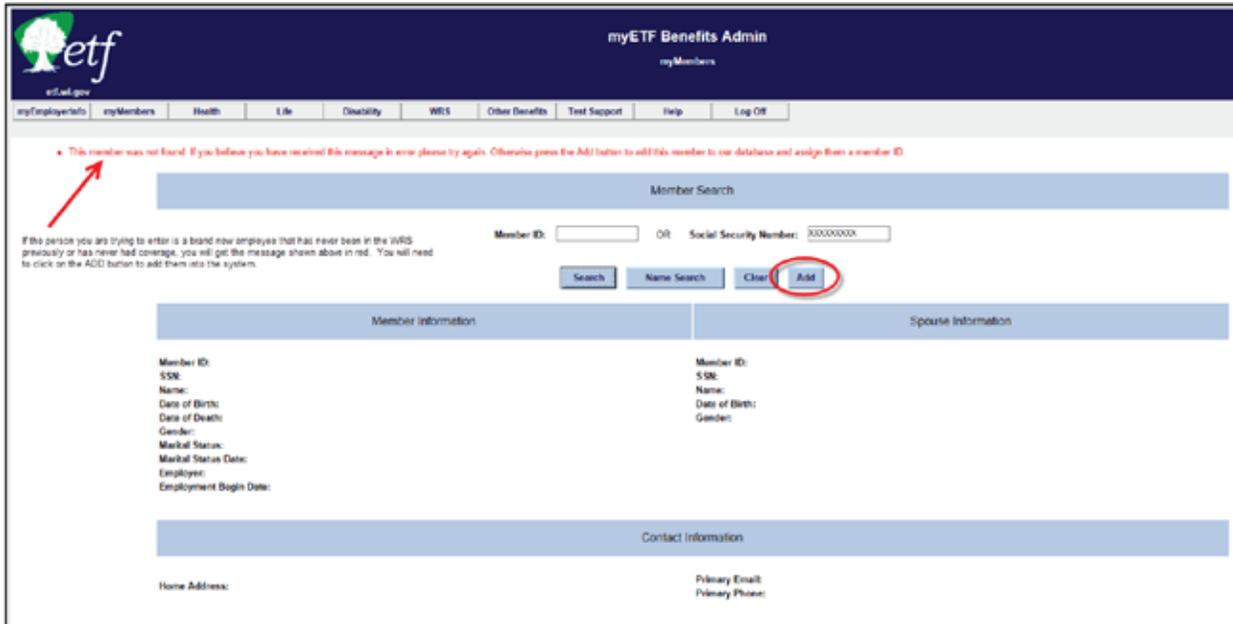
1. In myETF Benefits, highlight the myMembers tab and select myMembers from the drop down list.



2. Enter the employee's ETF Member ID or SSN into the appropriate box and click the 'Search' button or click 'Enter' (if it is a brand new employee with no prior WRS service, there will not be an ETF Member ID).



- a. If the employee’s basic demographic information pops up, scroll to the bottom of the page and click the ‘Edit’ button to enter any remaining missing information.
- b. If the employee can not be found, click the ‘Add’ button near the top of the screen.



- 3. Enter all relevant demographic information into the required fields, including the employee’s full address and phone number and click the ‘Submit’ button.



- 4. An address validation program will run and ask you to verify and select the correct address from the bottom of the screen. Select the “Finalist” address which includes the ZIP+4, and click the ‘Submit’ button again.

If the address returns to the validation screen, you may be missing the apartment number or unit number designation. Either contact the member to verify the address or if you know it is correct, then select the ‘Radio’ button in front of the address as keyed and click the ‘Submit’ button.

5. Once you are on the review page, review the data (any changes/additions will appear in red).
 - a. If all corrections/additions are correct, click the 'Confirm' button.
 - b. If additional changes are needed, click the 'Cancel' button and return to the previous screen and follow the procedures under Number 3.



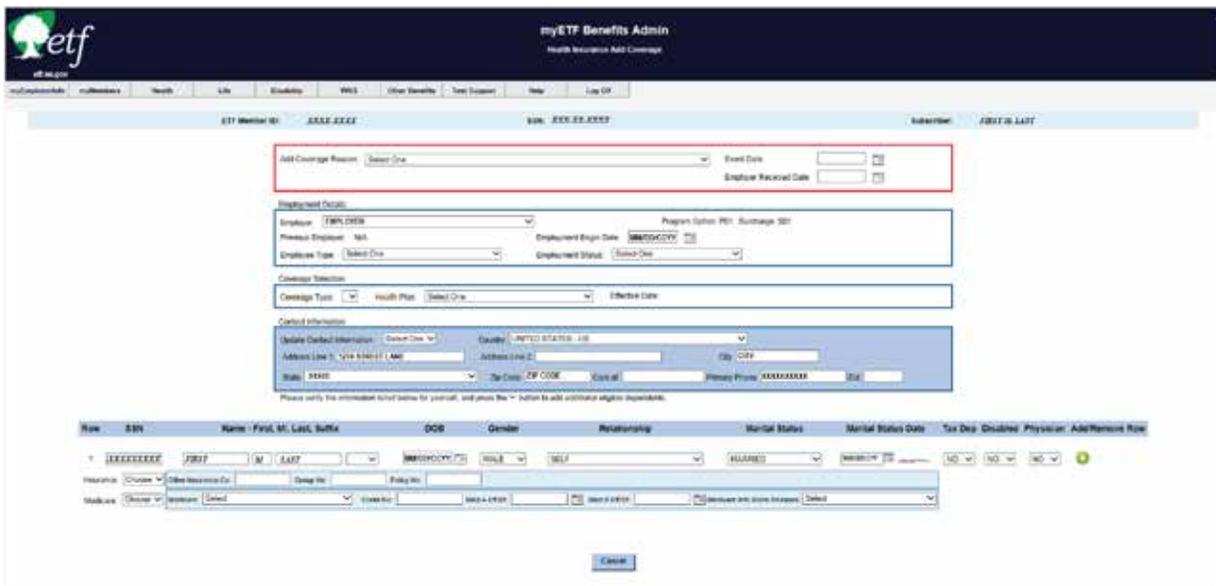
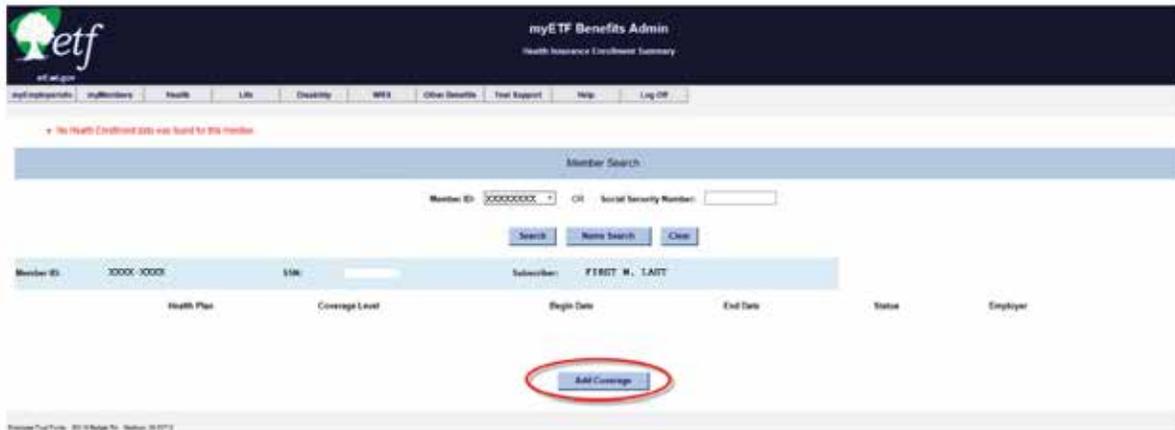
Note: This is the confirmation page you receive when adding a member into my-ETF Benefits who has never been covered by our program with any employer. This confirmation screen provides you the Member ID for this employee, which they will need if they are enrolling through member self service. The confirmation screen will look different if you are only updating information; that confirmation screen will show a summary of changes made and will have a print button in the upper right corner as well as a Return to myMembers button at the bottom of the page.

If you wish to print the confirmation page, click on the green 'Print' button in the upper right corner.

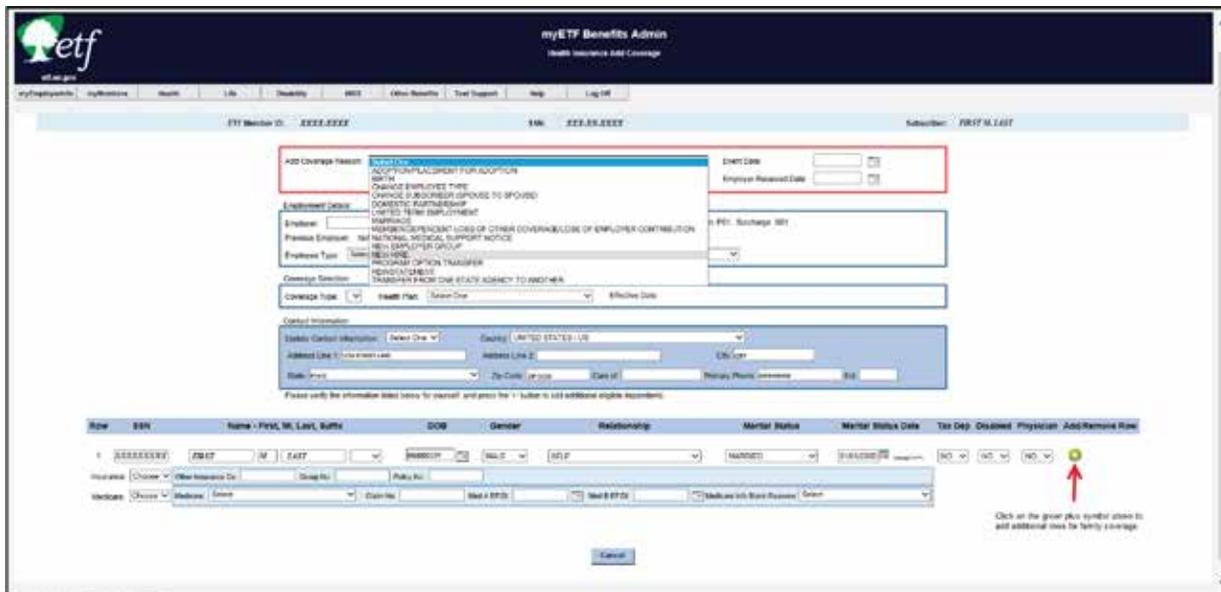
6. If you are enrolling the member, at the top of the screen, highlight the Health Tab and select Member Enrollment from the drop-down. You must have a completed *Group Health Insurance Application (ET-2301)* from the employee if you are entering the enrollment on their behalf.



- Click the 'Add Coverage' button at the bottom of the screen to open the enrollment function.



- Select the reason for the application. (For Example – New Hire).



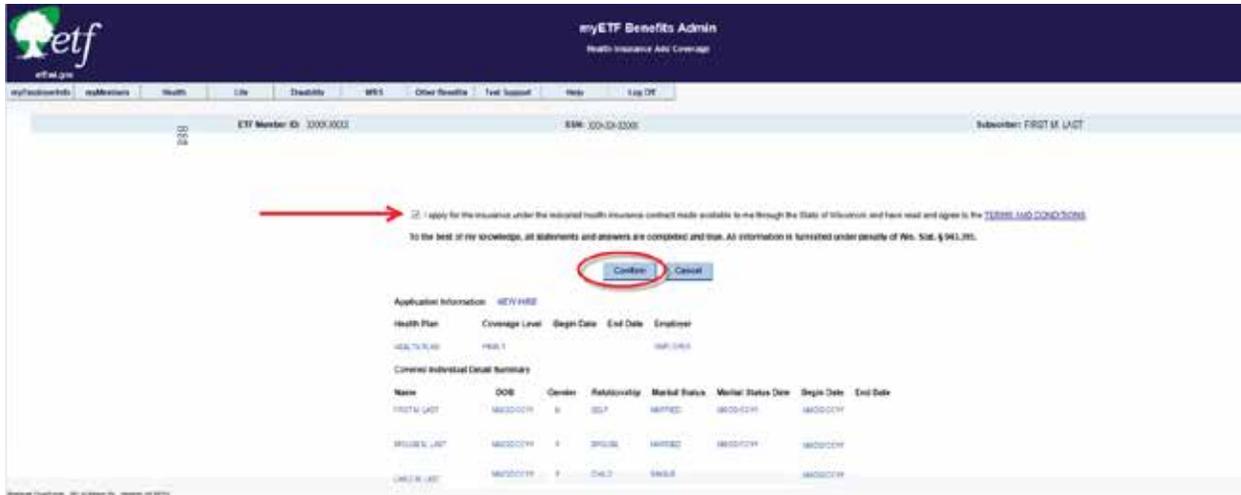
9. Enter the Event Date (hire date).
10. Enter the Received Date (date application received by the employer).
11. Select the Coverage Effective Date and hit Tab. You may need to click on it a second time to get it to stay.
 - a. If you click on 'As soon as possible,' move onto the next step.
 - b. If you click on 'When Employer Contributes,' a date box will appear and you need to enter the date for when the employer contribution begins.
12. Complete the Employment Details Section.
13. Complete the Coverage Selection Section.
14. Complete the Contact Information Section.
 - a. Select Yes if you need to make any changes.
 - b. Select No if you do not need to make any changes.
15. Complete the Dependent Information section, per the information on the *Health Application/Change Form (ET-2301)*.
 - a. If a family contract, you can select the green plus sign to add rows or the red minus sign to remove rows.
16. Once all data has been entered, click the 'Submit' button at the bottom of the page.

The screenshot displays a web-based application form for myETF Benefits. At the top, there are navigation tabs and user information. The main form is divided into several sections:

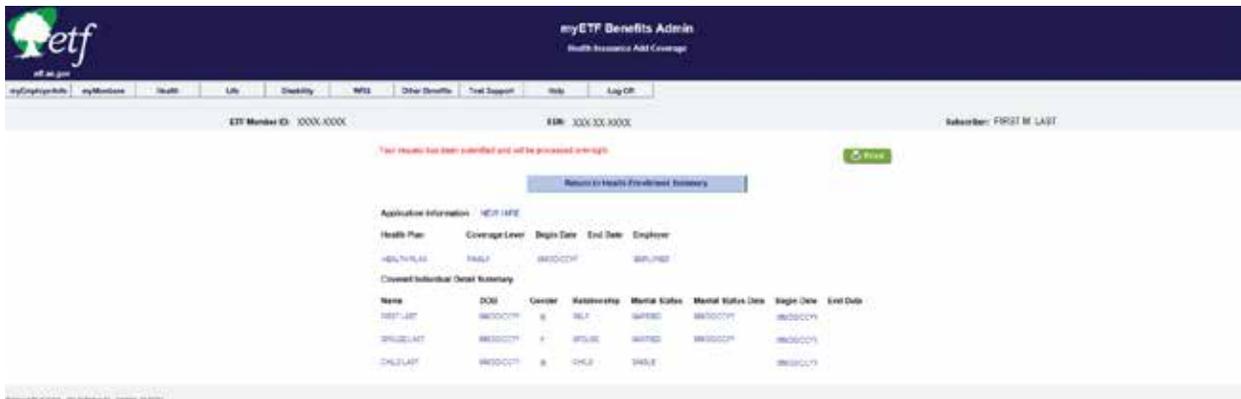
- Coverage Plan:** A section at the top with a red box around it, containing dropdown menus for plan selection and date pickers.
- Employment Details:** A section below with fields for Employer, Employee, and various dates.
- Contact Information:** A section with fields for name, address, and phone number.
- Dependent Information:** A table with columns for ID, Name, DOB, Gender, Relationship, Market Status, and Tax Status. It contains three rows of dependent data. Red arrows point to the green plus sign and red minus sign in the right-hand column of this table.
- Submit Button:** A blue button at the bottom center of the form, circled in red.

 A small text box at the bottom right of the dependent table reads: "Click on the green plus sign to add additional rows for family coverage or click on the red minus sign to remove a row."

