State Agency Health Insurance Standards, Guidelines, and Administration Employer Manual

For UWs

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53713

Employer Communications Center
1-877-533-5020

etf.wi.gov

ET-1118UW (REV 3/28/2025)

Department of Employee Trust Funds
State Agency Health Insurance Standards, Guidelines, and Administration Manual

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Preface

The *State Agency Health Insurance Standards, Guidelines, and Administration Manual* (ET-1118UW) is a reference source intended to aid your administration of and participation in the State of Wisconsin Group Health Insurance Program. Its contents are based on state statute and administrative code. It includes group health contract language and policy relevant to the administrative and reporting practices of the Group Health Insurance Program. Employers should consult the Process Manual for instructions on how to work in My Insurance Benefits and the Employer User Guide (see section 104 for more information). You may recommend to Employees and Retirees that they review the Member Guide as they add or change coverage in My Insurance Benefits. Wisconsin statutes, administrative code, and group health contract language are reviewed on an ongoing basis and may be revised. This contract and policy manual will be updated regularly.

The Department of Employee Trust Funds (ETF) will make every effort to communicate changes to employers via the ETF website and ETF E-mail Updates. This *Employer Standards, Guidelines, and Administration Manual* (ET-1118UW) contains policy relevant to the administration of the Group Health Insurance Program but may not cover every eventuality. Specific program questions and situations will be considered regarding current statute, administrative code, this document and/or case law by ETF. The health insurance benefits are provided through the State of Wisconsin Group Health Insurance Program Agreement (ET-1136).

Consult this Employer Standards, Guidelines, and Administration Manual as a first-step resource when you encounter Group Health Insurance Program and policy related questions or concerns. If questions remain, contact the Employer Communications Center in ETF's Employer Insurance Unit (EIU). EIU 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 EIU 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 EIU telephone number is 1-877-533-5020 or email using Ivanti

Your efforts to accurately administer the provisions of the State of Wisconsin Group Health Insurance Program are appreciated. If you have comments on this edition or suggestions for the next edition of this *Employer Standards, Guidelines, and Administration Manual* (ET-1118UW), please contact ETF at 1-877-533-5020.

Chapter 1—Background Information

101 Applicable Policies, Statutes, and Legislation

101 A) Wisconsin Statutory Authority: § 40.51

The State of Wisconsin 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 (BOARD). The program offers EMPLOYEES and ANNUITANTS the opportunity to choose between multiple health plan choices.

Statutes can be searched and read at the Wisconsin Legislature website. See http://docs.legis.wisconsin.gov/statutes .

101 B) Group Insurance Board

The BOARD sets policy and oversees administration of the group health, life, supplemental benefits and income continuation insurance programs for eligible state and local EMPLOYEES. The BOARD reserves the right to change to a fiscal year or to some other schedule that it deems appropriate. The BOARD can allow other types of insurers and third-party vendors to provide other insurance plans, if employees pay the entire premium.

101 C) 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. Administrative rule can be searched and read at the Wisconsin Legislature website. See https://docs.legis.wisconsin.gov/code.

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

The program is offered by HEALTH PLANS who participate under the terms of the CONTRACT. The goals and objectives of the CONTRACT between the BOARD and the HEALTH PLANS are to:

(1) Encourage the growth of health benefit plans that can deliver quality health care efficiently and economically.
(2) Offer EMPLOYEES a choice between two or more health plans.

101 E) Act 10 and Act 32

2011 Wisconsin Act 10 and 2011 Wisconsin Act 32 contained a number of provisions that affected the Group Health Insurance Programs administered by ETF. For more information, please visit ETF's website at etf.wi.gov.

101 F) 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.

(1) The three components of this effort are:

(a) **Electronic Data Transaction Standards**—Sets uniform methods for conducting electronic transactions.

(b) **Privacy**—Limits how health information can be used and disclosed.

(c) **Security**—Requires safeguards for health information maintained in electronic form.

(2) ETF must comply with the following HIPAA regulations:

(a) When an employee does not apply for health insurance when first eligible, a new opportunity to apply occurs during the annual health benefits open enrollment period. Coverage is then effective January 1 of the following year.

(b) Certain qualifying life events such as loss of other group coverage, marriage, or the birth or adoption of a child, permit an enrollment opportunity without restriction. For more information, see the *Life Events Guide* in Insurance materials at etf.wi.gov or 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 online under *State and Federal Notifications*.

101 G) Affordable Care Act

The Affordable Care Act (ACA) was signed into law on March 23, 2010. 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:

(1) Rights and protections.
(2) Insurance choices.
(3) Full coverage for federally required preventive care services.

The consulting actuary to the BOARD has stated that all group health insurance plans offered to the EMPLOYEE and early (non-Medicare) ANNUITANTS of the State of Wisconsin groups are considered MINIMUM ESSENTIAL COVERAGE.

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

102 Employer Agent Responsibilities

102 A) Designate a Health Insurance Representative to:

(1) Receive, respond, and forward as necessary ETF E-mail Updates, which

contain important news and information from ETF. Your ETF case manager will automatically subscribe you to the appropriate topics for your agency. Contact your case manager with any questions.

(2) Explain eligibility, cost, enrollment procedures and effective dates to EMPLOYEES.

(3) EMPLOYERS should confirm that the SUBSCRIBER uploaded digital copies of acceptable documentation for births, marriages, divorces, deaths, and other life events and that they are valid. See *Life Change Events and Documentation Requirements* (ET-2846). SUBSCRIBERS must cover all eligible DEPENDENTS. However, effective January 1, 2025, for SUBSCRIBERS who do not provide required documentation (such as marriage or birth certificates), the SUBSCRIBERS will have 90 days to submit the documentation or the request to add the spouse or child will be declined and coverage will not be effective since there is no proof that the person is an eligible DEPENDENT.

(4) Provide the annual *Health Benefits Decision Guide,* either paper or electronic, to all new hires and current SUBSCRIBERS prior to the annual health benefits OPEN ENROLLMENT period and track when each EMPLOYEE received one. The annual *Health Benefits Decision Guides*, available on the ETF website and updated annually (please see ET-2107 (actives) and ET-2108 (ANNUITANTS and CONTINUANTS)) provide information on what's changing, health insurance rates, Uniform Benefits and plan availability for the plan year.

(5) Provide information upon initial enrollment, during health benefits open enrollment, continuation-conversion provisions and when applicable, Medicare.

(6) Secure, audit, and maintain health insurance applications, audit and approve online enrollments, and arrange payroll deductions.

(7) Respond timely to ETF requests for information, for example, for IAS-related items.

(8) Review, reconcile and pay monthly ETF invoices online by the 24th of each month. Refer to Chapter 14.

(9) Refer EMPLOYEES to the appropriate HEALTH PLAN contacts for claim or benefit questions. Customer service contact information is available in the open enrollment materials online under *Contact Info for Health Plans* (EMPLOYERS are also provided contacts for more specific areas such as claims and complaints. The *Health Plan and Vendor Contact List* (ET-1728) is updated quarterly and provided in an Employer News bulletin. This list is not meant to be shared with EMPLOYEES, but as a tool for EMPLOYERS only).

(10) Refer ANNUITANT health insurance questions to ETF's Employer Insurance Unit (EIU) .

(11) Refer questions regarding the CONTRACT to ETF (Refer to subchapter 106).

(12) Respond to HEALTH PLAN questions and audits in a timely manner.

(13) Visit etf.wi.gov to obtain forms as needed to ensure you are using the most current version.

(14) All documentation must be submitted to ETF in English.

102 B) Ensure confidential information is safeguarded

Through participation in the State of Wisconsin Group Health Insurance Program (GHIP), employers may gain access to confidential information including:

(1) Personally Identifiable Information under Wis. Stat. s. 19.62(5);

(2) Individual Personal Information under Wis. Adm. Code s. ETF 10.70(1);

(3) proprietary information;
(4) non-public information related to the State of Wisconsin's employees, customers, technology (including databases, data processing and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon;
(5) information that is restricted or prohibited from disclosure by state or federal law, including Individual Personal Information and Medical Records as governed by Wis. Stat. s. 40.07 and Wis. Adm. Code ss. ETF 10.70(1) and 10.01(3m); and (vi) Protected Health Information under HIPAA, 45 CFR 160.103.

Employer agent agrees to ensure employer maintains the confidentiality of all information obtained through participation in the State of Wisconsin Group Health Insurance Program.

In the event of an unauthorized disclosure, employer agent agrees to inform ETF of unauthorized disclosures in a timely manner and comply with all applicable laws, including providing notice under Wis. Stat. s. 134.98. Employer agent also agrees to coordinate with ETF regarding disclosure response activities, such as determining whether it is appropriate for the employer or ETF to provide required notices and the content of the notices.

103 Employer Training and Support

103 A) Training

Training for EMPLOYERS administering benefits under the Group Health Insurance Program is provided via the ETF website.

103 B) Group Health Plan Questions and Technical Support

Questions about HEALTH PLANS or benefits should be directed to the Employer Insurance Unit (EIU) unit at 1-877-533-5020 (toll-free). For email address, see section 106 A) below.

104 My Benefits

My Benefits is a self-service benefits management system. EMPLOYERS will need to be familiar with the applications, below. *When the manual states that EMPLOYEES must "submit (or file) an application", this generally means they must submit it electronically in My Insurance Benefits. Paper applications will still be available but should be used infrequently. Employers who enter information into My Insurance Benefits on a member's behalf must have paper documentation of the election choices.*

104 A) The Employer Transaction Application (ETA):
The ETA is an application that EMPLOYERS will use when My Insurance Benefits goes live to enter and update their EMPLOYEE demographic, eligibility, and enrollment data to support My Insurance Benefits transactions. Common transactions include new hires, change in job status, change in dependents, change in address, and any demographic and employment updates that impact

enrollment and eligibility. This is the first step of enrolling a new member in ETF. Large employers may leverage an ETA file transfer. All EMPLOYERS may use the User Interface (UI).

104 B) My Insurance Benefits:
The new system that will let members securely enroll in, change, or review their insurance benefits administered by ETF. As an EMPLOYER, you will be able to review and approve EMPLOYEE selections.

See the HR Administrator Guide and/or User Guide at etf.wi.gov for how to use My Insurance Benefits.

104 C) Procedures
You will find the steps to complete many My Insurance Benefits procedures in the My Insurance Benefits HR Administrator Guide. Employer Insurance Procedures (ET-1111) offers additional procedures for more complicated situations that require specific steps or include the use of the Employer Transaction Application. They are available on ETF's website.

104 **D**) **Invoicing/Billing (Certifi)**
When EMPLOYERS view their monthly invoice, they can access it in My Insurance Benefits using the Billing Manager function. This function links with another application called Certifi through single sign on. EMPLOYERS are responsible for reviewing and reconciling their invoice every month.

104 E) Employer Payment Application (EPA)
When the EMPLOYER is ready to pay the PREMIUMS, they will access ETF's Employer Payment Application (EPA). This application leverages US Bank's ePay system. Employers are required to pay the invoice in full.

104 F) Voya, the COBRA/Continuation platform
Voya, the parent company of Benefitfocus, offers COBRA benefits administration. Voya will handle COBRA for ETF and HR Admins. See Chapter 9 for more information.

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 and/or Retiree insurance unit regarding a problem or complaint. EMPLOYERS should direct EMPLOYEES in this situation to email, write, or call ETF's ombudsperson at the following:

Department of Employee Trust Funds
P.O. Box 7931
Madison WI 53707-7931

1-608-261-7947

Email: 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. If a member's issue cannot be resolved informally, formal written complaints should be made in writing, using the *Insurance Complaint Form* (ET-2405) if possible and should include an explanation of the issue the member is attempting to resolve. Additional information regarding ETF ombudsperson services can be found under the Benefits section at etf.wi.gov on the Benefits Dispute webpage..

106 Employer Insurance Unit (EIU) Contact Information

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

106 A) Employee Trust Funds (ETF)

Mailing Address	P.O. Box 7931 Madison WI 53707-7931
Shipping Address	Department of Employee Trust Funds 4822 Madison Yards Way Madison WI 53705-9100
Telephone	1-877-533-5020 select option 2 (toll free)
TTY	711
Fax	1-608-267-4549
Website	etf.wi.gov
Email	• Ivanti should be used by a Central Payroll Agency, the University of Wisconsin or the UW Hospital Authority. • If the employee works for one not listed, contact ETFSMBEmployerInsurance@etfwi.gov *If you are sending demographic or sensitive documentation to ETF via email, it must be sent securely. If you are unable to send securely, fax it to ETF.*

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

106 B) 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	www.navitus.com

106 C) Wellness and Disease Management Program Administrator Contact Information

Mailing Address	WebMD Health Services Group, Inc. 2701 NW Vaughn Street, Suite 700 Portland, Oregon 97210
Telephone	1-800-821-6591 (toll free)
Website	https://webmdhealth.com/wellwisconsin

Chapter 2 — Health Plan and Program Requirements and Information

The State of Wisconsin Group Health Insurance Program consists of two types of plans: IYC health plans and the ACCESS PLAN. Effective January 1, 2015, ETF also offered a High Deductible Health Plan (HDHP) option for both types of plans. Eligible EMPLOYEES, ANNUITANTS and currently insured CONTINUANTS can choose between at least two competing health benefit plans. If dental coverage is elected by the subscriber in this program, it is Uniform Dental Benefits.

201 Health Plans and HDHPs (HMOs and PPOs)

201 A) Health Plans
HEALTH PLANS are health maintenance organizations (HMOs) or preferred provider organizations (PPOs)) that provide Uniform Benefits at a lower cost than the ACCESS PLAN in exchange for some health care provider limitations. Most EMPLOYEES select an HMO. PPOs may have different copayment and deductible schedules for out-of-network providers, except in the case of emergency, urgent care or when the service is not reasonably available from an in-network provider.

All HEALTH PLANS participating in the Group Health Insurance Program offer the same level of coverage, called Uniform Benefits, with the exception of the Medicare Plus plan offered to Medicare eligible retirees by UnitedHealthcare. Note that plans may have differing medical policies that impact coverage, for example, differences in what services are considered experimental.

Uniform Benefits, as detailed in the Health Benefits materials online, 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, access to specific physicians or other health care providers and quality of services.

While Uniform Benefit coverage is the same for HEALTH PLANS, offerings differ in other ways, namely out-of-pocket costs, overall premium amount, provider network, benefit determinations and administrative requirements. Uniform Benefits and premium amounts change on an annual basis effective January 1st. The latest annual *Health Benefits Decision Guides,* available at etf.wi.gov (please see ET-2107 (actives) and ET-2108 (annuitants and continuants)) provide information on what's changing, health insurance rates, Uniform Benefits and HEALTH PLAN availability for the plan year. The Decision Guides, Certificates of Coverage and Schedules of Benefits (listed below) available online, are the most reliable resources for details.

Form # ET-	***Title of Certificate of Coverage or Schedule of Benefits***
2180	Uniform Benefits Certificate of Coverage [For Access Plans too]
2107sb	IYC Health Plan Schedule of Benefits
2112sb	Access Plan Schedule of Benefits
2107sbs	SMP Schedule of Benefits
2107sbhd	High Deductible Health Plan (HDHP) Schedule of Benefits
2170sb	Access High Deductible Health Plan (HDHP) Schedule of Benefits
2170sbhs	SMP HDHP Schedule of Benefits
2108sb	Health Plan Medicare Schedule of Benefits
4113	Medicare Plus (Certificate of Coverage including Schedule of Benefits)
2100cc	IYC Medicare Advantage (Evidence of Coverage)

Note: Benefits differ for retirees and their dependents enrolled in Medicare for example, deductibles do not apply.

201 B) High Deductible Health Plan (HDHP) Information

1. *General Information:* Each HEALTH PLAN will offer health care coverage through a High Deductible Health Plan (HDHP) to all eligible PARTICIPANTs who have enrolled in a State sponsored Health Savings Account (HSA) that meets all applicable state or federal requirements.

   The HDHP mirrors Uniform Benefits except that it contains an overall, up-front deductible and a larger out-of-pocket limit. The deductible *does* apply to pharmacy benefits. After the deductible, office visits and pharmacy copays again apply to an out-of-pocket limit. In a family plan, the entire family deductible must be met before the family coinsurance coverage begins. The deductible applies to all services except for federally required preventive care. Such care is covered at 100%. For more details, refer to the Health Benefits materials online.

2. *Eligibility:* The HDHP is available to most EMPLOYEES and ANNUITANTS younger than age 65.

   Ineligible members are as follows.
   a. EMPLOYEES who are eligible for the graduate assistant/short term academic staff benefits package and are not in the WRS.
   b. SUBSCRIBERS who are enrolled in Medicare or any other disqualifying health plan (for example, a spouse's health insurance plan including a medical flexible spending account, certain foreign travel insurance or TRICARE). See also 3., below.
   c. Effective January 1, 2024, ANNUITANTS who are or who insure a dependent who is enrolled in Medicare.

3. *For EMPLOYEES who enroll in other, disqualifying coverage, that is, a plan that pays medical expenses before the deductible in the HDHP plan:* Due to annual verification requirements that exist within My Insurance Benefits, the Coordination of Benefits (COB) process no longer applies for individuals enrolled in High Deductible Health Plans (HDHPs) including a Health Savings Account (HSA). Your employees who participate will confirm their eligibility annually within My Insurance Benefits, resulting in reduced effort for employers. If however, it is found later that a SUBSCRIBER has enrolled in disqualifying coverage, they are ineligible for the HDHP/HSA.
    a. Their coverage shall be changed to the non-HDHP Uniform Benefit with the same HEALTH PLAN**.**
        i. If the disqualifying other coverage is effective in the current year, the change to the non-HDHP benefit will occur the first of the month the other coverage is effective.
        ii. If the disqualifying other coverage was effective in the previous year, the change to the non-HDHP benefit will be retroactive to January 1 of the current year.
    b. If needed, PREMIUMS and claims shall be retroactively adjusted to align with these effective dates. During that time, the EMPLOYER may want to reach out to the State's HSA vendor to discuss recovery of EMPLOYER contributions that were made after the disqualifying other coverage became effective, to address a concern over IRS "improper contributions". ETF cannot provide tax advice. Members should consult a tax professional for advice.

    After the SUBSCRIBER disenrolls in the other disqualifying coverage, they may only reenroll in the HDHP during open enrollment or with a life event that permits a plan change.

4. *For active EMPLOYEES who are nearing age 65*: EMPLOYERS should make the EMPLOYEE aware of the potential consequences if they become enrolled in Medicare Part A, that is, they become ineligible for the HDHP/HSA benefit option. **To continue in the HDHP/HSA, the EMPLOYEE who is nearing age 65 must document that they will not enroll or be auto enrolled in Part A. If an EMPLOYEE takes their Social Security benefit, they will be automatically enrolled in Part A.**

5. *For EMPLOYEES over age 65 in the HDHP who intend to retire in the future:*
    a. EMPLOYEES age 65 and older on an HDHP plan should consider stopping contributions to their HSA six months before they apply for Social Security retirement benefits to avoid potential tax penalties. When they sign up for Social Security retirement benefits, Social Security will give them up to six months of "back pay" in retirement benefits. This means that their enrollment in Part A will also be backdated by six months. Under IRS rules, that leaves them liable to pay six months of tax penalties on HSA contributions from themselves and their EMPLOYER. ETF cannot provide tax advice. Members should consult a tax professional for advice.

    b. EMPLOYEES enrolled in an HDHP who retire, are over the Social Security Administration's (SSA's) full retirement age (e.g. age 65) and apply for SSA benefits, will begin their SSA benefit retroactively, for up to a maximum of 6 months. If they are enrolled in the HDHP at this time:
        i. The EMPLOYEE'S health contract must be changed to the non-HDHP policy with their same health plan, effective on the first of the month in which they are first enrolled in any part of Medicare. They will be responsible to pay additional EMPLOYEE premium contribution for the retroactive change in plan design. ETF can only adjust premiums

three months due to Medicare rules.

ii. Any HSA contributions they or the EMPLOYER has made will be subject to tax penalty as they will be considered “improper contributions”. That’s because retirees on Medicare cannot contribute to an HSA. ETF cannot provide tax advice. Members should consult a tax professional for advice.

If the EMPLOYEE over age 65 thinks they will retire in the next year, they should not enroll in the HDHP in that year, to prevent any improper contributions towards their HSA.