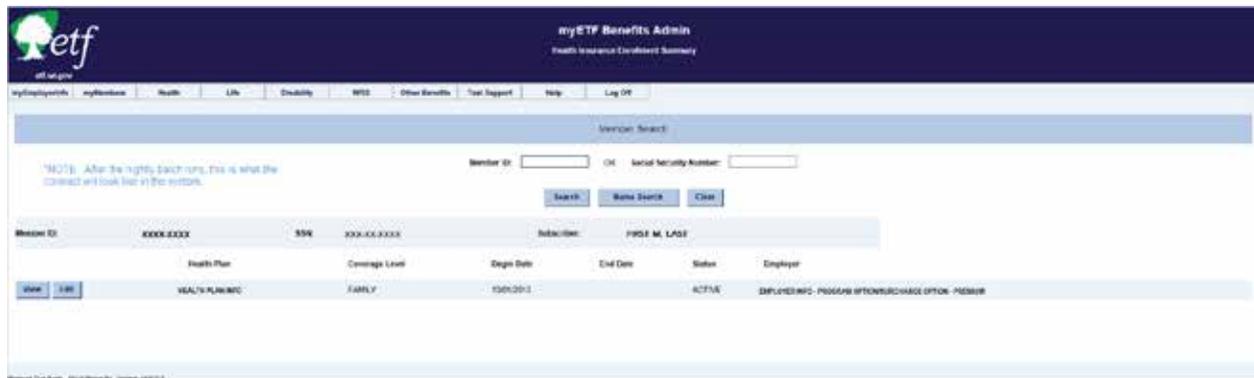
17. Verify all the information on the review page.
 - a. If all the information is correct, check the 'Terms and Conditions' box and click the 'Confirm' button.



- b. If the information is not correct, click the 'Cancel' button and return to the previous screen to make changes.
18. Print a copy of the confirmation screen (if desired) by clicking on the green print button in the upper right hand corner of the screen.



After the nightly batch runs, you can go in on the following day and view the contract you entered.



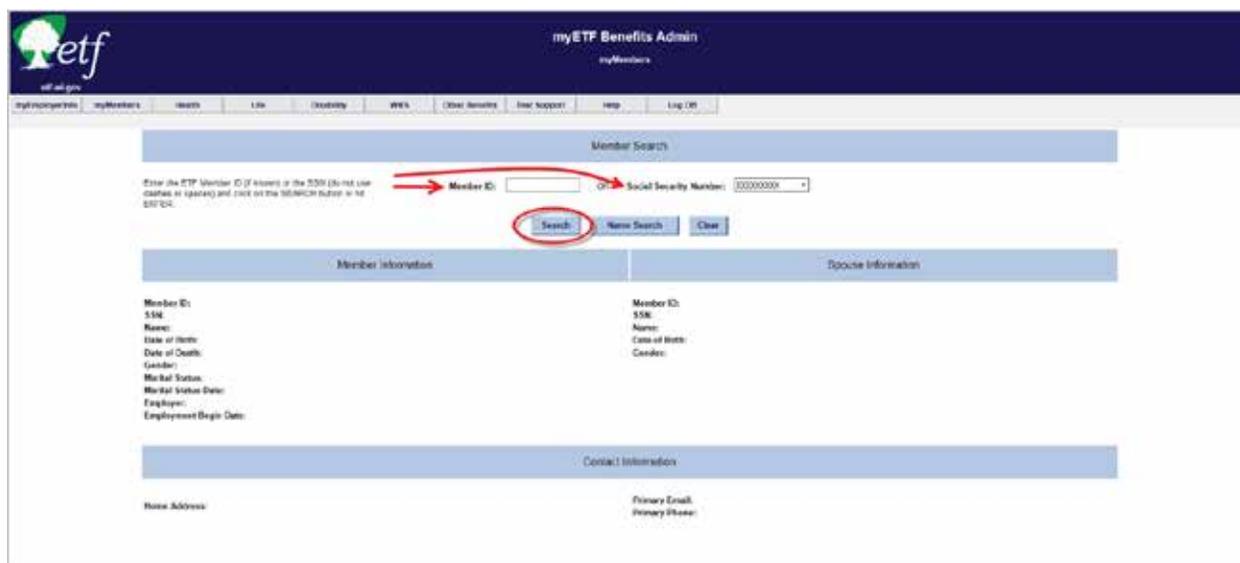
C-3. Add Dependent

A Health Insurance Application/Change Form (ET-2301) has been received for one of the Add Dependent reasons, all information has been verified, the employer section completed, and any necessary documentation has been verified/approved.

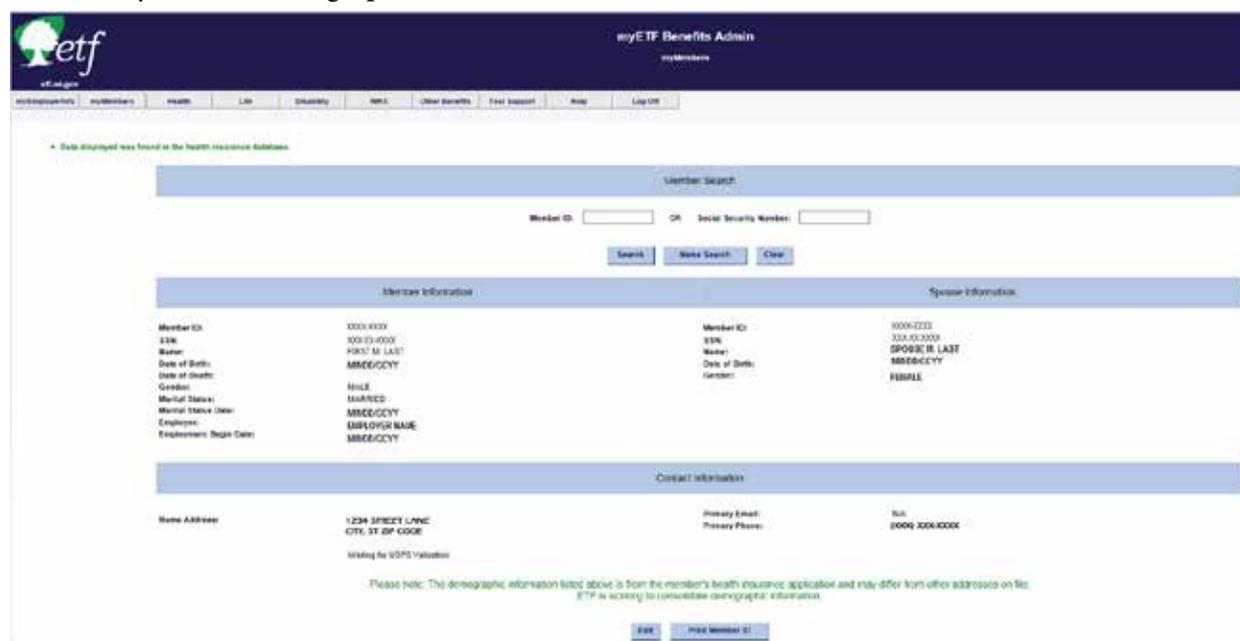
1. In myETF Benefits, highlight the myMembers tab and select myMembers from the drop down list.



2. Enter the employee's ETF Member ID or SSN into the appropriate box and click the 'Search' button or click Enter.



3. Verify that all demographic data is current.



- a. If any updates/changes need to be made, then click the 'Edit' button at the bottom of the screen.
 - b. Make any updates/changes to the appropriate editable fields.
 - c. If it was an address update, an address validation program will run and ask you to verify and select the correct address from the bottom of the screen.
 - d. Select the 'Finalist' address which includes the ZIP+4, and click the 'Submit' button again.
- Note:** If the address returns to the validation screen, you may be missing the apartment number or unit number designation. Either contact the member to verify the address or if you know it is correct, then select the "Radio" button in front of the address as keyed and click the 'Submit' button.
4. Once you are on the review page, review the data (any changes/additions will appear in red).
 - a. If all corrections/additions are correct, click the 'Confirm' button.
 - b. If additional changes are needed, click the 'Cancel' button and return to the previous screen and follow the procedures under Number 3.
 - c. If you wish to print the confirmation page, click on the green 'Print' button in the upper right corner.
 5. At the top of the screen, highlight the Health tab and select Member Enrollment from the drop-down.

The screenshot displays the 'myETF Benefits Admin' web application. At the top, there is a navigation bar with the 'etf' logo and the text 'myETF Benefits Admin myMembers'. Below this is a menu with tabs for 'myEmployers', 'myMembers', 'Health', 'Life', 'Disability', 'WRS', 'Other Benefits', 'Text Support', 'Help', and 'Log Off'. The 'Health' tab is selected, and a dropdown menu is open showing 'Member Enrollment' and 'Premium'. A message states: '* Data displayed was found in the health insurance database.'

The main content area is titled 'Member Search' and includes input fields for 'Member ID:' and 'Social Security Number:', along with 'Search', 'Name Search', and 'Clear' buttons.

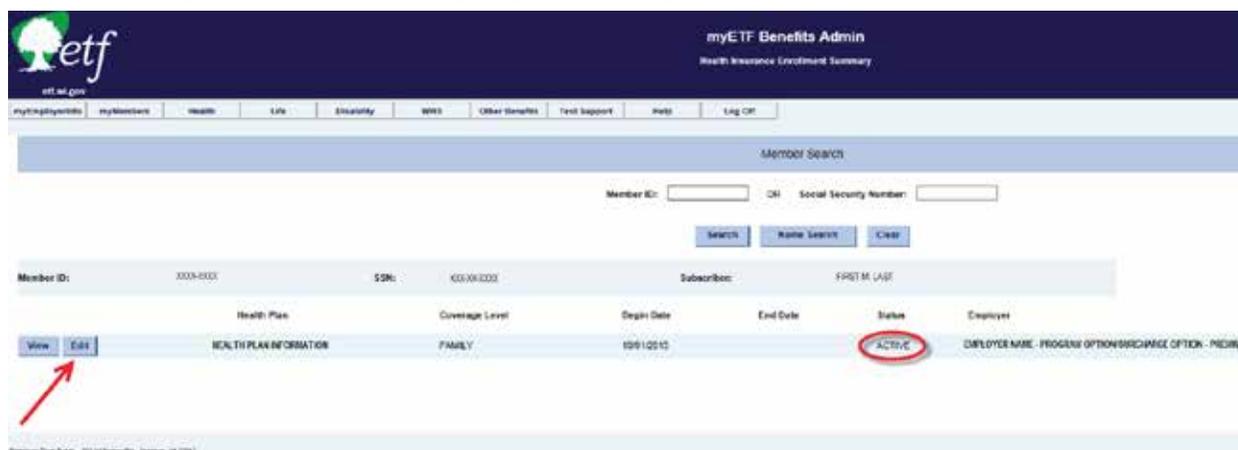
Below the search section, there are two columns of member information:

Member Information		Spouse Information	
Member ID:	XXXX-XXXX	Member ID:	XXXX-XXXX
SSN:	XX-XX-XXXX	SSN:	XX-XX-XXXX
Name:	FIRST M. LAST	Name:	SPOUSE M. LAST
Date of Birth:	MMDDCCYY	Date of Birth:	MMDDCCYY
Date of Death:		Gender:	FEMALE
Gender:	MALE		
Marital Status:	MARRIED		
Marital Status Date:	MMDDCCYY		
Employer:	EMPLOYER NAME		
Employment Begin Date:	MMDDCCYY		

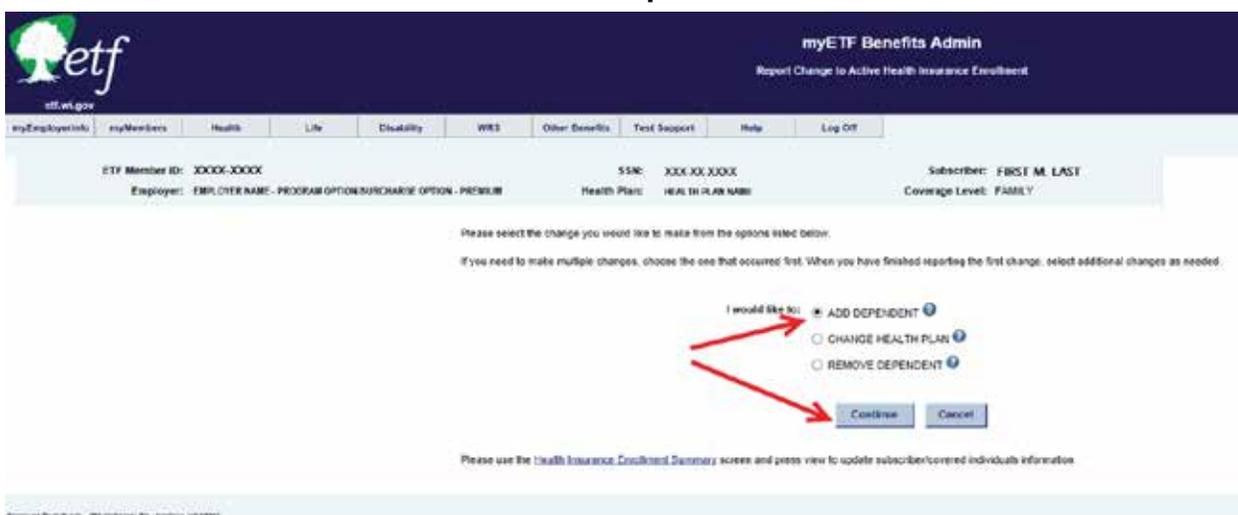
At the bottom, there is a 'Contact Information' section with the following details:

Home Address:	1234 STREET LANE CITY, ST ZIP CODE	Primary Email:	NA
	Waiting for USPS Validation.	Primary Phone:	(000) 200.0000

6. Click the 'Edit' button on the line for the **Active** contract.



7. Select the "Radio" button next to **Add Dependent** and click the 'Continue' button.



8. Select the "Reason for Adding Dependent" from the drop-down menu. (For Example – Loss of Other Coverage).

9. Enter the Event Date (date of the qualifying event).
10. Enter the Employer Received Date (date application received by the employer).
Note: The Effective Date will auto-populate based on the Event and Received dates entered.
11. Complete the “Identification Section” for the dependent being added.
12. Complete the “Other Health Insurance.”
 - a. Select **No** from the drop down if there is **no** other health insurance coverage listed on the application for the member.
 - b. Select **Yes** from the drop down if there **is** other health insurance coverage listed on the application for the member. Enter any information provided about the other insurance in the appropriate fields which open after Yes is selected.
13. Complete the “Medicare” section for the dependent being added.
 - a. Select **No** from the drop-down if there is **no** Medicare coverage for the member.
 - b. Select **Yes** from the drop down if there **is** Medicare coverage for the member. Complete the required Medicare information for the dependent in the appropriate fields which open after Yes is selected.
14. Complete the “Physician” Section for the dependent being added.
15. Verify data entered and click the ‘Submit’ button.

18. Review the summary screen and print the confirmation (if desired).

19. Additional Changes on same application (if applicable).

- a. If you have additional dependents to add for the same reason / same effective date, click the 'Add Additional Dependent' button and follow the steps for adding a dependent.

20. If you have completed all necessary transactions from the application, click 'Return to Enrollment Summary'.

21. After the nightly batch runs (once transaction has been approved), you can go in on the following day and view the contract changes you entered.