202 ACCESS Plan and HDHP

The ACCESS PLAN (formerly the Standard Plan) is a statewide/ nationwide Preferred Provider Organization (PPO) that is currently administered by Dean Health Plan. PARTICIPANTS enrolled in the ACCESS 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 (Uniform Benefits) or out-of-network (lesser benefit level). PPOs have different copayment and deductible schedules for out-of-network providers, except in the case of emergency or urgent care. PARTICIPANTS can review the online ACCESS PLAN Certificate of Coverage (ET-2180) and Schedule of Benefits (ET-2112sb non-HDHP or ET- 2170sb HDHP) for more details.

Dean Health Plan will offer health care coverage through a High Deductible Health Plan (HDHP) ACCESS PLAN to all eligible PARTICIPANTs who have enrolled in a State sponsored Health Savings Account (HSA) that meets all applicable state or federal requirements. See 201 B for important HDHP and HSA information.

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 IYC Health Plan. If an EMPLOYEE lives and is assigned to work out-of-state, they pay the Tier 2 premium contribution for the ACCESS PLAN. All other EMPLOYEES pay the Tier 3 premium contribution. See 204 for more information about Tiering.

203 State Maintenance Plan (SMP) and Health Plan Qualification

The State Maintenance Plan (SMP) offers the same Uniform Benefits package as the IYC Health Plans but is available only in those counties that do not have a qualified Tier 1 IYC Health Plan as noted in the current *Insurance benefits* materials online. The SMP is administered by Dean Health Plan.

Health Plan Qualification: Health plans are determined to be qualified on a county-by-county basis. Plans become "qualified" by meeting requirements for a specified number of providers in a given area. The BOARD reserves the right to make enrollment and eligibility decisions as necessary to implement the Group Health Insurance Program, including whether to make a Tier 1 plan available in those counties in which no qualified health plan in Tier 1 otherwise exists and/or a Tier 2 plan is available. ETF may take such action as necessary to implement this intent.

204 Three Tier Health Premium Structure

Since the passage of the 2003-2005 biennial budget, the state of Wisconsin has sought to reduce health insurance costs for EMPLOYEES and EMPLOYERS by utilizing a 3 Tier system for PREMIUM contributions. This was implemented to mitigate the trend of increasing health care costs. Each year the 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 EMPLOYEE contribution is determined by the Division of Personnel Management in DOA per the non-represented compensation plan or collective bargaining agreement. The EMPLOYER shall contribute the balance of the total PREMIUM.

The 3 Tier system is designed to foster competition between the HEALTH PLANS bidding to provide coverage through ETF while maintaining high-quality health care. All plans are assigned to one of the three tiers based on their cost effectiveness and the quality of care provided.

The health plans offered by ETF are predominately Tier 1, although some plans may fall into Tiers 2 or 3.

(1) Tier 1 plans – Low cost.
(2) Tier 2 plans – Moderate cost.
(3) Tier 3 plans – High cost.

The annual *Health Benefits Decision Guides,* available on the ETF website and updated annually (please see ET-2107 (EMPLOYEES) and ET-2108 (ANNUITANTS and CONTINUANTS)) provide information on what's changing, health insurance rates, Uniform Benefits, and plan availability for the plan year for the monthly PREMIUM rates.

205 Contribution Rates

Each year, the monthly amount that state EMPLOYEES are required to pay for health insurance is established by the Division of Personnel Management (DPM). DPM determines the EMPLOYEE contribution towards PREMIUM based on the provisions in Wis. Stat. § 40.05 (4) (ag) and (ah). Effective January 1, 2015, DPM also began to determine the EMPLOYER contribution for the HSA that accompanies the HDHP.

Effective on January 1, 2022, all represented and non-represented EMPLOYEES in craft-related classifications will be eligible for the monthly PREMIUMS, the HSA contributions and the health insurance Opt-Out incentive.

206 Opt-Out incentive

State EMPLOYEES may be eligible to receive an annual $2,000 health insurance opt-out incentive from the EMPLOYER.

To be eligible the EMPLOYEE:

(1) cannot have opted out at any time in 2015,
(2) cannot be covered for even one day in the calendar year, and
(3) cannot be covered under the state group health insurance program as a State EMPLOYEE'S dependent.

Eligible EMPLOYEES include Limited Term Employees (LTEs), less than ½ time EMPLOYEES, and those on leave of absence.

As of January 1, 2022, Craftworkers are eligible for the opt-out incentive if they have met the eligibility criteria above, for EMPLOYER contribution.

Every year EMPLOYEES must electronically enroll during the health benefits open enrollment period or within 30 days of hire for an EMPLOYEE new to the WRS. Select the Medical Opt-out in My Insurance Benefits.

Before paying any opt-out incentives, the EMPLOYER should refer to the "Opt-out of health benefits" employer procedure. See 104 C for more information.

If the opted-out EMPLOYEE experiences a mid-year involuntary loss of non-state coverage, incentive payments will stop as soon as the EMPLOYEE enrolls for coverage. This is due to the HIPAA special 30-day enrollment opportunity, even though the statute says the EMPLOYEE would not be eligible for coverage.

EMPLOYEES on a leave of absence are eligible to participate in the opt out program, but once their EMPLOYER contributions end, any opt-out incentives also end.

More information about the Opt-Out Incentive for EMPLOYEES is available online on the Frequently Asked Questions webpage.

207 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, managing the network of available pharmacies, and maintaining the preferred drug list, called the formulary. 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 ANNUITANTS enrolled in the Group Health Insurance Program will be automatically enrolled in the Medicare Pharmacy Part D plan, which is underwritten by Dean Health Insurance Inc., a federally qualified Medicare Part D prescription drug plan. In addition, these ANNUITANTS will also have supplemental "Wrap" coverage that pays secondary to the Medicare Pharmacy Part D plan.

ANNUITANTS may choose to be enrolled in another Medicare Part D plan, but it is neither recommended nor required. Those who choose to enroll in another Medicare Part D plan will be disenrolled from ETF's Medicare Pharmacy Part D 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, ANNUITANTS who maintain their enrollment in ETF's Medicare Pharmacy Part D plan will receive a separate ID card specifically for the Medicare Pharmacy Part D plan.

208 Wellness & Disease Management Program Administrator - WebMD

WebMD is the third-party administrator of Well Wisconsin, the uniform wellness and disease management program. Well Wisconsin is available to all SUBSCRIBERS and spouses enrolled in the Group Health Insurance Program. Well Wisconsin participants who complete a health check, health assessment, and a well-being activity are eligible to receive a $150 incentive. Some well-being activity options include health coaching, disease management, wellness challenges, and other online well-being programs.

All incentives earned by PARTICIPANTS are considered taxable income to the SUBSCRIBER and are reported to EMPLOYERS semiannually. COBRA/continuant PARTICIPANTS will see some taxes withheld from their incentive.

WebMD offers onsite biometric screenings and flu vaccine clinics for EMPLOYERS to host at their location. There is a minimum of 20 participants for each event. EMPLOYERS may request events directly through WebMD.

209 Health Plan & Vendor Contacts

Health plan and vendor contact information including general phone numbers are listed in the Insurance resources online. 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.

EMPLOYERS may use the contacts on the Health Plan and Vendor Contacts (ET-1728) to get answers to questions on membership, claims, grievances, supplies, and other information. It is found on ETF's website under the *Employer Forms and Brochures* section for health insurance. This form should not be shared with EMPLOYEES.

210 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 online at etf.wi.gov under the Uniform Benefits Certificate of Coverage (ET-2180), COB section. See also the chart in section 201 A. Questions regarding COB should be directed to the HEALTH PLANS.

211 Administration of Benefit Maximums

211 A) If a PARTICIPANT changes HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums, deductibles, or out-of-pocket limits under the group health benefit program will start over at $0 with the new HEALTH PLAN as of the EFFECTIVE DATE of coverage with the new HEALTH PLAN with the exception of the prescription drug BENEFIT annual out-of-pocket maximum for the HEALTH PLAN. The deductibles and out-of-pocket limits are combined for the HDHP, therefore, the prescription drug BENEFIT annual out-of-pocket accumulation will start over if the PARTICIPANT changes insurers. However, a change within the same HEALTH PLAN but with a different provider network, such as Quartz, would result in a continuation of the accumulated maximums.

211 B) If a PARTICIPANT changes the level of coverage (e.g., individual to family), transfers to another State agency, or has a spouse to spouse transfer resulting in a change of SUBSCRIBER, but does not change HEALTH PLANS, the annual BENEFIT maximums, deductibles, and out-of-pocket limits will continue to accumulate for that year. Note: No accumulations transfer if an EMPLOYEE moves from state to local (or vice versa) coverage, regardless of if they remain covered by the same insurer.

211 C) The HEALTH PLAN shall provide the PARTICIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of a plan explanation of benefits.

212 Errors

212 A) No clerical error made by the EMPLOYER, ETF or the HEALTH PLAN shall invalidate benefits of a PARTICIPANT otherwise validly in force, nor continue such BENEFITS otherwise validly terminated except for the constructive waiver provision below.

212 B) If an EMPLOYEE or ANNUITANT has made application during a prescribed enrollment period for either individual or family coverage and has authorized the premium contributions, benefits shall not be invalidated solely because of the failure of the EMPLOYER or ETF, due to clerical error, to give proper notice to the HEALTH PLAN of such EMPLOYEE'S application except for the constructive waiver provision below.

212 C) Constructive waiver: Any enrolled EMPLOYEE in active pay status for whom the EMPLOYEE portion of PREMIUMS has not been deducted from salary by the EMPLOYER for a period of 12 consecutive months, shall be deemed to have prospectively waived coverage upon a 30-day notice to the EMPLOYEE, unless all required PREMIUMS are paid. Coverage then may be obtained only under the deferred coverage provisions of 601 G.

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

212 E) If a person is erroneously omitted from participation under the Wisconsin Retirement System and the omission is corrected retroactively, including payment of all WRS required contributions for the retroactive period the member must apply within 30 days of notice from EMPLOYER of the error. Coverage will be prospective if the person would have been eligible for the coverage had the error never occurred.

212 F) If a graduate assistant becomes eligible for WRS and is reported late, their graduate assistant coverage is retroactively changed to active WRS coverage. Premiums will be adjusted accordingly.

213 Premium Refunds due to Errors are Limited

If an EMPLOYER erroneously continues to pay the PREMIUM for an EMPLOYEE who terminates employment or is on a leave of absence, refunds of such PREMIUMS shall be limited to no more than two months of PREMIUMS paid prior to the current month of coverage. Also see 801F.

214 Limited Premium and Claim Adjustments

Except in cases of fraud, material misrepresentation, resolution of BOARD appeal, or when required by Medicare, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to no more than six months of PREMIUMS paid. In cases where Medicare is the primary payer, retroactive adjustments to PREMIUM or claims for coverage not validly in force shall correspond with the shortest retroactive enrollment limit set by Medicare (currently 90 days) for either medical or prescription drug claims, not to exceed six months and in accordance with 1301 F. No retroactive premium refunds shall be made for coverage resulting from any application due to fraud or material misrepresentation. The HEALTH PLAN is responsible for resolving discrepancies in claims payment for all Medicare data match inquiries.

215 Benefits Non-Transferable

No person other than a PARTICIPANT, as recorded in My Insurance Benefits, is entitled to BENEFITS under this CONTRACT. The SUBSCRIBER or any of his or her DEPENDENTS who assigns or transfers their rights under the CONTRACT, aids any other person in obtaining BENEFITS or knowingly presents or causes to be presented a false or fraudulent claim shall be guilty of a Class A misdemeanor as prescribed under Wis. Stat. § 943.395, and subject to the penalties set forth under Wis. Stat. § 939.51 (3) (a).

Chapter 3—Eligibility

301 Employee, Annuitant and Continuant Eligibility

EMPLOYEES, ANNUITANTS and CONTINUANTS shall become or be SUBSCRIBERS if they have filed with the EMPLOYER or ETF, if applicable, an application in the form prescribed by ETF, and are eligible in accordance with the State of Wisconsin Group Health Insurance Agreement, the law, the administrative rules, and regulations of ETF.

301 A) For group health insurance purposes (per Wis. Stat. § 40.02 (25) (b)), eligible EMPLOYEES include:

(1) General participating state employees: Active state and university employees participating in the Wisconsin Retirement System.

(2) Elected state constitutional officials.

(3) Any members or officers of the legislature and other positions mentioned in 40.02 (25) (b) 6g.

(4) The blind employees of Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. §47.03 (1) (b) or § 47.03 (1m)

(5) Any employee on leave of absence who has chosen to continue their insurance.

(6) Any employee on layoff whose health insurance premiums are being paid from accumulated unused sick leave (Wis. Stat. § 40.05 (4) (bm)).

(7) The following in the University of Wisconsin System and University of Wisconsin Hospital and Clinics Authority as authorized under Wis. Stat. § 40.52 (3):

(a) Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six months on at least a one-third full-time appointment.

(b) Any teacher who is a participating employee and who is employed by the University of Wisconsin System for an expected duration of not fewer than six months on at least a one-third full-time appointment.

(c) Certain visiting faculty members in the University of Wisconsin System.

(d) Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one semester per academic year (nine month) appointments or six months for annual (twelve month) appointments.

(e) Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one semester for academic year (nine month) or six months for annual (twelve month) appointments.

(f) Short-term academic staff who are employed in positions not covered under the WRS and who are holding a fixed-term terminal, acting/provisional or interim (non-UW-Madison) appointment of 28% or more with an expected duration of at least one semester but less than one academic year if on an academic year (nine month) appointment or have an appointment of 21% or more with an expected duration of at least six months but fewer than twelve months if on an annual (twelve month) appointment.

(g) Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible for the health insurance benefits.

(h) Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the University of Wisconsin Hospitals and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six months.

*NOTE: In the event an EMPLOYEE is hired, WRS eligible, and elected insurance coverage that is in force and the EMPLOYEE terminates before completion of 30 days of service the insurance remains in force and the EMPLOYEE **must** be offered COBRA. Coverage as an active EMPLOYEE will end as of the end of the month of termination.*

301 B) ANNUITANTS and CONTINUANTS (Former EMPLOYEES/DEPENDENTS) For information related to accumulated sick leave conversion credit eligibility, see the *Sick Leave Conversion Program Employer Manual* (ET-1170).

(1) Any insured EMPLOYEE who is retired on an immediate annuity, receives disability retirement, duty disability (see 1001B 2), or Long-Term Disability Insurance (LTDI) benefits, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1). An immediate annuity means the annuity effective date is within 30 days of the termination date.

(2) The surviving spouse of an EMPLOYEE or of a retired EMPLOYEE who is covered on the EMPLOYEE'S health insurance at the time of death of the EMPLOYEE or retired EMPLOYEE.

(3) Insured EMPLOYEES who terminate employment, have attained minimum retirement age (50 for protective services or 55 for all other categories), have 20 years of WRS creditable service and defer their annuity are eligible to continue in the State of Wisconsin Group Health Insurance Program if a timely application is submitted.

(4) Any participating state EMPLOYEE who terminates employment after attaining 20 years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll in the Group Health Insurance Program at a later date. Enrollment is restricted to:

a) the open enrollment period in the fall (typically beginning in October) for coverage effective the following January 1, or

b) when the former EMPLOYEE begins their annuity.

(5) Any rehired ANNUITANT electing to return to active WRS participation is immediately eligible to apply for health insurance coverage through the EMPLOYER upon termination of their annuity and participation in the annuitant health insurance program (any state agency

or local employer that participates in the Wisconsin Public Employers Group Health Insurance Program).

302 Dependent Coverage Eligibility

302 A) Individual coverage covers only the eligible EMPLOYEE. All eligible, listed dependents are covered under a family contract. A SUBSCRIBER/EMPLOYEE cannot choose to exclude any eligible DEPENDENT from family coverage (refer to subchapter 102A 3). Eligible DEPENDENTS for family coverage include:

(1) Spouse (must be legally recognized in the State of Wisconsin).

(2) Children who include:

(a) Natural children.

(b) Stepchildren.

(c) 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 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 HEALTH PLAN may terminate coverage of the child when the adoptive placement ends.

(d) 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.

(e) 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:

(a) Children may be covered until the end of the month in which they attain age 26 except for grandchildren. Their spouse and/or dependents are not eligible. Upon the child's loss of eligibility, the child may be eligible for COBRA Continuation.

(b) 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).

(c) A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the State Group Health Insurance Program (including the Wisconsin Public Employers Group Health Insurance Program). In the event it is determined that a DEPENDENT is covered by two separate SUBSCRIBERS, the SUBSCRIBERSwill be notified and will have 30 days to determine which SUBSCRIBERwill remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. If the DEPENDENT (s) is to be newly covered by a SUBSCRIBERthat has individual coverage, the contract may be converted to a family contract. The effective date will be the first of the month following receipt of the application. The HEALTH PLAN(s) will be notified.

302 B) Coverage of Spouse or Dependent

(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one spouse elects family coverage, the other eligible spouse may be covered as a DEPENDENT but may not have

any other coverage. PARTICIPANTS can only be covered under one State Group Health Insurance Program (including Wisconsin Public Employers Group Health Insurance Program) contract. As permitted by Section 125 of the Internal Revenue Code, two individual contracts may be combined to one family contract, a family contract may be converted to two individual contracts, or the family coverage may be changed from one spouse to the other (spouse to spouse transfer) without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the spouses have coverage with different HEALTH PLANS at the time of marriage or when two individual contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the divorce.

(2) A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the State Group Health Insurance Program (including the Wisconsin Public Employers Group Health Insurance Program). In the event it is determined that a DEPENDENT is covered by two separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have 30 days to determine which SUBSCRIBER will remove coverage of the DEPENDENT and apply to remove the DEPENDENT. If the DEPENDENT(S) is to be newly covered by a SUBSCRIBER that has individual coverage, the contract may be converted to a family contract. The effective date will be the first of the month following receipt of the application. The HEALTH PLAN(s) will be notified. The exception is to escrow sick leave. See 601 H 5).

303 Employer Premium Contribution Eligibility

303 A) EMPLOYEES eligible to receive the EMPLOYER contribution toward the monthly PREMIUM payment include:

(1) A newly hired WRS covered EMPLOYEE, having been employed by the State of Wisconsin, University of Wisconsin Employee (except university faculty; see below) or a blind employee of Beyond Vision (aka WISCRAFT) (local government service does not apply) for a minimum of two months and having not taken a separation benefit (refer to WRS Manual chapter 300 to determine prior service). The EMPLOYEE must submit an application to his or her EMPLOYER within 30 days of the date of hire. Coverage will be effective the first of the month following date of hire (unless hire date is the first of the month, then coverage is effective the first of the month).

(2) A new EMPLOYEE with less than two months' prior service as a state, University of Wisconsin EMPLOYEE or a blind EMPLOYEE of Beyond Vision (aka WISCRAFT). A leave of absence may extend the date an EMPLOYEE becomes eligible for the EMPLOYER PREMIUM contribution. Also see 401D.

(a) A new EMPLOYEE can apply for coverage by submitting a completed application to their EMPLOYER within 30 days of their date of hire requesting coverage to be effective immediately, first of the month on or after date or hire. If the new EMPLOYEE does not have two months' prior state service, the EMPLOYEE will not be eligible for the EMPLOYER PREMIUM contribution until they have completed two months of state service and must pay the entire PREMIUM.

(b) A new EMPLOYEE may also elect coverage to begin when the EMPLOYER contributes

towards the monthly PREMIUM. The EMPLOYEE must submit a completed application to their EMPLOYER prior to becoming eligible for the EMPLOYER PREMIUM contribution. The new EMPLOYEE always becomes eligible for the EMPLOYER contribution on the first of a month.

i) Assuming there is no break in service, EMPLOYEES whose employment begins:

aa) The **first** of a month – Add two months to determine the month in which the EMPLOYEE is eligible to receive the EMPLOYER contribution.

Example 1: Hire date of March 1; health insurance application received March 1 (before becoming eligible for the EMPLOYER PREMIUM contribution), eligible for the EMPLOYER PREMIUM contribution on May 1. This effective date is determined by counting the month of March and April as the two full months of required state service because the EMPLOYEE was hired on the first of the month.

ab) The **second through the thirty-first** of a month – Add three months to determine the month in which the EMPLOYEE is eligible to receive the EMPLOYER contribution.