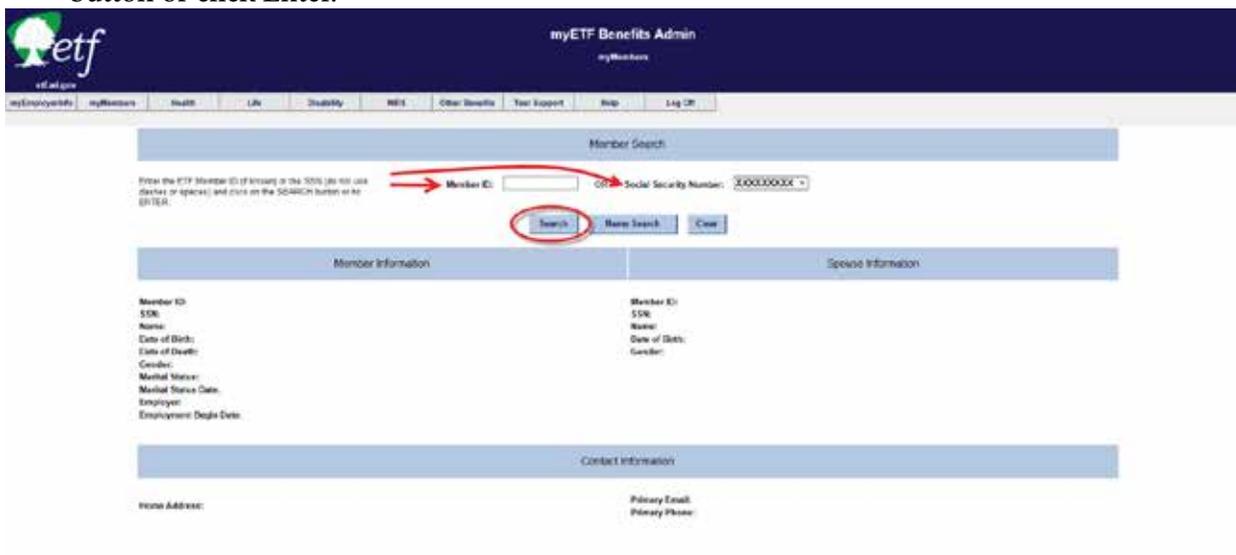
C-4. Remove Dependent

A Health Insurance Application/Change Form (ET-2301) has been received for one of the Remove Dependent reasons, all information has been verified, the employer section completed, and any necessary documentation has been verified/approved.

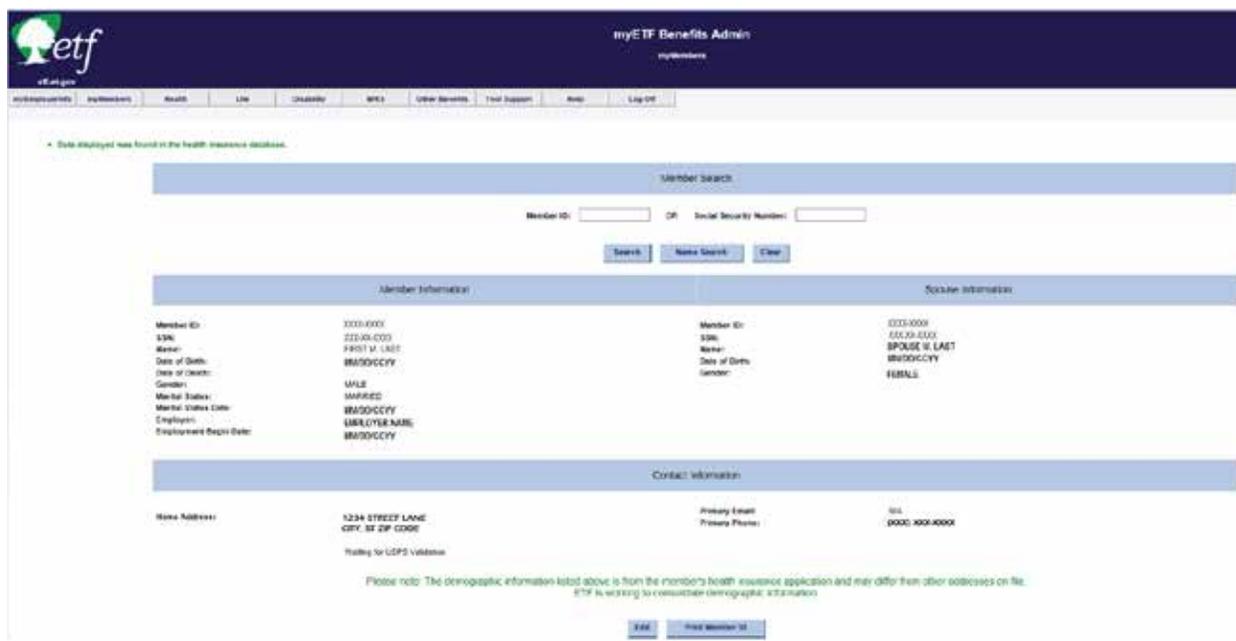
1. In myETF Benefits, highlight the myMembers tab and select myMembers from the drop down list.



2. Enter the employee's ETF Member ID or SSN into the appropriate box and click the 'Search' button or click Enter.



3. Verify that all demographic data is current.

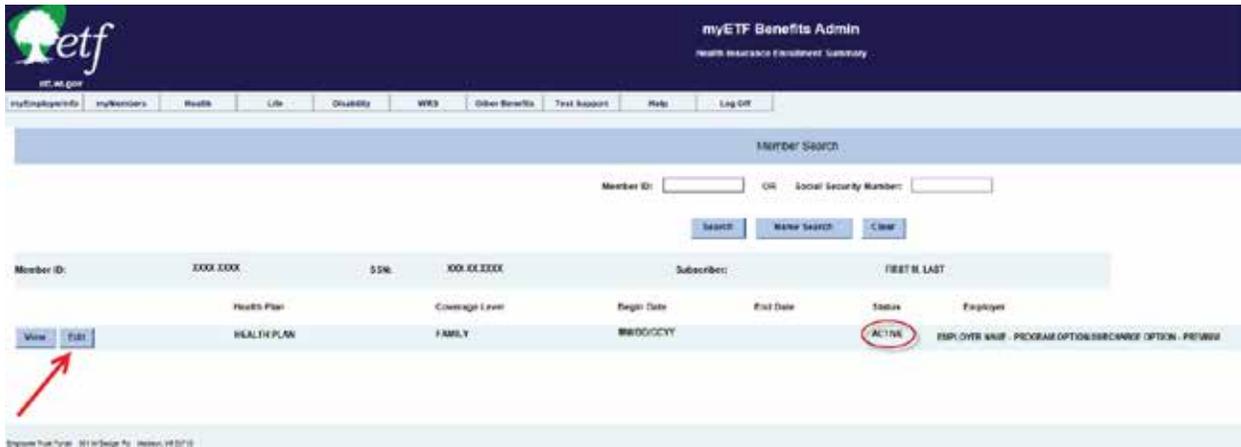


4. If any updates/changes need to be made, then click the 'Edit' button at the bottom of the screen.
 - a. Make any updates/changes to the appropriate editable fields.
 - b. If it was an address update, an address validation program will run and ask you to verify and select the correct address from the bottom of the screen.
5. Select the "Finalist" address which includes the ZIP+4, and click the 'Submit' button again.

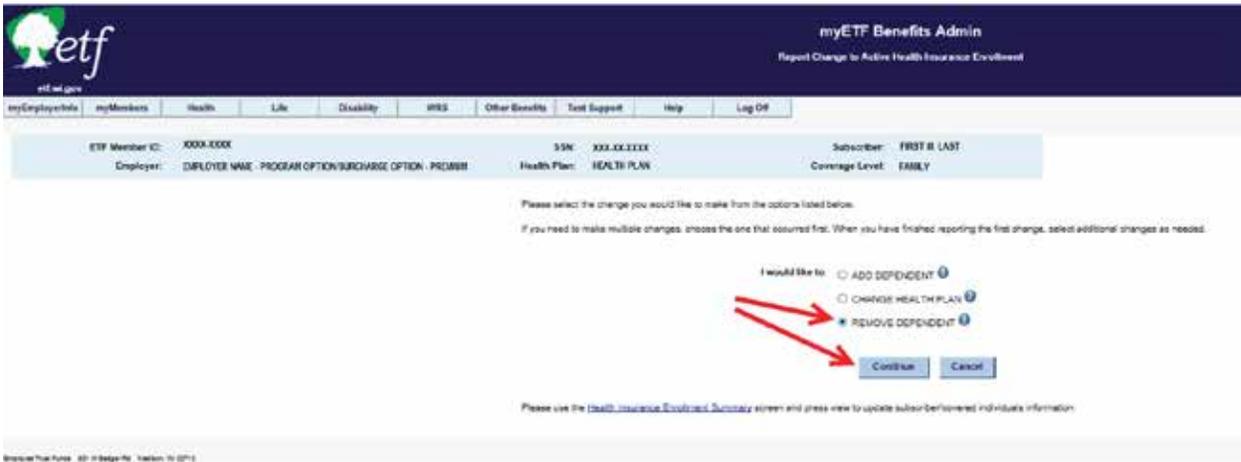
Note: If the address returns to the validation screen, you may be missing the apartment number or unit number designation. Either contact the member to verify the address or if you know it is correct, then select the 'Radio' button in front of the address as keyed and click the 'Submit' button.
6. Once you are on the review page, review the data (any changes / additions will appear in red).
 - a. If all corrections/additions are correct, click the 'Confirm' button.
 - b. If additional changes are needed, click the 'Cancel' button and return to the previous screen and follow the procedures under Number 3.
7. If you wish to print the confirmation page, click on the green 'Print' button in the upper right corner.
8. At the top of the screen, highlight the Health Tab and select Member Enrollment from the drop-down.

The screenshot displays the 'myETF Benefits Admin' web application. At the top, there is a navigation bar with the 'etf' logo and the text 'myETF Benefits Admin'. Below this is a menu bar with options: 'myMembers', 'Results', 'List', 'COUNCIL', 'SFC', 'Other Benefits', 'Tool Support', 'Help', and 'Log Off'. A message at the top left states: 'Data displayed was found in the health insurance database.' The main content area is divided into three sections: 'Member Search', 'Member Information', and 'Contact Information'. The 'Member Search' section contains input fields for 'Member ID' and 'Social Security Number', along with 'Search', 'New Search', and 'Clear' buttons. The 'Member Information' section is split into two columns. The left column lists fields: Member ID (XXX-XXX), SSN (XXX-XX-XXXX), Name (FIRST M. LAST), Date of Birth (MM/DD/CCYY), Gender (MALE), Marital Status (MARRIED), Marital Status Date (MM/DD/CCYY), Employer (UNEMPLOYED), and Employment Begin Date (MM/DD/CCYY). The right column lists: Member ID (XXX-XXX), SSN (XXX-XX-XXXX), Name (SPOUSE W. LAST), Date of Birth (MM/DD/CCYY), and Gender (FEMALE). The 'Contact Information' section shows 'Home Address' (1234 STREET LANE, CITY, ST ZIP CODE) with a note 'Waiting for USPS Validation', 'Primary Email' (NONE), and 'Primary Phone' (0000 XXX-XXXX). A note at the bottom states: 'Please note: The demographic information listed above is from the member's health insurance application and may differ from other addresses on file. ETF is working to consolidate demographic information.' At the bottom right, there are 'Print' and 'Print Member ID' buttons.

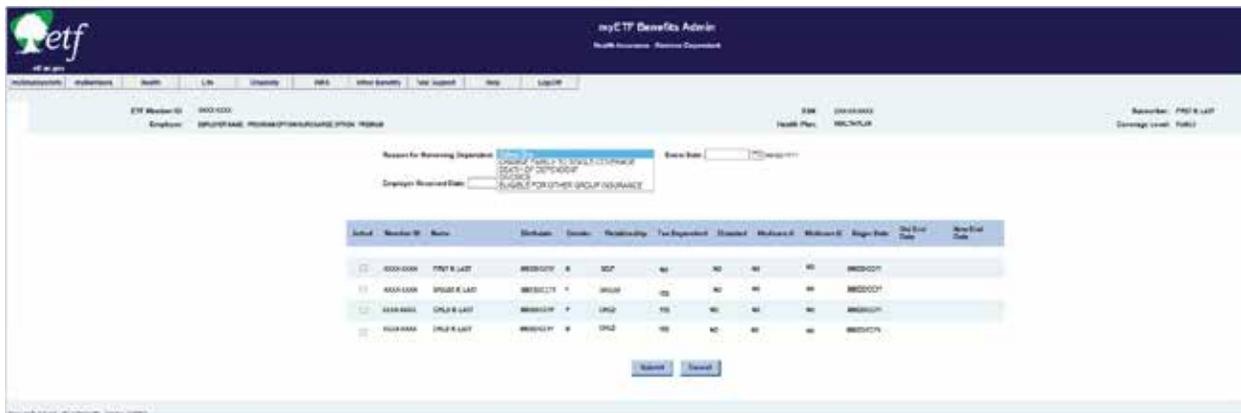
9. Click the 'Edit' button on the line for the **Active** contract.



10. Select the 'Radio' button next to **Remove Dependent** and click the 'Continue' button.



11. Select the "Reason for Removing Dependent" from the drop-down menu. (For example – Divorce).



12. Enter the Event Date (date of the qualifying event).
13. Enter the Employer Received Date (date application received by employer).
14. Check the box/boxes next to the dependent(s) being removed.

- a. For **Divorce** the system will automatically check the box next to the spouse and for any step-children.
 - b. For **Change From Family to Single Coverage**, the system will automatically check the boxes next to all dependents other than the subscriber.
15. Click the 'Submit' button at the bottom of the screen.

- a. For **Divorce**, a new box will pop up requesting the Date of COBRA Notice. You must enter the “Date Notice Provided” date from the *Continuation – Conversion Notice* (ET-2311), as the date you enter will affect the termination of coverage date for the former spouse/step-children. Click the ‘Submit’ button again.

- b. If removing spouse/step-children only, and family coverage will remain in place and the notification date is not within the same month as the divorce (event) occurred, the coverage will end the end of the month of the notification date or the application received date, whichever is later. (e.g., Divorce occurs 01/21/2014, ET-2301 received by employer 02/03/2014 and ET-2311 notification date (date sent to former spouse/dependents) is 02/05/2014 – coverage can not term until 02/28/2014).
- c. If switching from Family to Single Coverage due to the divorce (reason selected in myETF Benefits will be Change From Family to Single Coverage – not Divorce), then coverage will end the end of the month in which the divorce (event) occurred or the application received date, whichever is later. (e.g., Divorce occurs 01/21/2014, ET-2301 received by employer 01/27/2014

and ET-2311 notification date (date sent to former spouse/dependents) is 01/27/2014 – coverage ends 01/31/2014). If this is due to divorce and the divorce is not yet finalized, the spouse and any stepchildren must be sent a COBRA offer at the time the divorce is finalized. They should not be sent COBRA at the time the coverage changes from family to single unless the divorce is finalized.

16. Check the box next to the Terms and Conditions Statement.
 - a. If there is a second check box stating that documentation is required, check the box acknowledging you are aware of the this requirement. You must then either have the documentation in hand, expect to receive it soon, or request it from the employee at that time.

Note: Where there is a second check box, it means that documentation/proof is required in order to be eligible for that add reason. The contract/transaction will go into “Waiting for ETF Approval” status until ETF receives a copy of the required documentation. Once the documentation has been received, reviewed and approved by ETF, then the transaction will be approved and will process overnight. If ETF does not approve the documentation, the employer will be contacted with the reason why and what if any additional documentation is needed for processing.

17. Review the data and if correct, click the ‘Confirm’ button.

When family coverage will remain in effect, the documentation required for ETF to approve the remove dependent transaction is a copy of the Custodian - Continuation Notice, ET-2311, sent to the former spouse.

By confirming this request, I agree to or am ending the transaction under the indicated health insurance contract made available to me through the State of Oklahoma and have read and agree to the [Terms and Conditions](#).

I am aware of my knowledge, all statements and answers are completed and true. All information is furnished under penalty of perjury, 22A O.S. § 141.12B.

Documentation is required to process the change. I acknowledge that it is my responsibility to provide the appropriate documents to my employer within 30 days.