Example 2: Hire date of March 2; health insurance application received on April 2 (before becoming eligible for the EMPLOYER PREMIUM contribution), eligible for the EMPLOYER PREMIUM contribution on June 1. This effective date is determined by counting April and May as the two full months of required state service. March is not counted as a full month since the hire date was not on March 1.

ii) When an EMPLOYEE has a break in service and no previous state WRS service, **any** period worked in a month is counted as a month towards WRS service.

Example: Hire date of August 2; EMPLOYEE who either terminates or goes on a leave of absence beginning on September 2; EMPLOYEE returns to work (see 701B) on October 7; no prior service before August 2.

Because there is a break in service, any period worked in a month counts as a full month towards WRS state service. For example, if an EMPLOYEE works one day in August, one day in September and one day in October, these are counted as three full months because there were hours worked in each. The EMPLOYEE is eligible for the EMPLOYER PREMIUM contribution beginning November 1 if a health insurance application was received on or before that date. A leave of absence must also be deemed ended under Wis. Stat. § 40.02 (40) for the EMPLOYEE to be eligible for the EMPLOYER contribution on November 1.

Note: In this instance, the EMPLOYEE has until November 6 to submit a completed health insurance application (30 days from the date of return to work (see 701B)) for a plan of their choice. For an application received on or before

November 1, coverage is effective November 1. The coverage effective date is December 1 for an application received between November 2 and November 6.

(c) An EMPLOYEE who is newly eligible for the EMPLOYER contribution—due to a position change to more than 49%—is eligible for the EMPLOYER contribution the first of the month following the change. However, the application **must** be received within 30 days of the position change. Coverage will be effective the first of the month following date of position change (unless change date is the first of the month, then coverage is effective the first of the month).

Example: Jamaal works in a 40% FTE WRS-eligible position. He declined to enroll in health insurance because he thought the premium was rather expensive, which was due to his EMPLOYER only paying 50% of the premium. Jamaal's position will be increasing to a 100% FTE position.

This change in FTE from less than-half-time to half-time or more creates an enrollment opportunity for Jamaal, and—because the position is now half-time or more—he will be eligible for the full EMPLOYER premium contribution.

Because his health insurance premium is now more affordable with the full EMPLOYER premium contribution, Jamaal enrolls in health insurance.

(3) A graduate assistant or employee-in-training at the University of Wisconsin. EMPLOYER PREMIUM contribution for graduate assistants:

Under Wis. Stat. § 40.52 (3), University of Wisconsin graduate assistants, employees-in-training, short-term academic staff, fellows and scholars are also eligible for health insurance under this program. A new EMPLOYEE can apply for coverage by submitting a completed application to their EMPLOYER within 30 days of their date of hire requesting coverage to be effective immediately upon the first of the month on or after their EMPLOYER'S receipt of their application. A graduate assistant is eligible for the EMPLOYER contribution toward the premium upon hire.

If this is not the graduate assistant's first eligible appointment, they may still be eligible for the "initial" 30-day enrollment period if they had a 30-day employment break between appointments.

Example: Becca works in a 40% FTE WRS-eligible position. She declined to enroll in health insurance because she thought the premium was rather expensive, which was due to her EMPLOYER only paying 50% of the premium.

Becca is also going to school to get her master's degree, and she was recently offered a position as a graduate assistant. This new position creates an enrollment opportunity for Becca even if she will keep her current 40% position, and—because the position is a graduate assistant position—she will be eligible for the full EMPLOYER PREMIUM contribution in that position.

Because her health insurance PREMIUM is now more affordable with the full EMPLOYER PREMIUM contribution, Becca enrolls in graduate assistant health insurance.

If an EMPLOYEE enrolled under graduate assistant coverage becomes eligible for and enrolled in any WRS position with any state agency or local employer, they cannot be enrolled under graduate assistant coverage or retain graduate assistant coverage (§ 40.22 (4), Wis. Stat.).

(4) A teacher who is a WRS participating EMPLOYEE and employed by the University of Wisconsin for an expected duration of not fewer than six months with at least a one-third full-time appointment (UW faculty). UW faculty members are immediately eligible for the EMPLOYER PREMIUM contribution and must apply for coverage within 30 days of hire with coverage to be effective the first of the month that first occurs on or following the date of hire.

(5) A member of the Legislature or an elected state official, an EMPLOYEE of the Legislature, a state constitutional officer, a Supreme Court Justice, an Appeals Court Judge, a Circuit Court Judge, the chief clerk or sergeant at arms of the Senate or Assembly, or a district attorney who did not elect under § 978.12 (6) to continue insurance coverage with a county (or who did elect such coverage but terminated that election and elected state coverage within three months of the terminated election). These EMPLOYEES are immediately eligible for the EMPLOYER PREMIUM contribution and must apply for coverage within 30 days of taking office or the event.

303 B) Employer premium contribution for full- and part-time employees:

The BOARD, in accordance with Wis. Stat. § 40.51 (6), established the three-tier model with EMPLOYEE PREMIUM shares based on the three separate PREMIUM tiers (The three-tier model is explained in subchapter 204.). Wis. Stat. § 40.05 (4) (ag) and (at) provide guidance regarding the state PREMIUM contribution. Compensation plans and bargaining agreements, approved by the state Legislature, determine the exact EMPLOYEE and EMPLOYER share. The EMPLOYER PREMIUM contribution for part-time eligible EMPLOYEES is also subject to compensation plans.

For EMPLOYEES that are hired to work fewer than 1,040 hours per year, the EMPLOYER PREMIUM contribution is limited to half of the total PREMIUM (§ 40.05 (4) (ag), Wis. Stat.).

Health insurance plan PREMIUMS and EMPLOYEE contributions are published in the annual *Health Benefits Decision Guide,* available on the ETF website (please see ET-2107 (actives) and ET-2108 (ANNUITANTS and CONTINUANTS)) provide information on what's changing, health insurance rates, uniform benefits and plan availability for the plan year.

303 C) Employer premium contribution for limited term employees (LTEs):

Health insurance eligibility is based on WRS eligibility. Refer to Chapter 3 of the *WRS Administration Manual* (ET-1127) for information regarding WRS eligibility for LTEs.

Once LTEs begin participation under the WRS, they are immediately eligible to enroll in the Group Health Insurance Program but must pay the entire PREMIUM, or they may defer enrollment until the EMPLOYER contributes toward the PREMIUM. An LTE must have six months of state service to be eligible to receive the EMPLOYER contribution towards PREMIUMS. A completed application must be received by the EMPLOYER prior to becoming eligible for the EMPLOYER contribution.

EMPLOYEES hired to a WRS eligible LTE appointment and the anticipated hours per year are fewer than 1,040 hours, the EMPLOYEE is required to pay half the total PREMIUM cost with the EMPLOYER paying the remaining half. EMPLOYEES hired to work concurrent WRS eligible LTE appointments and the anticipated hours per year are 1,040 hours or more, either with the same state agency or different state agencies, they are treated as full-time EMPLOYEES for the determination of the EMPLOYER PREMIUM contribution.

303 D) Premium contribution for other represented and non-represented employees:

Some represented EMPLOYEES may have a different EMPLOYER PREMIUM contribution. Consult the applicable collective bargaining contracts. Some non-represented EMPLOYEES may also have a different EMPLOYER PREMIUM contribution. Consult applicable Division of Personnel Management Publications.

303 E) Premium contribution for covered state employees on military leave:

The EMPLOYER PREMIUM contribution for EMPLOYEES on military leave continues beyond the three months normally allowed under leave of absence provisions. EMPLOYEES on military leave who have not yet fulfilled the two-month employment provision are eligible for the EMPLOYER PREMIUM contribution on the date they would have been eligible had the military leave not occurred.

Under Wis. Stat. § 40.05 (4g) (b), if an eligible EMPLOYEE is not covered, the EMPLOYEE or designated representative may make an election on a form provided by the EMPLOYER no later than 60 days after the date the eligible EMPLOYEE begins to serve on active duty in the U.S. armed forces. The EMPLOYEE may receive the EMPLOYER contribution toward the PREMIUM if the EMPLOYEE or designated representative pays any EMPLOYEE contributions that are required to be paid toward PREMIUM payments.

304 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 state and or University of Wisconsin service:

(1) Access the *Previous Service Benefit Inquiry* application on ETF's web site at: etf.wi.gov/employers/wisconsin-retirement-system/etf-web-applications-employers

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

(2) Call the Employer Insurance Unit toll-free at 1-877-533-5020 or 1-608-266-3285 and request a previous service check.

305 Rehired Employee Coverage

305 A) Any insured EMPLOYEE who terminates employment with the state and is re-employed by

the state in a position eligible for health insurance within 30 days or who terminates employment for a period of more than 30 days that does not comply with Wis. Adm. Code § ETF 10.08 (2) and (3) shall be deemed to have been on leave of absence for that time and is limited to previous coverage.

305 B) Rehired ANNUITANTS who terminate their annuity and participate in the Wisconsin Retirement System may continue the same health insurance coverage by filing an application with the EMPLOYER within 30 days following the Wisconsin Retirement System participation begin date.

Rehired ANNUITANTS at the UW System are not eligible for the health insurance program under Wis. Stat. § 40.52 (3) for graduate assistants regardless of whether they are eligible to participate in the Wisconsin Retirement System. Also, see Chapter 11.

305 C) If an insured EMPLOYEE transfers from one state payroll center to another (for example, STAR to UW), an application must be filed within 30 days to maintain continuous coverage. If no application is filed within the 30-day enrollment period, continuous coverage may be reinstated by filing an application and paying back PREMIUM. The constructive waiver of coverage under section 211 C will apply. **Note:** If the break of 30 days or less spans two months, the new employer is responsible to offer coverage the first of the month so there is no gap in employer contribution. This means that if the transferred employee begins November 10, their coverage and employer contribution begins November 1. If there is more than a 30-day period where the employee is not at work at either of the two payroll centers, the EMPLOYEE should be offered COBRA.

Chapter 4 — Initial Enrollment

401 Initial Enrollment and Effective Dates

401 A) Immediately upon hire, EMPLOYERS must provide newly eligible EMPLOYEES with the:

- Current annual health benefits materials online or the *Health Benefits Decision Guide*,
- Information on how to enroll in My Insurance Benefits, and
- Notice of Privacy Practices and COBRA: Continuation of Coverage for Group Health Insurance notices (to meet federal COBRA and HIPPA notice requirements).