Reason for Removing Dependent: DIVORCE

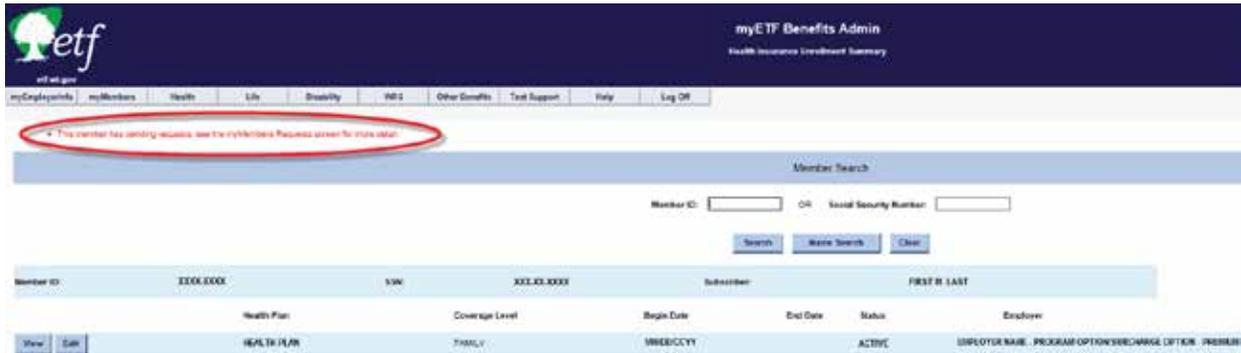
Select	Member ID	Name	Enrollment	Gender	Relationship	Tax Dependent	Disabled	Medicare A	Medicare B	Begin Date	Old End Date	New End Date
<input type="checkbox"/>	0000-0000	PREP A LAST	MEMBER	M	SELF	NO	NO	NO	NO	MEMBER		
<input checked="" type="checkbox"/>	0000-0000	PREP B LAST	MEMBER	F	SPOUSE	YES	NO	NO	NO	MEMBER		MEMBER
<input type="checkbox"/>	0000-0000	PREP C LAST	MEMBER	F	CHILD	YES	NO	NO	NO	MEMBER		
<input type="checkbox"/>	0000-0000	PREP D LAST	MEMBER	M	CHILD	YES	NO	NO	NO	MEMBER		

18. Review the summary screen and print the confirmation (if desired).

Reason for Removing Dependent: DIVORCE

Select	Member ID	Name	Enrollment	Gender	Relationship	Tax Dependent	Disabled	Medicare A	Medicare B	Begin Date	Old End Date	New End Date
<input type="checkbox"/>	0000-0000	PREP A LAST	MEMBER	M	SELF	NO	NO	NO	NO	MEMBER		
<input checked="" type="checkbox"/>	0000-0000	PREP B LAST	MEMBER	F	SPOUSE	YES	NO	NO	NO	MEMBER		MEMBER
<input type="checkbox"/>	0000-0000	PREP C LAST	MEMBER	F	CHILD	YES	NO	NO	NO	MEMBER		
<input type="checkbox"/>	0000-0000	PREP D LAST	MEMBER	M	CHILD	YES	NO	NO	NO	MEMBER		

- If you have completed all necessary transactions from the application, click on the “Return to Enrollment Summary” button.



- After the nightly batch runs (once the transaction has been approved by ETF), you can go in on the following day and view the contract changes you entered.

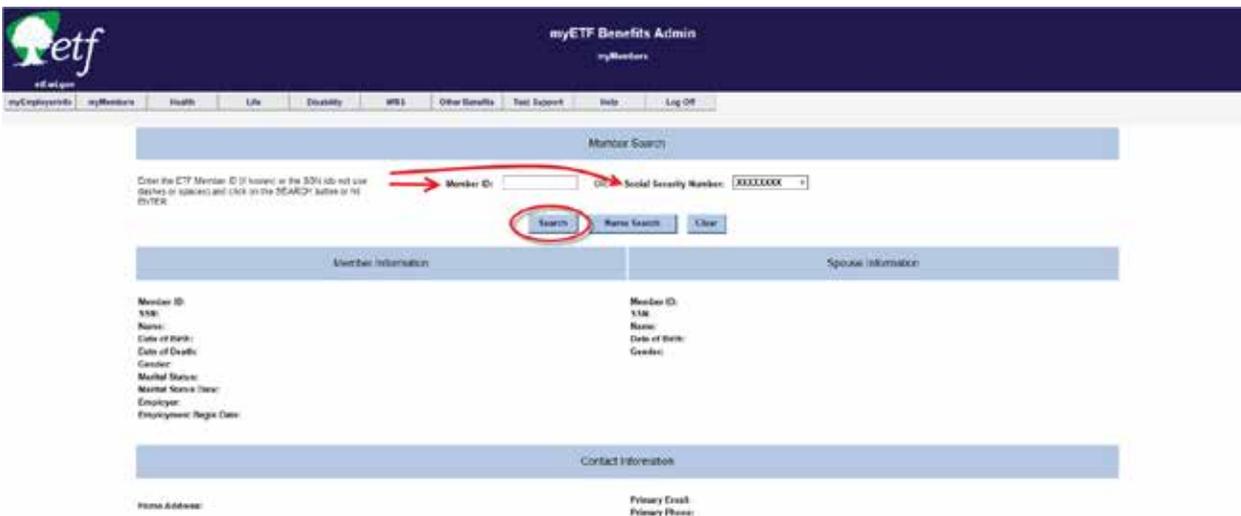
C-5. Change Health Plans

A *Health Insurance Application/Change Form* (ET-2301) has been received for one of the Change Health Plan reasons, all information has been verified, the employer section completed, and any necessary documentation has been verified/approved.

- In myETF Benefits, highlight the myMembers tab and select myMembers from the drop down list.



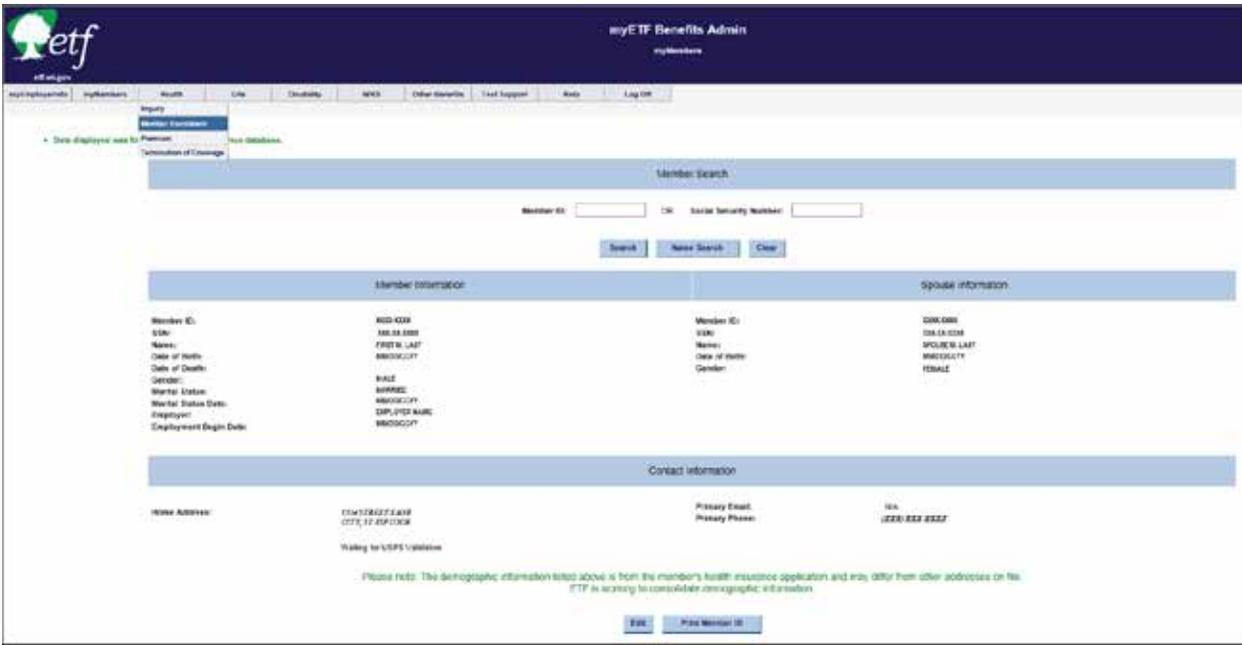
- Enter the employee’s ETF Member ID or SSN into the appropriate box and click the ‘Search’ button or click ‘Enter’.



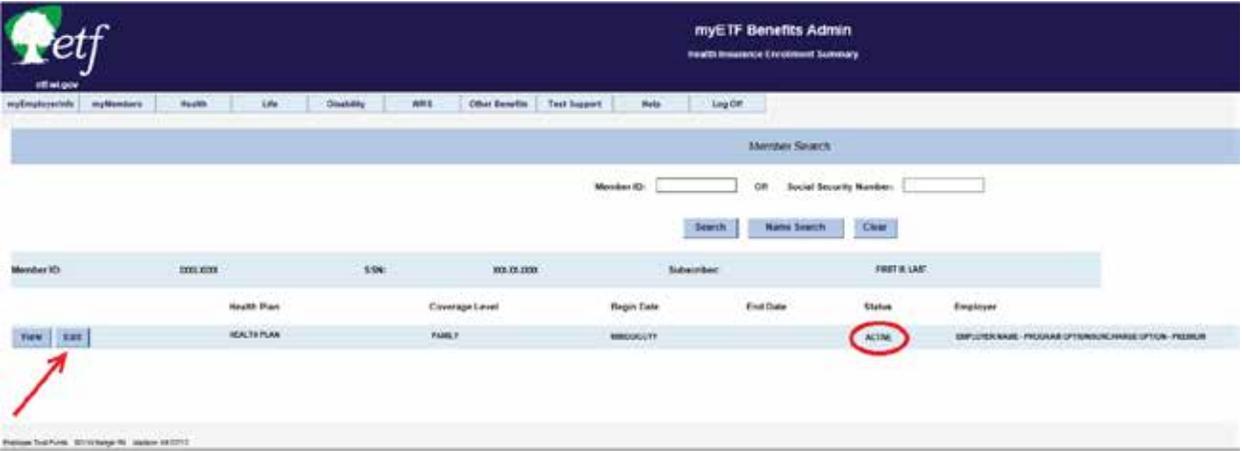
3. Verify that all demographic data are current.

The screenshot displays the 'myETF Benefits Admin' web application. At the top, there is a navigation bar with the 'etf' logo and the text 'myETF Benefits Admin' and 'myMembers'. Below the navigation bar, there is a 'Member Search' section with input fields for 'Member ID' and 'Social Security Number', and buttons for 'Search', 'New Search', and 'Clear'. Below the search section, there are two columns of demographic information: 'Member Information' and 'Spouse Information'. The 'Member Information' column includes fields for Member ID, SSN, Name, Date of Birth, Date of Death, Gender, Member Status, Member Status Code, Employer Name, and Employment Begin Date. The 'Spouse Information' column includes fields for Member ID, SSN, Name, Date of Birth, Gender, and Spouse Name. Below these columns, there is a 'Contact Information' section with fields for Home Address, Primary Email, Primary Phone, and Fax. At the bottom of the page, there are buttons for 'Print' and 'Print Member ID'. A note at the bottom states: 'Please note: The demographic information listed above is from the member's health insurance application and may differ from other addresses on file. ETF is working to consolidate demographic information.'

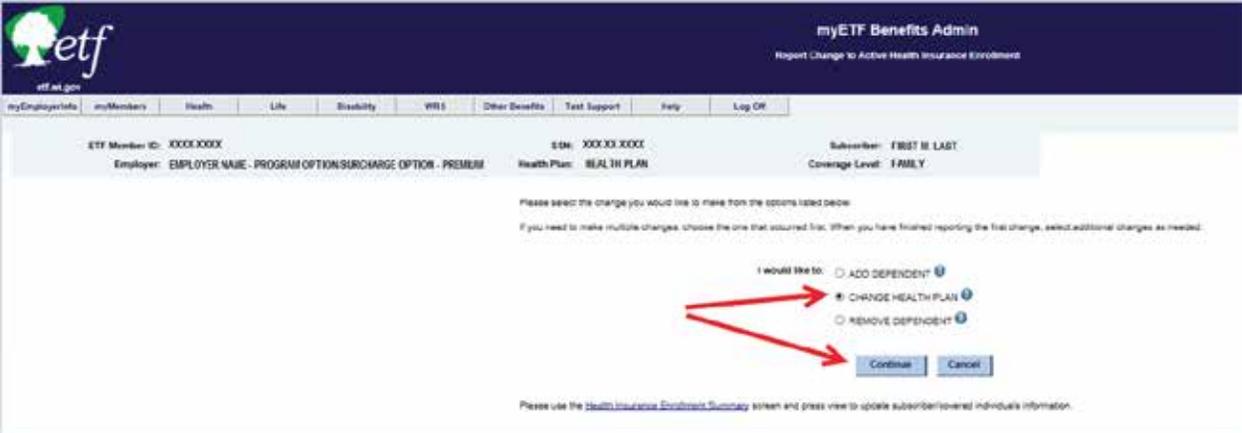
4. If any updates/changes need to be made, click the 'Edit' button at the bottom of the screen.
 - a. Make and updates/changes to the appropriate editable fields.
 - b. If it was an address update, an address validation program will run and ask you to verify and select the correct address from the bottom of the screen.
5. Select the "Finalist" address which includes the ZIP+4, and click the 'Submit' button again.
 - a. If the address returns to the validation screen, you may be missing the apartment number or unit number designation. Either contact the member to verify the address or if you know it is correct, then select the radio button in front of the address as keyed and click on the 'Submit' button.
6. Once you are on the review page, review the data (any changes/additions will appear in red).
 - a. If all corrections/additions are correct, click the 'Confirm' button.
 - b. If additional changes are needed, click the 'Cancel' button and return to the previous screen and follow the procedures under Number 3.
7. If you wish to print the confirmation page, click the green 'Print' button in the upper right corner.
8. At the top of the screen, highlight the "Health Tab" and select "Member Enrollment" from the drop-down.



9. Click the 'Edit' button on the line for the **Active** contract.



10. Select the 'Radio' button next to **Change Health Plan**.



11. Select the “Reason for Changing Health Plan” from the drop-down menu. (For Example – Move From Service Area).

myETF Benefits Admin
Health Insurance - Change Health Plan

ETP Member ID: 00000000
Employer: 00000000 - PROGRAM INFORMATION OF THE 00000000

SN: 00000000
Health Plan: HEALTH PLAN

Subscriber: 00000000
Coverage Level: FAMILY

Reason for Changing Health Plan: **MOVE FROM SERVICE AREA** Event Date: 11/02/2014

Employer Received Date: 11/02/2014

New Residential County: INDIANA

*NOTE - It is necessary to update the physician's clinic address for applications.

You are requesting a change in health plan for member and all dependents.

Health Plan	Coverage Level	Begin Date	End Date	Status	Employee
HEALTH PLAN	FAMILY	11/02/2014	11/02/2014	PENDING	00000000 - 0000 - 00000000
HEALTH PLAN	FAMILY	11/02/2014			00000000 - 0000 - 00000000

Row	SSN	Name	First, MI, Last, Suffix	DOB	Gender	Relationship	Tax Exp	Disabled	Physician	
1	XXXXXXXX	FRANK	M	LAST	MM/DD/YY	MALE	SELF	YES	NO	YES
2	XXXXXXXX	DALE	M	LAST	MM/DD/YY	MALE	CHILD	YES	NO	YES
3	XXXXXXXX	DALE	M	LAST	MM/DD/YY	MALE	CHILD	YES	NO	YES

Submit Cancel

12. Enter the Event Date (date of the qualifying event).
13. Select the New Residential County from the drop down list. (There is an “Out of State / NA” option).
14. Enter the Employer Received Date (date application received by employer).
15. Select the new health plan from the drop-down menu.
16. Update any physician information, Other insurance information or Medicare information for each member listed.
17. Click the ‘Submit’ button at the bottom of the screen.

myETF Benefits Admin
Health Insurance - Change Health Plan

ETP Member ID: 00000000
Employer: 00000000 - PROGRAM INFORMATION OF THE 00000000

SN: 00000000
Health Plan: HEALTH PLAN

Subscriber: 00000000
Coverage Level: FAMILY

Reason for Changing Health Plan: **MOVE FROM SERVICE AREA** Event Date: 11/02/2014

Employer Received Date: 11/02/2014

New Residential County: INDIANA

*NOTE - It is necessary to update the physician's clinic address for applications.

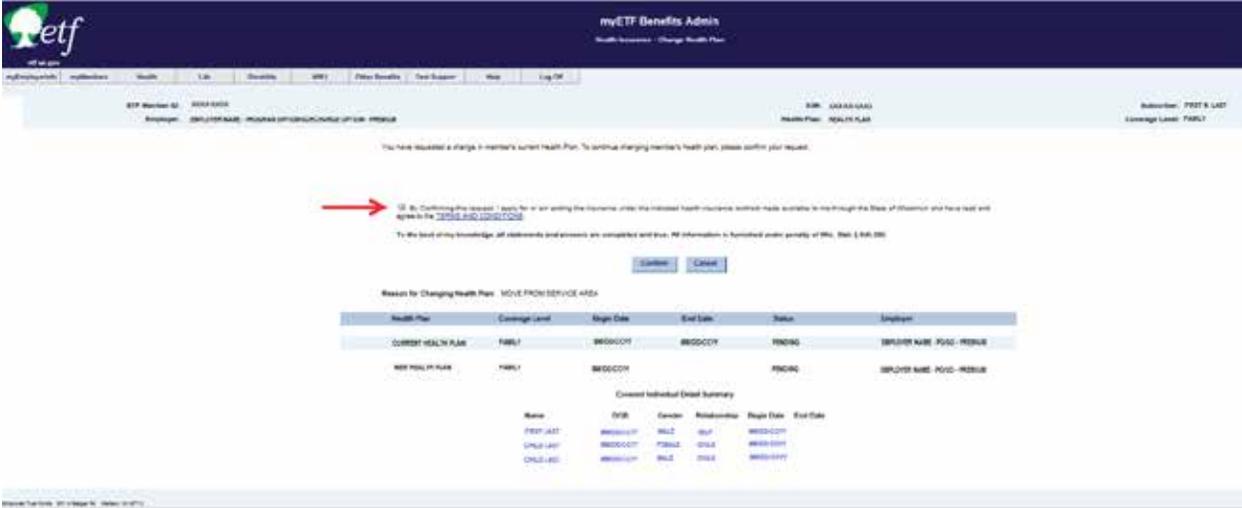
You are requesting a change in health plan for member and all dependents.

Health Plan	Coverage Level	Begin Date	End Date	Status	Employee
HEALTH PLAN	FAMILY	11/02/2014	11/02/2014	PENDING	00000000 - 0000 - 00000000
HEALTH PLAN	FAMILY	11/02/2014			00000000 - 0000 - 00000000

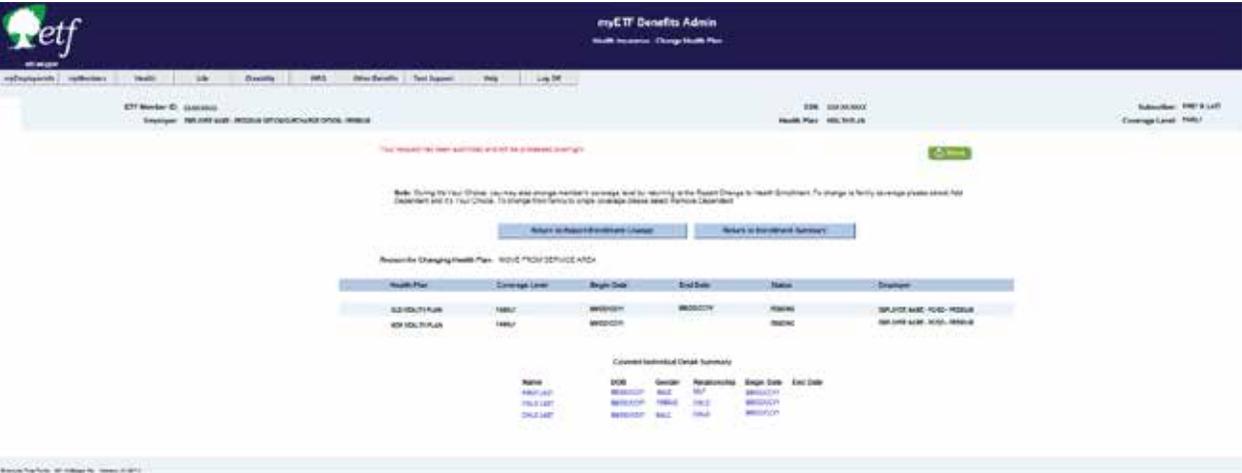
Row	SSN	Name	First, MI, Last, Suffix	DOB	Gender	Relationship	Tax Exp	Disabled	Physician	
1	XXXXXXXX	FRANK	M	LAST	MM/DD/YY	MALE	SELF	YES	NO	YES
2	XXXXXXXX	DALE	M	LAST	MM/DD/YY	MALE	CHILD	YES	NO	YES
3	XXXXXXXX	DALE	M	LAST	MM/DD/YY	MALE	CHILD	YES	NO	YES

Submit Cancel

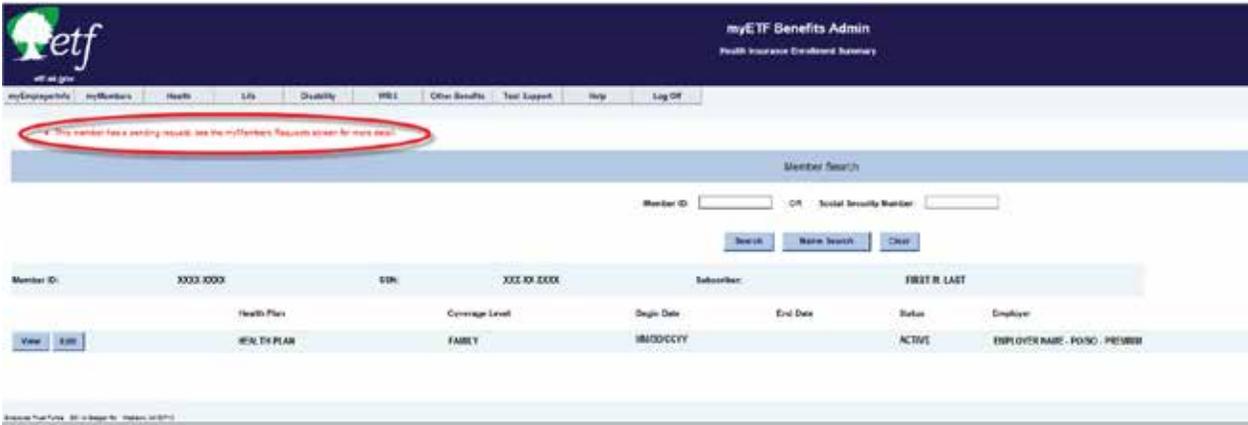
- 18. Check the box next to the Terms and Conditions statement.
- 19. Review the data and if correct, click the 'Confirm' button.



- 20. Review the summary screen and print the confirmation, if desired.



- 21. If you have completed all necessary transactions from the application, click on the 'Return to Enrollment Summary' button.



22. After the nightly batch runs, you can go in on the following day and view the contract changes you entered.

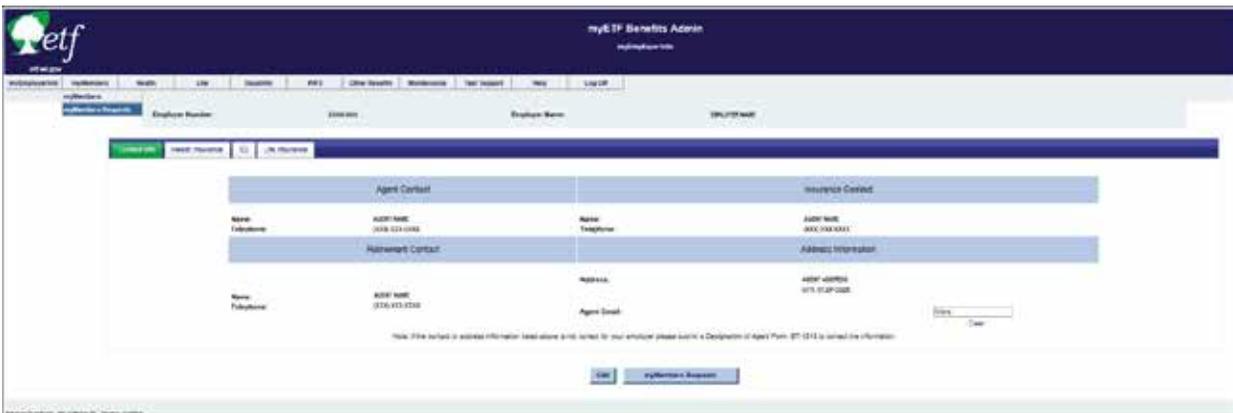
C-6. Termination of Coverage

Termination of health insurance coverage can occur for multiple reasons. Some reasons require a *Health Insurance Application/Change Form (ET-2301)*, such as Cancel Coverage or Cancel Due To Spouse-To-Spouse Transfer. The remaining reasons, Death of Subscriber, Disability Approval (Non-ICI), Retirement, and Termination of Employment, do not require an application. In order to process the termination of a member's health insurance, you will need to follow the procedure listed below (e.g., termination of employment, last day being 04/18/2014, employer received notice on 04/04/2014):

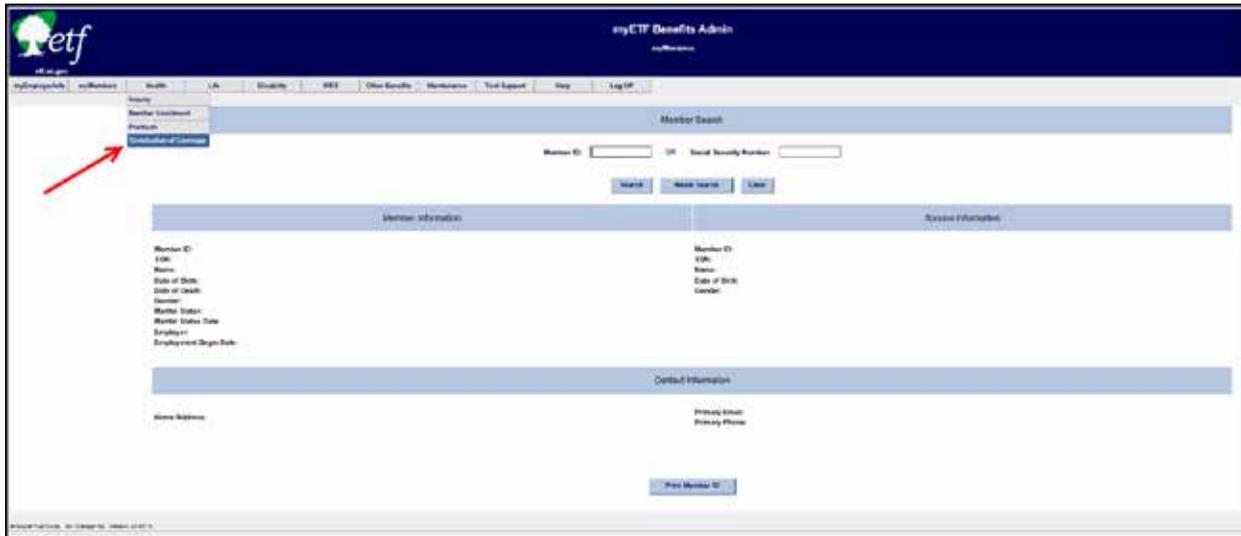
1. In myETF Benefits, highlight the Health tab and select Termination of Coverage from the drop-down list.



Note: If using Internet Explorer, you will need to highlight myMembers and select myMembers. Otherwise, you may not see the whole drop down menu under the Health Tab, part of it will be hidden behind the screen.



2. Highlight the Health tab and select Termination of Coverage.



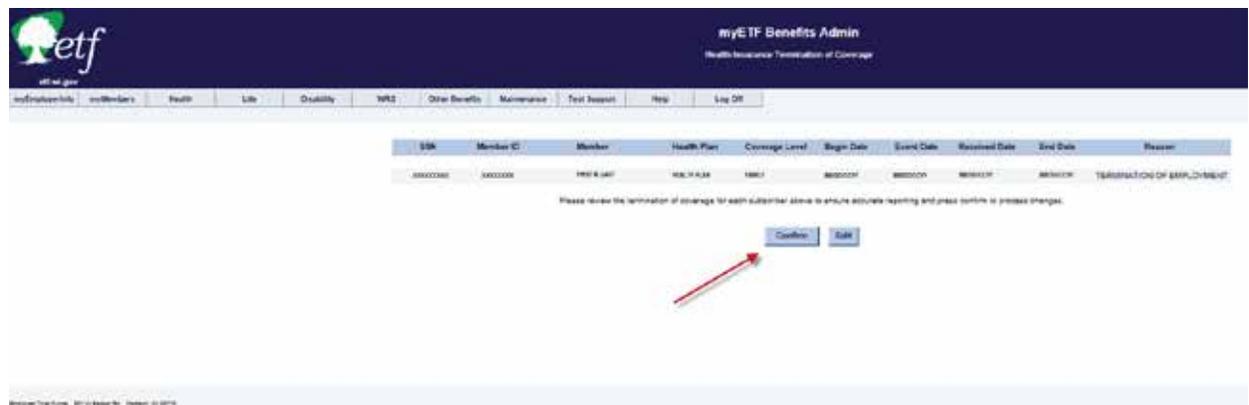
3. Enter the SSN or ETF Member ID.
4. Leave the Begin Date field blank.
5. Enter the Event Date.
6. Enter the Received Date (date the employer received app or term notice).
7. Enter the End Date (last day of health insurance coverage).
8. Select the Reason from the drop-down menu.
 - a. If you select the reasons Cancel Coverage, or Cancel Due to Spouse to Spouse transfer, you will receive a secondary drop-down menu asking you to select whether or not the employee share of the premium is deducted “Post-Tax” or “Pre-Tax.” If the premiums are deducted “Pre-Tax” then you select the appropriate qualifier.



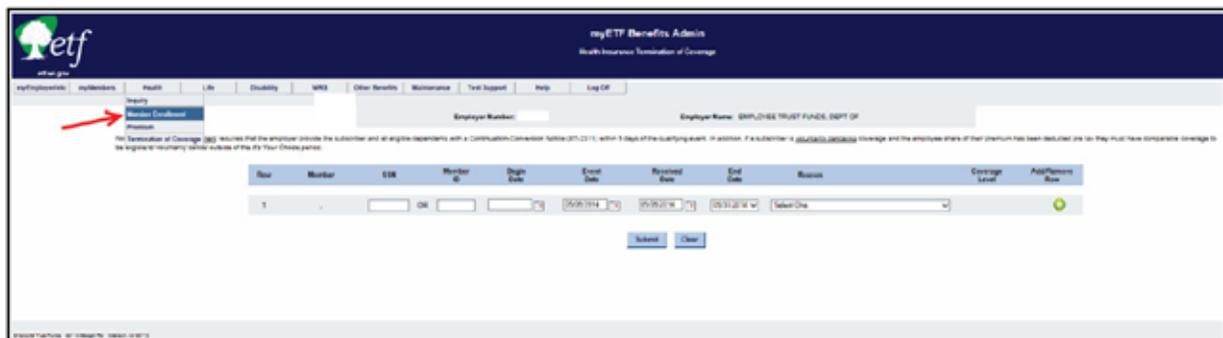
10. Click the 'Submit' button at the bottom of the screen.



11. Review/verify that the information is correct and click the 'Confirm' button. The system will automatically take you back to a blank termination screen.



a. If you wish to review/verify the term processed highlight the Health tab and select Member Enrollment.