These are available at etf.wi.gov and updated annually.

If the EMPLOYEE wants to cover DEPENDENTS, they must cover all eligible DEPENDENTS and provide documentation such as a marriage and/or birth certificate or paternity acknowledgement. If not provided, the DEPENDENT will not be added to family coverage. If provided late, the DEPENDENT will be added retroactive to the EMPLOYEE's effective date. If the new EMPLOYEE is rehired and documentation is not on file for DEPENDENTS, it must be provided, even if they were previously insured (refer to subchapter 102A 3).

A Social Security number or Individual Taxpayer Identification Number (ITIN) is required for any DEPENDENT over the age of one for tax purposes. If the DEPENDENT does not have an SSN or ITIN, an EMPLOYER developed affidavit should be completed by the PARTICIPANT or parent and submitted to the EMPLOYER.

All eligible EMPLOYEES must either enroll or decline/waive coverage online with My Insurance Benefits (refer to subchapter 402).

> **Note**: It is recommended to instruct the EMPLOYEE to add the Social Security numbers (SSNs) of all DEPENDENTS as soon as possible. SSNs are needed for HEALTH PLAN reporting to the IRS annually, and if not entered, vendors will reach out to SUBSCRIBERS to gather that information. An EMPLOYER developed affidavit should be completed by the PARTICIPANT or parent and submitted to the EMPLOYER.

When coverage becomes effective, multiple PREMIUM payments may be required initially to make PREMIUM payments current.

401 B) Eligible EMPLOYEES and ANNUITANTS can enroll as described below*:*

(1) For EMPLOYEES who request coverage within 30 days of the EMPLOYEE'S date of hire: An EMPLOYEE shall be insured if a completed electronic enrollment through ETF's enrollment system, My Insurance Benefits, is received by the EMPLOYER within 30 days of the date of hire. Coverage will be effective as of the first day of the month that occurs on or following the date of hire. New WRS EMPLOYEES will be responsible for paying the full PREMIUM until EMPLOYER contributions begin.

(2) For EMPLOYEES who request coverage on or before becoming eligible for the EMPLOYER contribution:

a. An EMPLOYEE shall be insured if a completed ETF electronic enrollment through My Insurance Benefits is received by the EMPLOYER within 30 days of the date of hire or prior to the date EMPLOYER contributions begins. Coverage will be effective upon becoming eligible for EMPLOYER contribution. Eligibility for EMPLOYER contribution follows completion of two months of state service under the WRS for permanent/project EMPLOYEES/Beyond Vision (aka WISCRAFT) or six months of state service for limited term EMPLOYEES. This *does not apply to UW unclassified faculty/academic staff*.

b. EMPLOYEES who chose coverage beginning as soon as possible have the option of changing HEALTH PLANS and/or coverage levels effective on the first of the month that the EMPLOYER premium contribution begins.

(3) For UW unclassified faculty/academic staff: Includes a teacher who is a participating EMPLOYEE and who is employed by the University of Wisconsin for an expected duration of not fewer than six months with at least a one-third full time appointment (UW Faculty). UW Faculty members are eligible for the State PREMIUM contribution beginning on the date coverage begins.

(4) For Graduate Assistants: If eligible, they may enroll for individual or family coverage in any of the available non-high deductible HEALTH PLANS. Their benefits/payroll/personnel office must receive the application within 30 days of the date of first eligible appointment. Health insurance coverage will be effective as of the first day of the month that occurs on or following the date of hire. If this is not the graduate assistant's first eligible appointment, they may still be eligible for the initial 30-day enrollment period if there was a 30-day employment break between appointments.

Note: If currently an active WRS participant, graduate assistant positions are **not** eligible for coverage under the graduate assistant program. For example, a WRS EMPLOYEE on a leave of absence could not gain graduate assistant coverage.

401 C) For the purposes of selecting a High Deductible Health Plan (HDHP), a completed application requires the submission and acceptance of a Health Savings Account (HSA) application to the third-party administrator. The HSA application must be submitted concurrently with the HDHP application.

401 D) EMPLOYEES who chose coverage beginning as soon as possible have the option of changing HEALTH PLANS and/or coverage levels effective on the first of the month that the state PREMIUM contribution begins. EMPLOYEES canceling coverage prior to the date that the state PREMIUM contribution begins may re-enroll with the coverage becoming effective on the first of the month that the EMPLOYER contribution begins.

401 E) For initial enrollment, if the new EMPLOYEE'S spouse is also an eligible state or participating WPE EMPLOYEE or ANNUITANT, there are several options available. Double coverage of a PARTICIPANT in either or both the state and local group health insurance program is not permitted.

(1) If their spouse is already enrolled with individual coverage, the new EMPLOYEE may also elect individual coverage or elect family coverage in which case the spouse would have to submit an application to cancel their individual coverage in order to go onto the new EMPLOYEE'S family coverage.

(2) 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.

(3) If the parents are divorced and the child moves from household to household (for example, for the summer), the parents may file an application to remove the child from one contract and to the other.

402 Declining (Waiving) Coverage

402 A) An EMPLOYEE declining to enroll in the Group Health Insurance Program when initially eligible must make a waive election online through ETF's My Insurance Benefits system. Employees should be reminded that once declined, election of coverage later is limited to the onset of qualifying life events creating enrollment opportunities (refer to subchapter 403), or during the annual OPEN ENROLLMENT period for an effective date of January 1 of the following year.

402 B) An eligible EMPLOYEE may defer the selection of coverage if he/she is covered under another health insurance plan, or is a member of the US Armed Forces, or is a citizen of a country with national health care coverage comparable to the ACCESS PLAN as determined by ETF. ETF may permit an EMPLOYEE to cancel coverage or change from family to individual coverage if such coverage becomes newly available to them or their DEPENDENT. The request should be submitted to ETF before coverage is effective. If the EMPLOYEE or a DEPENDENT loses eligibility for that other coverage or the EMPLOYER'S contribution towards the other coverage ceases, the EMPLOYEE may elect coverage under any plan by filing an application with the EMPLOYER within 30 days of the loss of eligibility and by providing evidence satisfactory to ETF of the loss of eligibility. An EMPLOYEE enrolled for individual coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS covered under the other plan lose eligibility for that coverage or the EMPLOYER'S contribution towards the other coverage ceases. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan that replaces it without interruption of that person's coverage.

402 C) If permitted by state or federal law, as determined by ETF, an eligible SUBSCRIBER may defer or dis-enroll from coverage for themselves or a DEPENDENT if he/she is covered under medical assistance (Medicaid) (see 1-5 below), the Children's Health Insurance Program (CHIP), or TRICARE. A spouse may be dropped from family coverage if they are insured as an employee under an HDHP with an HSA that does not permit other disqualifying health coverage, that is, coverage under this program that would pay out-of-pocket health care expenses before meeting the spouse's employer sponsored plan deductible. ETF must be provided a copy of the spouse's employer sponsored plan documentation from the HDHP and the HSA that says the spouse cannot have any other group health insurance in order to be eligible for their employer's plan. This may include the Certificate of Coverage for the HDHP and HSA information.

Termination may be retroactive to the effective date of the other coverage upon request by the SUBSCRIBER. Family status changes under this provision remain subject to Section 125 of the Internal Revenue Code. If the EMPLOYEE or DEPENDENT loses eligibility for that coverage or

becomes eligible for a premium assistance subsidy for this program, the EMPLOYEE may elect coverage under this section by filing an application with the EMPLOYER within 60 days of the loss of eligibility or the date it is determined the EMPLOYEE or DEPENDENT is eligible for premium assistance and by providing evidence satisfactory to ETF. For dis-enrollment due to CHIP or TRICARE, EMPLOYEE should provide proof of coverage.

For requested dis-enrollment due to Medicaid, the following must be provided for ETF review:

(1) An explanation of why the SUBSCRIBER is requesting to drop the Medicaid enrolled PARTICIPANT. If it is due to provider network and/or claim payment issues, that should be described in detail.

(2) Documentation showing Medicaid coverage including effective dates, member number, monthly premium and plan coverage (for example BadgerCare).

(3) A Health Insurance Application/Change Form ((ET-2301) available on the ETF website and updated annually) requesting that the DEPENDENT's coverage be terminated.

(4) An Authorization to Disclose Medical Information (ET-7414) that specifically authorized ETF to speak with Medicaid and/or Navitus. If a social worker is involved in the case, authorize ETF to speak with her/him and provide her/his contact information.

(5) Note the child's relationship to the SUBSCRIBER, such as step-child or legal ward.

403 Enrollment Opportunities for Employees who Previously Declined or Canceled Coverage

403 A) EMPLOYEES who have declined coverage during a designated enrollment period can elect coverage either during the next OPEN ENROLLMENT period for an effective date of January 1 of the following year or due to a life event. An EMPLOYEE who deferred coverage may enroll if they have a new DEPENDENT because of birth, adoption, placement for adoption or marriage, provided they apply within 60 days of the birth, adoption or placement for adoption, or within 30 days of the marriage (refer to subchapter 102A 3). Coverage for this shall be effective on the date of termination of the prior plan or the date of the event. A quick reference guide is available in the It's Your Choice webpages, called the Life Events Guide.

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

Under federal law and by this contract, the following constitute qualifying life events that permit EMPLOYEES who previously declined or canceled coverage to enroll in any HEALTH PLAN without limitations:

(1) **Loss of Other Coverage:** EMPLOYEES who declined coverage under the Group Health Insurance Program have an opportunity to enroll due to loss in the following circumstances:

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

(d) Coverage as a citizen of a country with national/universal health-care coverage comparable to the ACCESS PLAN (non-HDHP);

(e) Complete loss of employer contribution for another health insurance program.

(f) Divorce.

(g) End of COBRA coverage.

Those who lose eligibility for the other coverage or the employer's entire premium contribution for the other coverage, 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. For example, non-payment of premiums, including for COBRA, is considered a voluntary loss of coverage.

EMPLOYEES should enroll online via ETF's My Insurance Benefits system, and upload information documenting the loss of coverage or employer premium contribution. All information must be received by the EMPLOYER within 30 days of the date the other coverage or the employer premium contribution ended. If all documentation is not readily available, submit the available items within the 30-day window. Follow up as soon as possible with any additional, required documents. Coverage will be effective the first of the month following application receipt by the EMPLOYER. Copies of the required documentation (described below) must be submitted to ETF for approval.