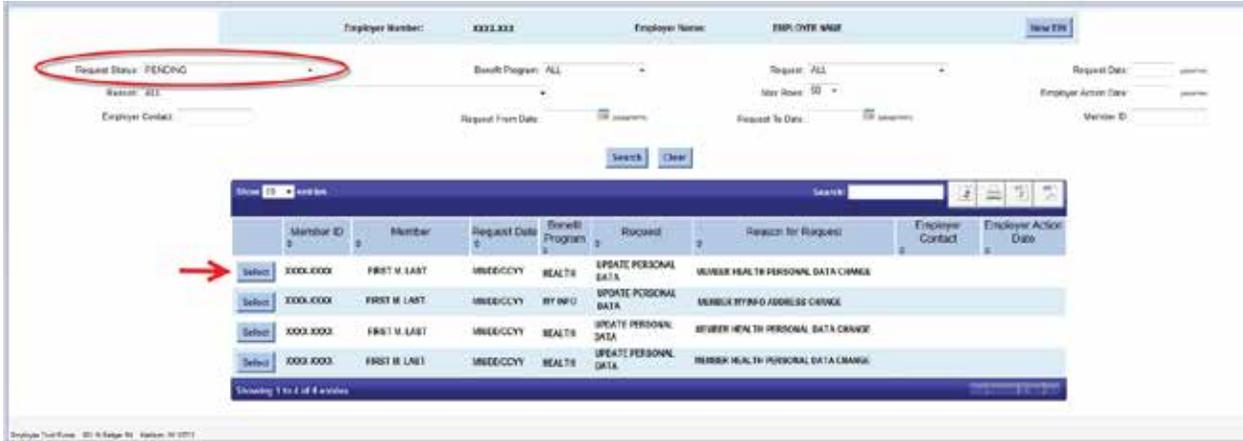
Transactions that are in *Pending, Approved-Not Applied, Waiting for ETF Approval – Disabled* and *Waiting for ETF Approval* can be edited, if necessary. They take you back to the entry screen and you follow the same submission procedures as before.

Access to the myMembers Requests screens can be accessed by the following steps:

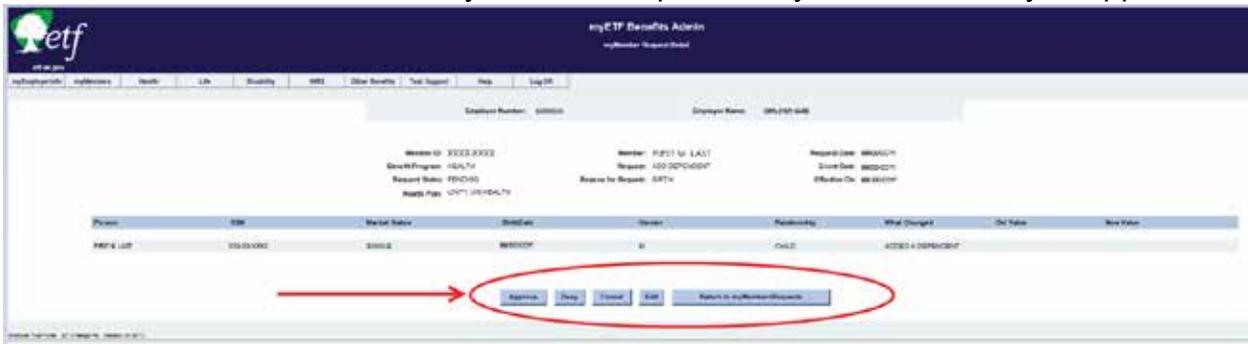
1. In myETF Benefits, highlight the myMembers tab and select myMembers Requests.



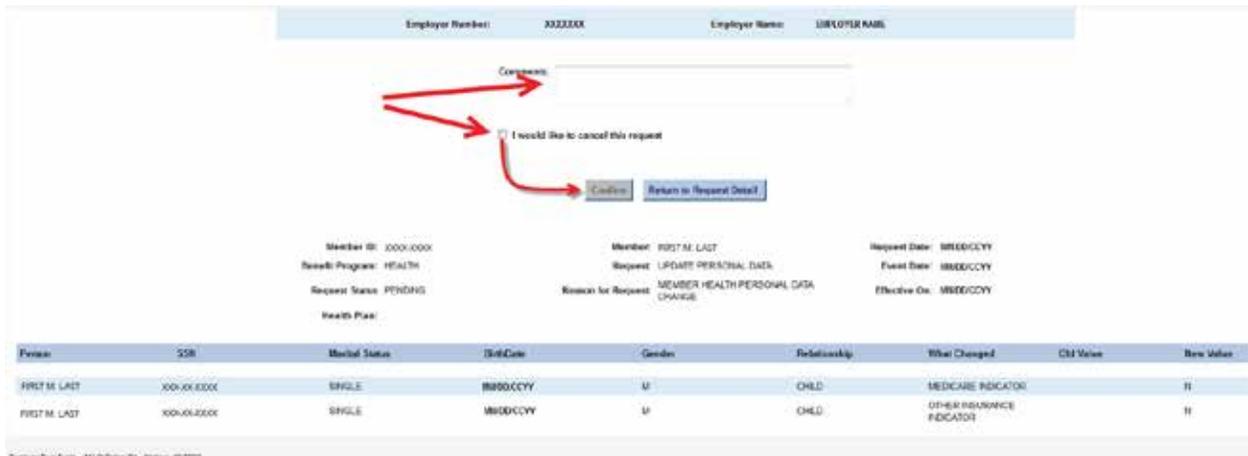
2. Select a “status” from the drop down menu. Define your search. The most common search is the default set up, however you can narrow the search by the following means:
 - a. Reason (the reason for the application).
 - b. Employer contact.
 - c. Benefit Program.
 - d. Request Type (Add Coverage, Add Dependent, Remove Dependent, etc.).
 - e. Max Rows (max number of rows to show).
 - f. Request Date.
 - g. Employer Action Date (date entered).
 - h. Member ID.
 - i. Range – Request From Date and Request To Date.
3. Click the ‘Search’ button. If there are more than 10 lines, you may need to select the number of lines to show from the drop down on the left, just above the displayed range of data.
4. Click the ‘Select’ button next to the transaction you want to view/approve.



- a. Review/verify that the information entered is correct. If the transaction is in the Pending queue, and all information is correct:
 - Click the 'Approved' button and it will automatically take you back out to the queue.
 - Click on "Return to myMember Requests", if you are not ready to approve.



- b. If the transaction is in the Pending queue, and all the information is not correct:
 - Click the 'Edit' button to update any information.
 - Click the 'Cancel' button to cancel the transaction, in which case it will need to be re-entered by the member (employee).
 - Enter a reason for the cancellation in the Comments box.
 - Check the box next to "I would like to cancel this request."
 - Click the 'Confirm' button.



- c. If the transaction is in the Pending queue, and after the review of information the member is not eligible to make the requested change.
- Click the 'Deny' button.
 - Enter a reason for the denial in the Comments box.
 - Check the box next to "I would like to deny this request."
 - Click the 'Confirm' button.

Employer Number: XXXXXX Employer Name: EMPLOYER NAME

Comments:

I would like to deny this request

Confirm Return to Request Detail

Member ID: XXX-XXX-XXXX Member: FIRST M. LAST Request Date: MM/DD/YYYY
 Benefit Program: HEALTH Request: UPDATE PERSONAL DATA Parent Date: MM/DD/YYYY
 Request Status: PENDING Reason for Request: MEMBER HEALTH PERSONAL DATA CHANGE Effective On: MM/DD/YYYY
 Health Plan:

Name	SSN	Marital Status	Date of Birth	Gender	Dependability	What Changed	DM Value	New Value
FIRST M. LAST	XXX-XX-XXXX	SINGLE	MM/DD/YYYY	M	CHILD	MEDICARE INDICATOR		N
FIRST M. LAST	XXX-XX-XXXX	SINGLE	MM/DD/YYYY	M	CHILD	OTHER INSURANCE INDICATOR		N

Employee Tool Panel: 01/14/2016 10:00 AM

- d. If the employer has approved the transaction, it will move into the Approved-Not Applied queue to be processed in the nightly batch run.

You can go in the following day to verify the transaction processed correctly by reviewing the members information/contract in myETF Benefits.

C-8 Enrollment Inquiry

The Enrollment Inquiry is a function of myETF Benefits where an employer can go to view a summary of all of their employees (subscribers) that have been enrolled in the State Group Health Insurance Program and entered in myETF Benefits. This is a monthly report based on available invoices. This query can either be very broad or broken down by a specific health plan and/or coverage type. To use this inquiry function, you will follow the procedures listed below.

1. In myETF Benefits, highlight the 'Health' tab.

myETF Benefits Admin
myEmployee Info

myEmployees Info myMembers **Health** Life Disability WVS Other Benefits Text Support Help Log Off

Inquiry
Member Enrollment
Premium
Administration of Premiums

Member ID: XXX-400 Employee Name: EMPLOYER NAME

Contract Health Insurance **CI** Life Insurance

Agent Contact		Insurance Contact	
Name:	AGENT NAME	Name:	AGENT NAME
Telephone:	(000) 000-0000	Telephone:	(000) 000-0000
Retirement Contact		Address Information	
Name:	AGENT NAME	Address:	AGENT ADDRESS
Telephone:	(000) 000-0000	Agent Email:	000.00.0000

Note: If the contact or address information listed above is not correct for your employer please submit a Disposition of Agent Form: ES-1112 to correct the information.

More Clear

myMembers Requests Employer Locations

Employee Tool Panel: 01/14/2016 10:00 AM

2. Highlight Inquiry.

myETF Benefits Admin
myEmployee Info

myEmployerInfo myMembers Health Life Disability PERS Other Benefits Test Support Help Log Off

Inquiry
 Member Enrollment
 Premium Reports
 Enrollment Inquiry
 Dependents Inquiry
 Address Inquiry

Employee Name: EMPLOYEE NAME

Health Insurance Life Insurance

Agent Contact		Insurance Contact	
Name:	AGENT NAME (000) 000-0000	Name:	AGENT NAME (000) 000-0000
Telephone:		Telephone:	
Retirement Contact		Address Information	
Name:	AGENT NAME (000) 000-0000	Address:	AGENT ADDRESS 00000 00000
Telephone:		Agent Email:	<input type="text"/> <input type="button" value="Clear"/>

Note: If the contact or address information listed above is not correct for your employer please submit a Designation of Agent Form, E-1144 to correct the information.

System Tool Path: 00-10-0000-00-0000-00-0000

3. Highlight Enrollment Reports.

myETF Benefits Admin
myEmployee Info

myEmployerInfo myMembers Health Life Disability PERS Other Benefits Test Support Help Log Off

Inquiry
 Member Enrollment
 Premium Reports
 Enrollment Inquiry
 Dependents Inquiry
 Address Inquiry

Employee Name: EMPLOYEE NAME

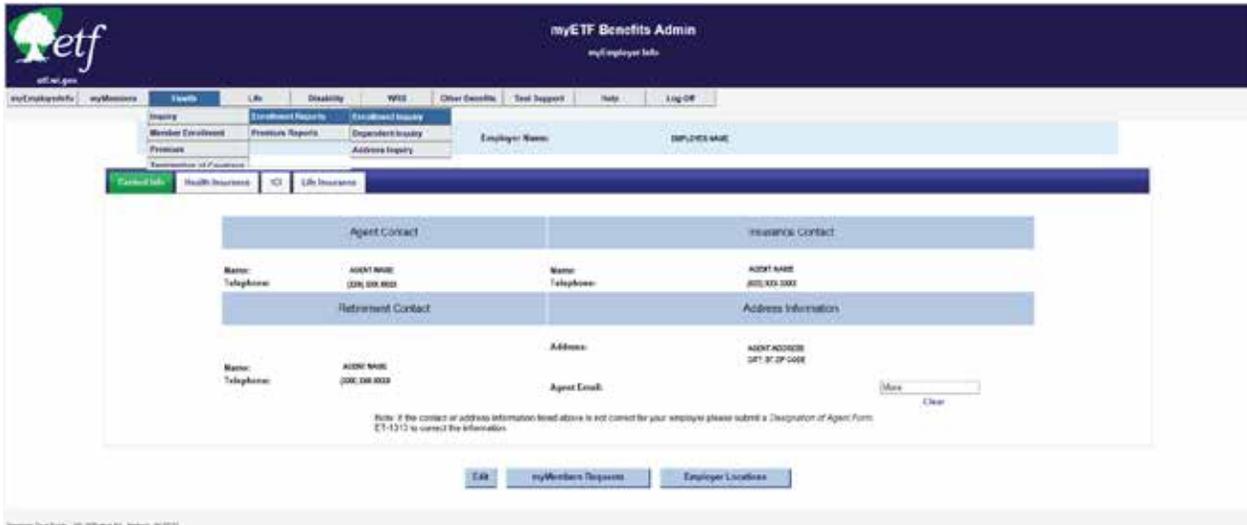
Health Insurance Life Insurance

Agent Contact		Insurance Contact	
Name:	AGENT NAME (000) 000-0000	Name:	AGENT NAME (000) 000-0000
Telephone:		Telephone:	
Retirement Contact		Address Information	
Name:	AGENT NAME (000) 000-0000	Address:	AGENT ADDRESS 00000 00000
Telephone:		Agent Email:	<input type="text"/> <input type="button" value="Clear"/>

Note: If the contact or address information listed above is not correct for your employer please submit a Designation of Agent Form, E-1144 to correct the information.

System Tool Path: 00-10-0000-00-0000-00-0000

4. Select Enrollment Inquiry.



5. Select the Coverage Month.



6. Select the Coverage Year.

The screenshot shows the myETF Benefits Admin interface. At the top, there is a navigation bar with the myETF logo and the text "myETF Benefits Admin Health Insurance Enrollment Inquiry". Below the navigation bar, there are several tabs: myEmployees, myMembers, Health, Life, Disability, WBS, Other Benefits, Tool Support, Help, and Log Off. The main content area displays a form for selecting a coverage year. The form includes the following fields:

- Employee Number: 0001.000
- Employee Group: 0000 - EMPLOYEE
- Coverage Month: May (dropdown)
- Year: 2018 (dropdown)
- Health Plan: (dropdown)
- Coverage Type: (dropdown)

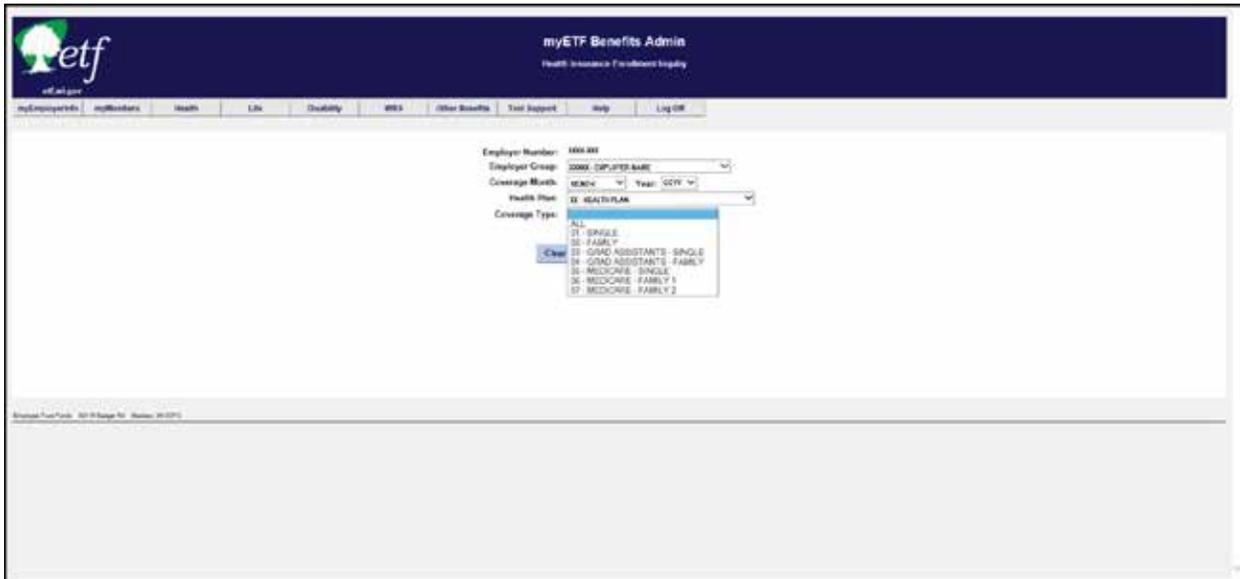
Below the form, there are three buttons: Clear, Display, and Save As.

7. Select the Health Plan option of your choice (default is ALL).

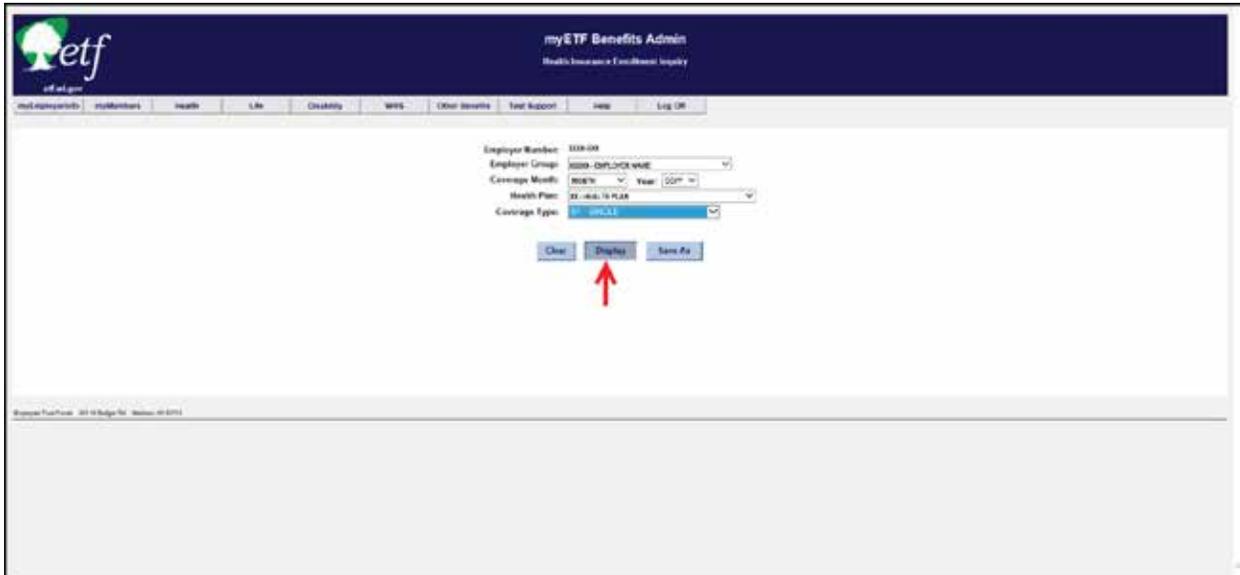
The screenshot shows the myETF Benefits Admin interface with the 'Health Plan' dropdown menu open. The form fields are the same as in the previous screenshot, but the 'Health Plan' dropdown is expanded to show a list of options. The list includes:

- ALL
- 01 - STANDARD PLAN
- 05 - SMP
- 11 - ANTHEM PPO IN SOUTHEAST
- 13 - ANTHEM PPO IN NORTHWEST
- 14 - ANTHEM PPO IN NORTHWEST
- 15 - DEAN HEALTH PLAN
- 17 - DEAN PPO/EARM
- 21 - HUMAN EASTERN
- 22 - HUMAN WESTERN
- 30 - IHC CAL CLARE
- 32 - IHC SDC
- 37 - GUNDESSON HEALTH PLAN
- 40 - ONYX COMMUNITY
- 47 - ANHE HEALTH PLAN
- 48 - HEALTH TRADITION
- 53 - MEDICAL ASSOCIATES HEALTH PLAN
- 66 - MHC VISION HEALTH PLAN
- 70 - METFORM HEALTH
- 71 - SECURITY HEALTH PLAN
- 74 - PROGRESS PLUS
- 84 - WPA WPTO CHOICE SOUTHWEST
- 85 - HEALTH PARTNERS
- 88 - WEA TRUST PPO EAST
- 89 - WEA TRUST PPO NORTHWEST
- 89 - WPS METRO CHOICE NORTHWEST
- 89 - WEA TRUST PPO SOUTH-CENTRAL
- 90 - UNITY HEALTH
- 94 - UNITED HEALTHCARE

8. Select the Coverage Type option of your choice (default is ALL).



9. Click the 'Display' button to display the results of your query.



- a. You can select the number of entries to show at one time.
- b. You can Search for specific information (example: Employee Type, MID#, SSN, Last Name etc.)
- c. You can skip to a certain page, next page, or last page.
- d. You can sort by a specific column (small arrows).

Local Health Insurance Administration Manual
Appendix C — myETF Benefits

myETF Benefits Admin
Health Insurance Enrollment Inquiry

myEmployerInfo myMembers Health Life Disability HSA Other Benefits Test Support Help Log Off

Employer Number: 000-000
Employer Group: 0000 EMPLOYEE NAME
Coverage Month: MONTH Year: 2017
Health Plan: 00 - HEALTH PLAN
Coverage Type: 01 - SINGLE

Clear Display Save As

#	Employee Type Code	Member ID	SSN	Last Name	First Name	Birthdate	Gender	Coverage Effective Date	Coverage Expiration Date
1	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
2	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
3	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
4	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
5	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	
6	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	
7	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	
8	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
9	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	
10	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	

Showing 1 to 10 of 1,302 entries

Download [Excel](#)

10. Click the 'Save As' button to export the results to a Microsoft Excel spreadsheet.

myETF Benefits Admin
Health Insurance Enrollment Inquiry

myEmployerInfo myMembers Health Life Disability HSA Other Benefits Test Support Help Log Off

Employer Number: 000-000
Employer Group: 0000 EMPLOYEE NAME
Coverage Month: MONTH Year: 2017
Health Plan: 00 - HEALTH PLAN
Coverage Type: 01 - SINGLE

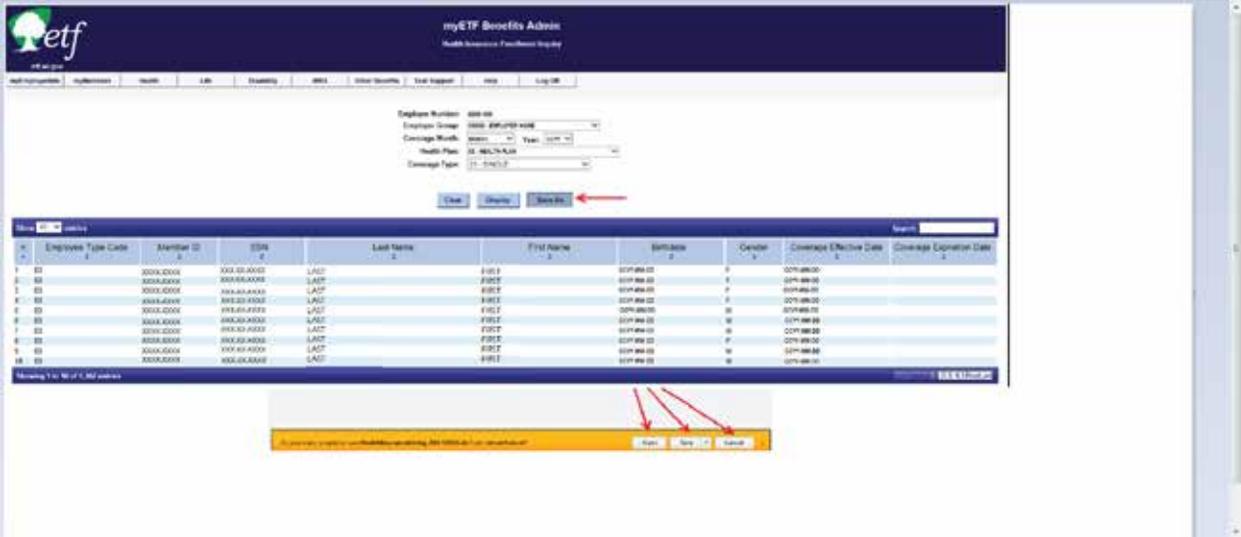
Clear Display Save As

#	Employee Type Code	Member ID	SSN	Last Name	First Name	Birthdate	Gender	Coverage Effective Date	Coverage Expiration Date
1	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
2	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
3	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
4	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
5	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	
6	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	
7	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	
8	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	F	2017-00-00	
9	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	
10	00	0000-0000	000-00-0000	LAST	FIRST	2017-00-00	M	2017-00-00	

Showing 1 to 10 of 1,302 entries

Download [Excel](#)

- a. You will be given the option to Open or Save the Excel spreadsheet or Cancel the export.



- b. Upon choosing to Open the spreadsheet, it will export the query to Excel and show it in the following format.

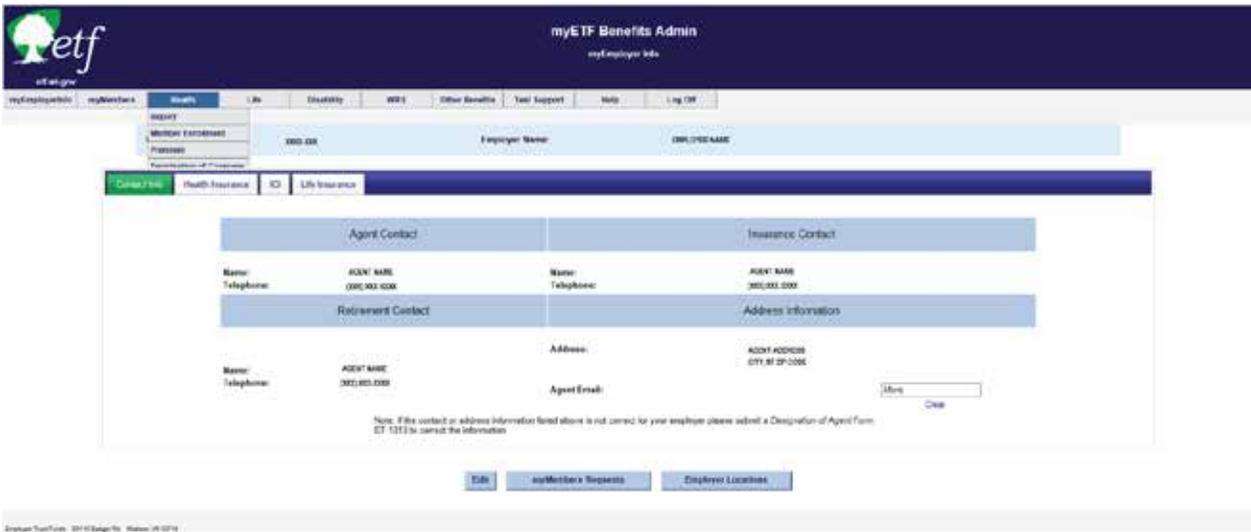
	A	B	C	D	E	F	G	H	I	J	K
	XXXXX - EMPLOYER NAME										
	MONTH - YEAR										
1											
2	Employee Type Code	Member ID	SSN	Last Name	First Name	Birth Date	Gender	Coverage Effective Date	Coverage Expiration Date	Health Plan	Coverage Type Code
3	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01
4	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	M	CCYY-MM-DD		XX	01
5	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01
6	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01
7	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	M	CCYY-MM-DD		XX	01
8	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01
9	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	M	CCYY-MM-DD		XX	01
10	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01

You can then choose to save the query or exit from Excel. It will not change your query in myETF Benefits.

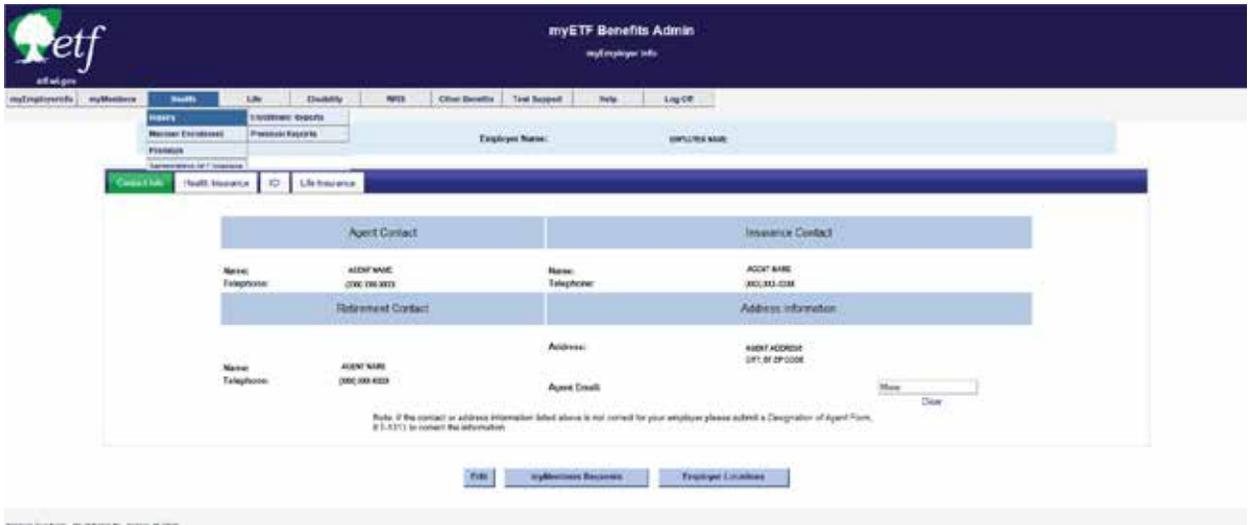
C-9. Dependent Inquiry

The Dependent Inquiry is a function of myETF Benefits where an employer can go to view a summary of all of their employees (subscribers) and their dependents that are, or have been enrolled in the State Group Health Insurance Program and entered in myETF Benefits. This is a monthly report based on available invoices. This query can either be very broad or broken down by a specific health plan, coverage type, relationship, and/or tax dependency status. To use this inquiry function, you will follow the procedures listed below.

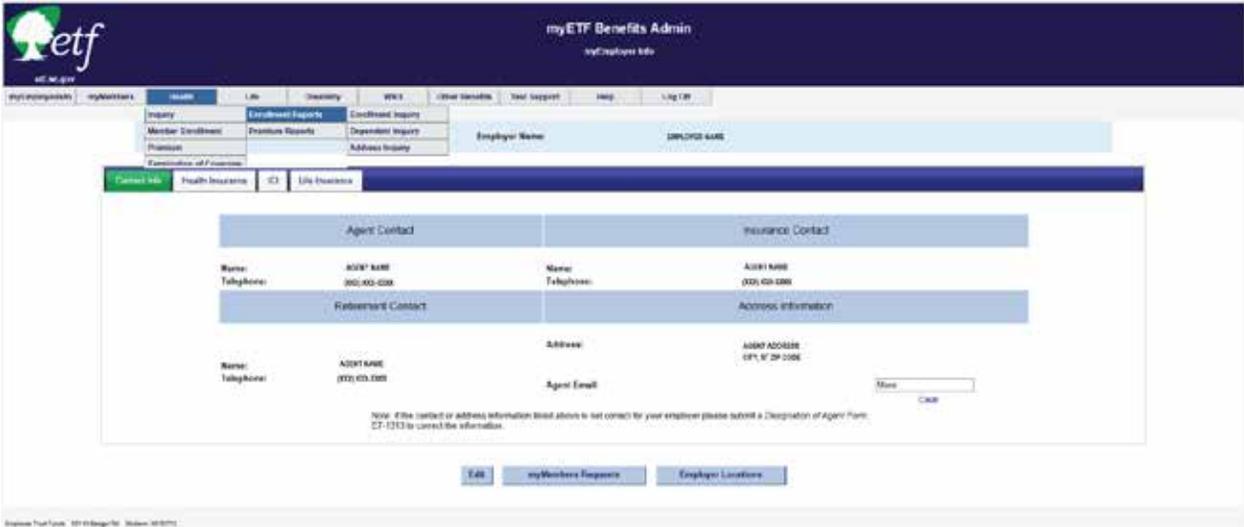
1. In myETF Benefits, highlight the 'Health' tab.