Note: The EMPLOYEE should complete and apply as soon as possible, 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.

Coverage is effective on the day following the last day of the other coverage if filed within 30 days of the event. For example, if coverage ended on May 13th with the other plan, coverage under the state program would begin on May 14. If the notice of coverage loss is provided to the member late, coverage will be effective the first of the month following the date of notice.

Documentation that ETF requires includes 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:

(a) Who was covered (must list the name of the member who is requesting this special, late enrollment)

(b) Name of Health Insurer

(c) Subscriber name

(d) Date coverage was terminated

(e) Reason for the cancellation (that is voluntary such as due to non-payment of

premium (including for COBRA) vs. involuntary such as being laid off, fired, expiration of COBRA or someone who quit and isn't eligible to keep group coverage)

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.

(2) **Marriage/Birth/Adoption/Permanent Legal Guardianship/ National Medical Support Notice/Paternity/Legal Custody Change:** EMPLOYEES who declined coverage under the Group Health Insurance Program have an opportunity to enroll in individual or family coverage if they have a new dependent as a result of marriage, birth, adoption or placement for adoption, placement for permanent legal guardianship (legal ward), 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 (refer to subchapter 102A 3).

(a) For marriage — You must terminate other coverage on the date of marriage or after. Coverage is effective on the date of marriage if an application is received within 30 days of that event date**.**

(b) For birth, adoption, placement for adoption, granting of permanent legal guardianship—coverage is effective on the date of birth, adoption, placement for adoption, or when permanent legal guardianship is granted if an application is received within 60 days of that event date.

(c) For paternity acknowledgement—coverage is effective on the first of the month following receipt of the application or if within 60 days of birth, retroactive to date of birth.

(d) 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 60 days of the court ordered support notice.

(e) For legal custody change (joint, full or transfer) – coverage is effective on the date of the event if an application is received, or online enrollment performed within 30 days of the event.

(3) **Increase in hours for LTEs and less than half-time employees:** LTEs and less than half-time EMPLOYEES who initially decline health insurance coverage have a new enrollment opportunity each time their appointment's hours increase to half-time or more. These EMPLOYEES may enroll in any HEALTH PLAN without restriction and have 30 days from the date the EMPLOYER contribution increases to file online via My Insurance Benefits. Coverage is effective the first of the month on or after the EMPLOYER'S receipt of the application.

Example:

- Jamaal works in a 40% FTE WRS-eligible position. He declined to enroll in health insurance because he thought the premium was rather expensive, which was due to his employer only paying 50% of the premium. Jamaal's position will be increasing to a 100% FTE position.
- This change in FTE from less than-half-time to half-time or more creates an enrollment opportunity for Jamaal, and—because the position is now half-time or more—he will be eligible for the full EMPLOYER PREMIUM contribution.
- Because his health insurance premium is now more affordable with the full EMPLOYER

PREMIUM contribution, Jamaal enrolls in health insurance.

(4) **Current employee becomes a graduate assistant or employee-in-training at the University of Wisconsin employer**: Under Wis. Stat. § 40.52 (3), University of Wisconsin graduate assistants, employees-in-training, short-term academic staff, fellows and scholars are eligible for health insurance under this program. A new EMPLOYEE can apply for coverage by submitting a completed application to their EMPLOYER within 30 days of their date of hire requesting coverage to be effective immediately upon the first of the month on or after their EMPLOYER'S receipt of their application. A graduate assistant is eligible for the EMPLOYER contribution toward the PREMIUM upon hire.

(a) If this is not the graduate assistant's first eligible appointment, they may still be eligible for the "initial" 30-day enrollment period if they had a 30-day employment break between appointments.

(b) If an EMPLOYEE enrolled undergraduate assistant coverage becomes eligible for and enrolled in any WRS position with any state agency or local employer, they cannot be enrolled under graduate assistant coverage or retain graduate assistant coverage (§ 40.22 (4), Wis. Stat.).

(c) **Example:**

- Becca works in a 40% FTE WRS-eligible position. She declined to enroll in health insurance because she thought the premium was rather expensive, which was due to her EMPLOYER only paying 50% of the PREMIUM.
- Becca is also going to school to get her master's degree, and she was recently offered a position as a graduate assistant. This new position creates an enrollment opportunity for Becca, but she must quit her current 40% position to be eligible for the full EMPLOYER PREMIUM contribution in that the graduate assistant position.
- Because her graduate assistant health insurance PREMIUM is now more affordable with the full EMPLOYER PREMIUM contribution, Becca quits her 40% WRS-eligible position and enrolls in health insurance.
- Or, Becca does not quit her WRS-eligible job, accepts the graduate assistant job, and is not able to take health insurance in either position until OPEN ENROLLMENT, when she could enroll under the WRS-eligible position.

(5) **Eligible adult child loses other coverage or employer contribution for it:** A SUBSCRIBER who does not request coverage for an adult child when first eligible under Wis. Stat. § 632.885, will thereafter be limited to enrolling the child when the child becomes newly eligible due to the loss of eligibility for other coverage or the loss of employer contribution for the other coverage. The SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days after the event and coverage for the DEPENDENT will be effective on the event date. If notice of loss of coverage is not timely, the SUBSCRIBER can add the DEPENDENT by filing an application with the EMPLOYER within 30 days after receipt of the notice and coverage for the DEPENDENT will be effective on the first of the month following receipt of the application. This paragraph does not prevent a SUBSCRIBER from adding the eligible DEPENDENT during the OPEN ENROLLMENT period for coverage effective the following January 1.

(6) **Escrow Sick Leave:** If an EMPLOYEE who deferred coverage wants to preserve sick leave credits for later use, they must enroll in the ACCESS PLAN (non-HDHP) 30 days prior to retirement. After one month of EMPLOYEE coverage, they may cancel and escrow their sick leave credits or they may continue this coverage. If an EMPLOYEE wants to retire, for example, as of April 15, they need to be insured as an EMPLOYEE in the non-HDHP ACCESS PLAN as of April first, then their ANNUITANT coverage would begin as of May first. The application must be

submitted no later than the first day coverage would be effective.

(7) **Leave of Absence:** Any insured EMPLOYEE for whom coverage lapses, or who allows family coverage to lapse during the leave of absence but continues individual coverage, as a result of non-payment of PREMIUM may reinstate coverage by filing an application with the EMPLOYER within 30 days after the return to work (see 701B). Coverage is effective the 1st day of the month on or after the date the EMPLOYER receives the application. The EMPLOYEE becomes eligible for the EMPLOYER contribution toward PREMIUM for the coverage month the leave of absence ends. Also, see section 701.

404 Applying for Coverage

Employer Responsibilities:

404 A) Verify the EMPLOYEE'S eligibility for group health insurance coverage (refer to subchapter 301.) See Life Change Events and Documentation Requirements ET-2846.

404 B) Provide the EMPLOYEE with the annual *Health Benefits* Decision Guides, available on the ETF website and updated annually (please see ET-2107 (actives) and ET-2108 (ANNUITANTS and continuants)). The Decision Guides provide information on what's changing, health insurance rates, uniform benefits and plan availability for the plan year. Inform the EMPLOYEE of the deadline for applying via My Insurance Benefits. Each eligible EMPLOYEE must submit an election (online or paper) to the employer even if declining coverage. EMPLOYEE instructions appear in the online My Insurance Benefits User Guide.

404 C) After the **EMPLOYEE** submits their application (online via My Insurance Benefits) the **EMPLOYER** will review and approve if appropriate. The EMPLOYER may reference the My Insurance Benefits Administration Guide for instructions.

405 Primary Care Provider or Primary Care Clinic

If a SUBSCRIBER files an application during a prescribed enrollment period listing a PCP/PCC that is not in-network with the selected HEALTH PLAN, the HEALTH PLAN must notify the SUBSCRIBER within five business days and aid the PARTICIPANT in selecting an in-network PCP/PCC. If the SUBSCRIBER is not responsive to the HEALTH PLAN'S efforts, the HEALTH PLAN will assign a PCP/PCC, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP/PCC.

In the event a SUBSCRIBER chose the wrong HEALTH PLAN, they may be allowed to correct their selection to one which has that physician or clinic available or to change physician or clinic selected, upon notice to the EMPLOYER that the error occurred and as approved by ETF. The HEALTH PLAN change shall be effective the later of first of the month following receipt of the application or the EFFECTIVE DATE of the original application.

406 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 207 for further information about the PBM). PARTICIPANT identification numbers are different on each card. The eight-digit ID number appearing on the pharmacy ID card is the PARTICIPANT'S member ID.

The application process 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 the PBM 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 are listed in the health benefits materials at etf.wi.gov.

Subscribers can contact the HEALTH PLAN directly to change their primary care physician or clinic.

Chapter 5 – Changing Coverage

501 Life Event Changes

501 A) There may be opportunities during the course of a year which allow SUBSCRIBERS to change coverage outside the initial enrollment opportunity. If there is a status change within the limitations imposed by this contract and statute, the SUBSCRIBER may be able to change HEALTH PLANS, add DEPENDENTS, remove DEPENDENTS, or change from individual to family coverage or family to individual coverage.

Status change opportunities are provided via etf.wi.gov in the Life Events Guide include:

(1) Move from service area (change HEALTH PLAN only).
(2) Birth, adoption or placement for adoption.
(3) Marriage (opposite or same sex).
(4) Establishment of a permanent legal guardianship.
(5) National Medical Support Notice (NMSN) or paternity acknowledgment.
(6) Loss of other coverage for EMPLOYEE or DEPENDENTS.
(7) Divorce.
(8) Spouse to spouse transfer.
(9) Disability of DEPENDENT.
(10) Open enrollment period.
(11) Legal custody change

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

501 B) The difference in PREMIUM between individual and family coverage for that month shall be due only if the change is effective before the 16th of the month. ANNUITANTS and CONTINUANTS for whom the EMPLOYER makes no contributions toward PREMIUM shall submit the application to ETF.

501 C) Changing the PARTICIPANT'S gender of record requires the PARTICIPANT to submit a copy of the *Address/Name/Gender Change* form (ET-2815) to the EMPLOYER or ETF. My Insurance Benefits is able to accept male, female and unspecified for sex. ETF is typically able to process requests within 30 days of receipt.