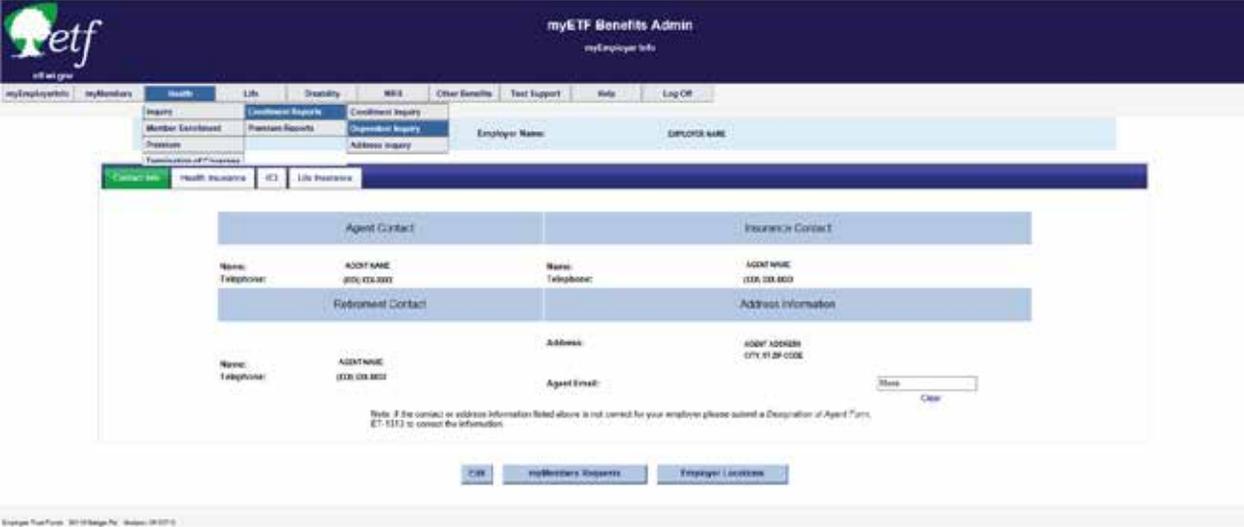
2. Highlight Inquiry.



3. Highlight Enrollment Reports.



4. Select Dependent Inquiry.



5. Select the Coverage Month.

The screenshot shows the myETF Benefits Admin interface. At the top, there is a navigation bar with the myETF logo and the text "myETF Benefits Admin Health Insurance Dependent Inquiry". Below the navigation bar, there are several tabs: myEmployeesInfo, myMembers, Health, Life, Disability, WFL, Other Benefits, Tool Support, Help, and Log Off. The main content area displays the following fields:

- Employee Number: 0000-000
- Employee Group: 0000-000 (dropdown)
- Coverage Month: [Month] (dropdown)
- Year: [Year] (dropdown)
- Health Plan: [Plan Name] (dropdown)
- Relationship: [Relationship] (dropdown)
- Coverage Type: [Type] (dropdown)
- Tax Dependents: ALL (dropdown)

At the bottom of the form, there are three buttons: Clear, Display, and Save As. The Coverage Month dropdown menu is open, showing a list of months from January to December.

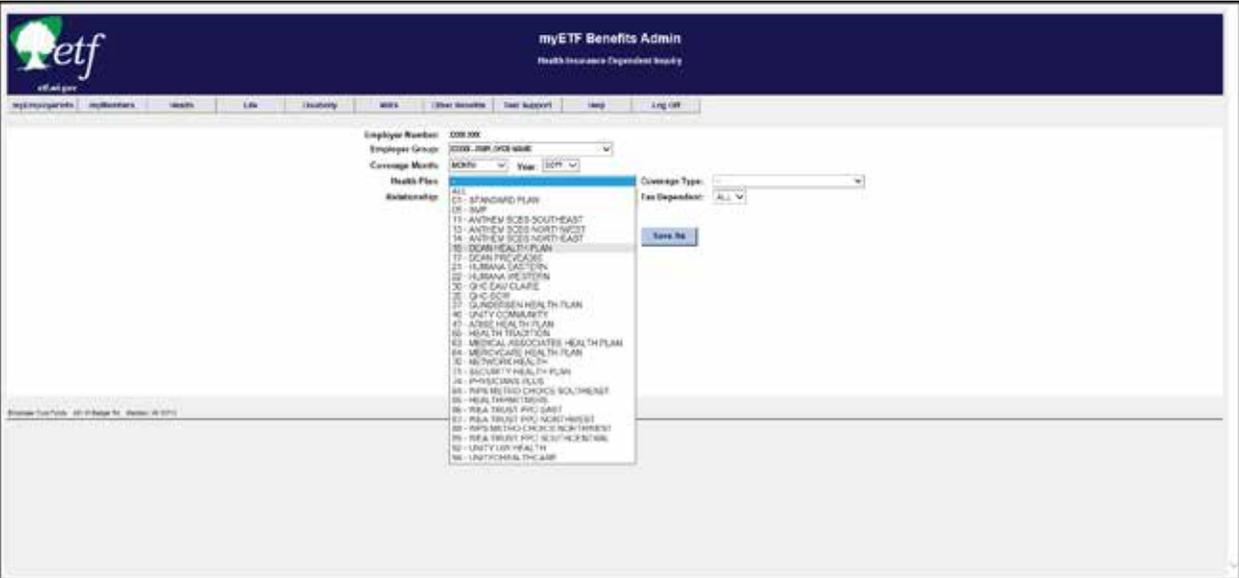
6. Select the Coverage Year.

The screenshot shows the myETF Benefits Admin interface, similar to the previous one. The main content area displays the following fields:

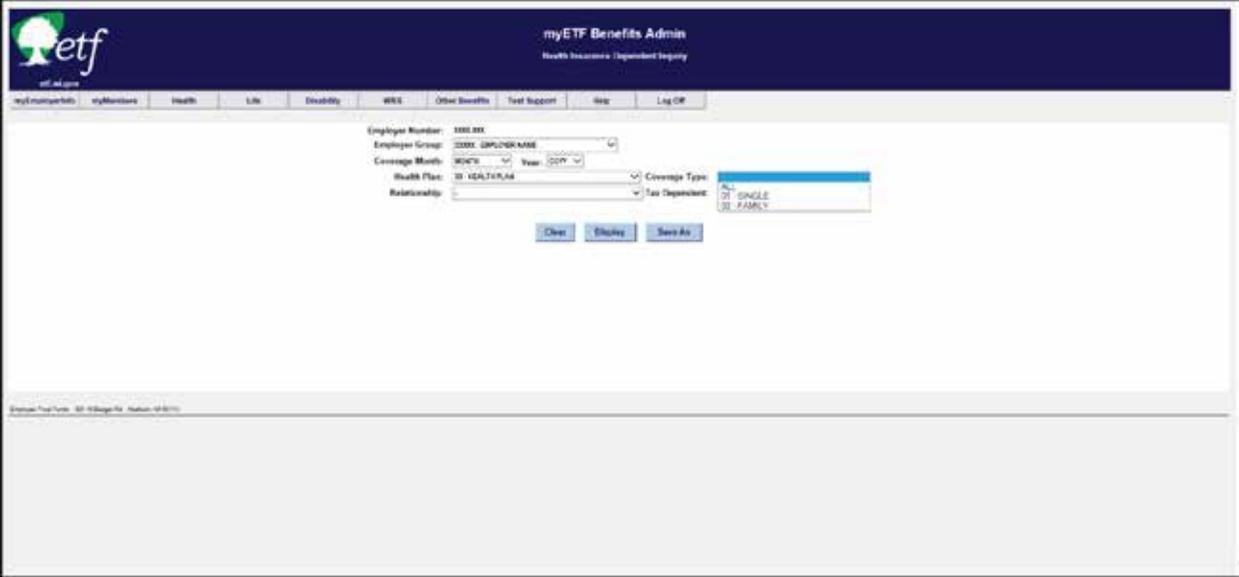
- Employee Number: 0000-000
- Employee Group: 0000-000 (dropdown)
- Coverage Month: [Month] (dropdown)
- Year: [Year] (dropdown)
- Health Plan: [Plan Name] (dropdown)
- Relationship: [Relationship] (dropdown)
- Coverage Type: [Type] (dropdown)
- Tax Dependents: ALL (dropdown)

At the bottom of the form, there are three buttons: Clear, Display, and Save As. The Year dropdown menu is open, showing a list of years from 2011 to 2015.

7. Select the Health Plan option of your choice (default is **All**).



8. Select the Coverage Type option of your choice (default is **All**).



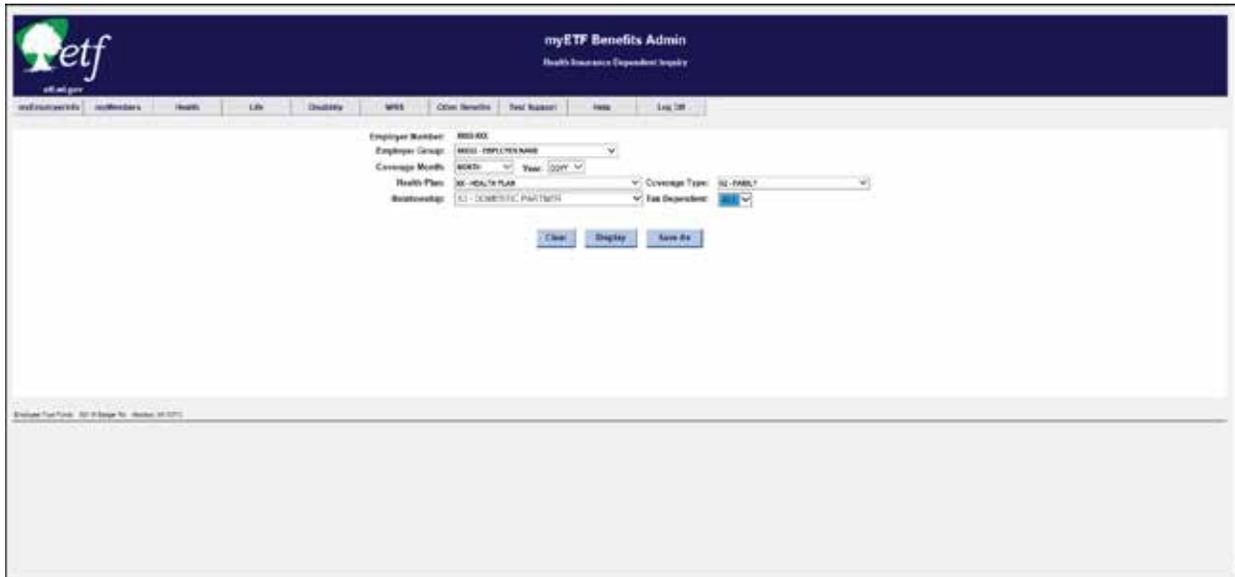
9. Select the Relationship option of your choice (default is **All**).

The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes the myETF logo and the text "myETF Benefits Admin" and "Health Insurance Dependent Inquiry". Below the navigation bar, there are several tabs: "myETFBenefits", "myETFBenefits", "Health", "LHA", "Coverage", "WFO", "Other Benefits", "Tool Support", "Help", and "Log Off". The main content area contains a form with the following fields: "Employee Number" (000-000), "Employee Group" (0000 EMPLOYEE), "Coverage Month" (00/00/00), "Year" (0000), "Health Plan" (00-0000/0000), "Coverage Type" (00-0000), and "Tax Dependent" (All). A dropdown menu for "Relationship" is open, showing the following options: "All", "01- SPOUSE", "02- PARENT OF BENEFIT DEPENDENT", "10- LEGAL WARD", "11- STEPCHELD", "19- CHILD", "24- DEPENDENT OF BENEFIT DEPENDENT", "28- DEPENDENT OF DOMESTIC PARTNER", and "31- DOMESTIC PARTNER". A "Save As" button is visible to the right of the dropdown menu.

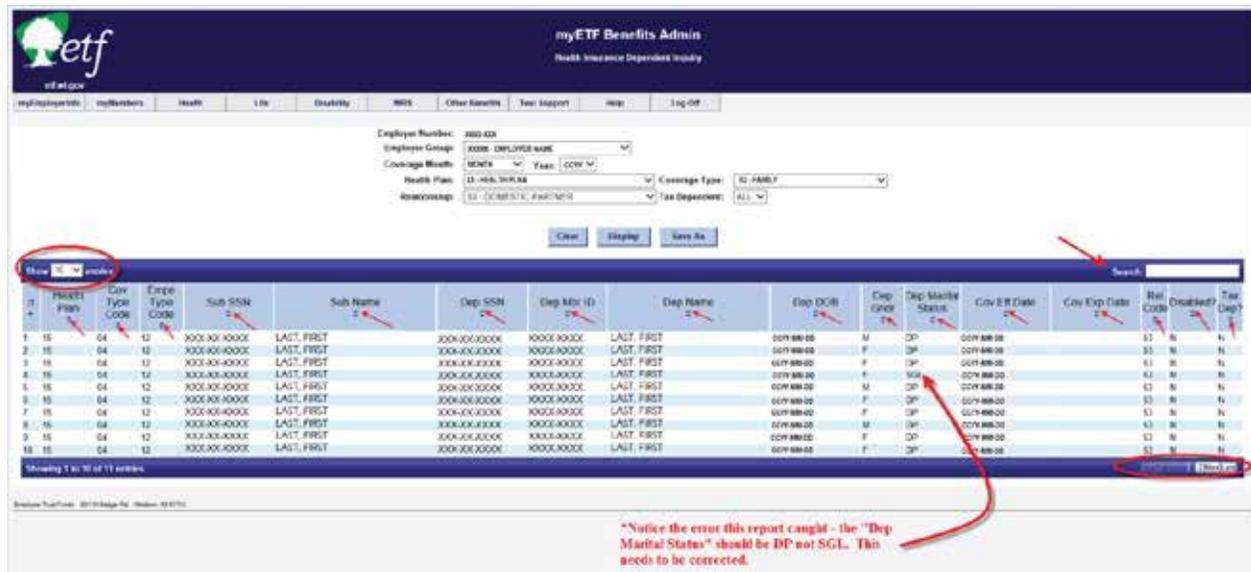
10. Select the Tax Dependent Status of your choice (default is **All**).

The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes the myETF logo and the text "myETF Benefits Admin" and "Health Insurance Dependent Inquiry". Below the navigation bar, there are several tabs: "myETFBenefits", "myETFBenefits", "Health", "LHA", "Coverage", "WFO", "Other Benefits", "Tool Support", "Help", and "Log Off". The main content area contains a form with the following fields: "Employee Number" (000-000), "Employee Group" (0000 EMPLOYEE), "Coverage Month" (00/00/00), "Year" (0000), "Health Plan" (00-0000/0000), "Coverage Type" (00-0000), and "Tax Dependent" (All). A dropdown menu for "Tax Dependent" is open, showing the following options: "All", "Yes", and "No". "Clear", "Display", and "Save As" buttons are visible below the dropdown menu.

11. Click the 'Display' button to display the results of your query.



- You can select the number of entries to show at one time.
- You can Search for specific information (example: Health Plan, Coverage Type, Employee Type, Subscriber SSN, Dependent SSN, Dependent MID#, etc.)
- You can skip to a certain page, next page, or last page.
- You can sort by a specific column (small arrows).



- b. Upon choosing to Open the spreadsheet, it will export the query to Excel and show it in the following format.

XXXXX - EMPLOYER NAME
MONTH YEAR
HEALTH PLAN = HEALTH PLAN, COVERAGE TYPE = FAMILY,
RELATIONSHIP = ALL, TAX DEPENDENT STATUS = ALL

1	Health	Coverage	Employee Type	Sub SSN	Sub Name	Dep SSN	Dep	Dep Name	Dep DOB	Dep Gender	Dep Marital Status	Cov Eff Date	Cov Exp Date	Rel Code	Disabled?	Tax Depen
2	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
3	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
4	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
5	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		01	N	Y
6	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		19	N	Y
7	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	F	SGL	CCYY-MM-DD		01	N	Y
8	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	F	MAR	CCYY-MM-DD		19	N	Y
9	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
10	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		19	N	Y

You can then choose to Save the query or Exit from Excel. It will not change your query in myETF Benefits.

C-10. Address Inquiry

The Address Inquiry function within myETF Benefits is currently under construction and will be available some time in the future.

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) and (d)(1)

The Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Officer, Department of Employee Trust Funds, 801 West Badger Road, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 1-800-947-3529; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 1-800-833-7813).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020 (TTY: 1-800-947-3529)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 1-800-947-3529)

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 1-800-947-3529).

Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-533-5020 (TTY: 1-800-947-3529).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-533-5020 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 1-800-947-3529).