Document Submittal Instructions: The participant may submit the ET-2815 as follows.

1. **Active EMPLOYEES:**
   Submit the document to human resources or benefits person at work.

2. **Active EMPLOYEES' DEPENDENTS:**
   a. Submit the document to human resources or benefits person at work; or
   b. Submit the documents directly to ETF following the instructions for retirees below.

3. **Retirees and DEPENDENTS:** Submit the document directly to ETF using one of the methods below:
   a. Securely via Box through ETF's website
   b. U.S. Postal Service: WI Dept of ETF, P.O. Box 7931, Madison WI 53707-7931
   c. In Person: WI Dept of ETF, 4822 Madison Yards Way, Madison, WI 53705-9100
   d. Fax to 608-267-4549

502 Changing Plans Due to a Residential Move

When a SUBSCRIBER moves for a minimum of three months, they have an enrollment opportunity to change HEALTH PLANS (including, for example, from an HDHP to non-HDHP), even if their current plan remains available in the county to which the SUBSCRIBER moved. (A move from one medical facility to another medical facility is not considered a residential move.) The relocating SUBSCRIBER must notify their EMPLOYER (retirees contact ETF) and then make the change online in My Insurance Benefits. Retirees may submit a *Health Insurance Application/Change Form*. Changes must be sent within 30 days before or after the move. If the SUBSCRIBER moved to a state that does not border Wisconsin, they should select the ACCESS 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 SUBSCRIBER in My Insurance Benefits or the receipt of the *Health Insurance Application/Change Form* by ETF.

If the application to change plans is not received within 30 days before or after the move, the SUBSCRIBER cannot change HEALTH PLANS until the annual OPEN ENROLLMENT period or until they experience another qualifying life event as outlined later in this chapter.

A SUBSCRIBER not wishing to change plans due to the move 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 My Insurance Benefits and update their address within 30 days before or after the move. Retirees should submit a *Health Insurance Application/Change Form* to ETF.

503 Changing Health Plans

503 A) The following SUBSCRIBERS may change HEALTH PLANS after the event if an application is submitted within 30 days of the event. Coverage with the new HEALTH PLAN will be effective the first day of the calendar month, on or after the date the EMPLOYER (ETF for retirees) receives the application. Also see 401D.

An insured EMPLOYEE, ANNUITANT or CONTINUANT who is:

1. Adding one or more DEPENDENTS to the policy due to marriage, birth, adoption, placement for adoption, National Medical Support Notice, establishment of paternity, guardianship or legal custody change
2. Dropping one or more DEPENDENTS from a policy due to a divorce
3. Having an involuntary loss of other coverage (for example being laid off, fired, or someone who quit and isn't eligible to keep group coverage) or complete loss of employer contribution for the other coverage (including loss of a DEPENDENT'S coverage or employer contribution toward other coverage)
4. A less than half time status EMPLOYEE who gains more EMPLOYER PREMIUM contribution toward their coverage.
5. An EMPLOYEE loses a significant share of EMPLOYER contribution toward their coverage (e.g. full time to less than half time).
6. For ANNUITANTS only: obtaining Medicare Part A and/or B coverage. Also see 503B.

503 B) Retirees (existing or new) or their DEPENDENTS enroll in Medicare

1. When a PARTICIPANT on a retiree contract becomes enrolled in Medicare, the SUBSCRIBER may change HEALTH PLANS if an application is submitted within 30 days of the Medicare effective date (it may be up to 3 months in advance). Coverage in the new plan begins the first of the month following the date the SUBSCRIBER's application is received by ETF (but no earlier than Medicare's effective date).

   For example, the PARTICIPANT'S Medicare is effective October 1, but the SUBSCRIBER does not submit the request to change HEALTH PLANS until October 5. The effective date for their selected plan, in this case Medicare Advantage, will be November 1. For the month of October, the member(s) will remain in their current plan. Their benefits will change to Medicare coordinated coverage for October. They will get ID cards for this coverage from their current plan. **Note:** To be permitted the October 1st enrollment date, a Health Insurance Application/Change for Retirees (ET-2331) must be submitted to ETF prior to the effective date. Once My Insurance Benefits is operational, if the SUBSCRIBER cannot electronically submit an application in September, they should submit a paper application that month or earlier in order to have an October 1 plan change.

2. When an EMPLOYEE terminates employment and begins their coverage as an ANNUITANT, and they and/or their DEPENDENT(s) are age 65 or older, the following may happen as long as the PARTICIPANT(s) eligible for Medicare enroll in Parts A and B to be effective the first of the month following their termination of employment:
   a. The PARTICIPANT(s) will remain with their current HEALTH PLAN but under Medicare coordinated coverage.
   b. The SUBSCRIBER may change HEALTH PLANS when they or a family member newly enroll in Medicare. Coverage in the new plan begins the first of the month following the date the SUBSCRIBER's application is received by ETF (but no earlier than Medicare's effective date).

   For example, the PARTICIPANT's Medicare is effective October 1, but the SUBSCRIBER does not submit the request to change HEALTH PLANS until October 5. The effective date, in this case Medicare Advantage, will be November 1. For the month of October, the

PARTICIPANT(s) will remain in their current plan. Their benefits will change to Medicare coordinated coverage for October. They will get ID cards for this coverage from their current plan. **Note**: To be permitted the October 1st enrollment date, a Health Insurance Application/Change for Retirees (ET-2331) must be submitted to ETF prior to the effective date. Once My Insurance Benefits is operational, if the SUBSCRIBER cannot electronically submit an application in September, they should submit a paper application that month or earlier in order to have an October 1 plan change.

504 Changing from Individual to Family Coverage

Documentation Guidelines: ETF has the responsibility to provide information as needed for federal, state and/or contractual requirements. The EMPLOYER must exercise the same level of due diligence. The EMPLOYER/EMPLOYEE relationship is the most effective way to gather the needed information. The EMPLOYER should document their attempts in requesting the required information (refer to subchapter 102A 3).

One example is that the law requires SSNs to be reported on federal form 1095-B. HEALTH PLANS provide federal form 1095-B to your EMPLOYEES and to the Internal Revenue Service. The information from the form will be used by EMPLOYEES to prepare their individual income tax return. As necessary, ETF or the HEALTH PLAN will reach out to verify Social Security numbers of PARTICIPANTS.

A Social Security number or Individual Taxpayer Identification Number (ITIN) is required for any DEPENDENT over the age of one for tax purposes. If the DEPENDENT does not have an SSN or ITIN, an EMPLOYER developed affidavit should be completed by the PARTICIPANT or parent and submitted to the EMPLOYER.

Another example is if adding children and documentation such as a birth certificate is not on file for previously covered DEPENDENTS, it must be provided. See Life Change Events and Documentation Requirements ET-2846 for more information.

504 A) A SUBSCRIBER can change from individual to family coverage in several situations outside of the OPEN ENROLLMENT period.

The following are qualifying HIPAA events or are otherwise permissible life events:

(1) Birth.
(2) Adoption.
(3) Placement for adoption.
(4) Marriage.
(5) Receives a National Medical Support Notice or paternity acknowledgment.
(6) Transfer or change of custody.
(7) Establishes a permanent legal guardianship.
(8) Involuntary loss of other coverage.
(9) Loss of entire employer contribution, (Note: layoff is not a reason to change from individual to family coverage as your EMPLOYER contribution continues as described in the Sick Leave Conversion Program Employer Manual (ET-1170).)
(10) Has a DEPENDENT older than age 26 who is newly disabled.
(11) In accordance with Wis. Stat. § 40.51 (2), an EMPLOYEE who enrolls for individual coverage within 30 days following the date of hire, may change to family coverage during the enrollment

period offered as a result of becoming eligible for EMPLOYER contribution toward PREMIUM.

(12) A less than half time status EMPLOYEE enrolled in individual coverage who gains more EMPLOYER PREMIUM contribution may change to family coverage within 30 days following the increase in EMPLOYER contribution.

The SUBSCRIBER must go online to My Insurance Benefits and add the new DEPENDENT(s) for the appropriate reason. Retirees must submit a *Health Insurance Application/ Change Form* (ET-2301) available on the ETF website and updated annually) to ETF. Several of the above events also allow the EMPLOYEE to change health plans under Internal Revenue Code Section 125.

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

1) **Marriage:** Online enrollment must be submitted within 30 days from the event date. A SUBSCRIBER with individual coverage may change to family coverage. Coverage is effective on the date of marriage if an application is received within 30 days of that event date.

Upon marriage between parties who are both employed by or retired from the state (including the University of Wisconsin) or a participating Wisconsin Public Employer, both may retain or select individual coverage (no plan change is allowed) or one may retain or select family coverage under one of their current plans that will cover the other spouse and any eligible DEPENDENTS. Double coverage of an PARTICIPANT in either or both the state and local group health insurance program is not permitted.

Cancellation of individual coverage and the change to family coverage can be coordinated provided one of the applications is received timely. If the application to cancel the individual coverage and/or the application to change to family coverage is not received timely, the change to family can only occur during the OPEN ENROLLMENT period.

The SUBSCRIBER also has the opportunity to change HEALTH PLANS within 30 days of the marriage, 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.

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

If the application is received after 60 days, contact the Employer Insurance Unit. Generally, a SUBSCRIBER with individual 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 SUBSCRIBER cannot change to family coverage until the OPEN ENROLLMENT period unless another qualifying life event occurs in the interim.
Note: An application must be completed in a timely manner.

Effective January 1, 2025, SUBSCRIBERS who want to cover DEPENDENTS must provide documentation supporting the birth, etc., for any newly added dependents. This applies even if the SUBSCRIBER had previously insured the DEPENDENT(s). SUBSCRIBERS must cover all eligible DEPENDENTS. Documentation requirements are outlined in the *Life Change Events and Documentation Requirements (ET-2846)* available at etf.wi.gov.

The SUBSCRIBER has the opportunity to change HEALTH PLANS within 30 days of birth, adoption, placement for adoption or establishment of permanent legal guardianship, provided the application to do so is submitted within the 30-day time frame. The change will be effective the first of the month on or after receipt of the application.

3) **Involuntary Loss of Coverage or Complete Loss of Employer Contribution:** Application must be received within 30 days before or after a DEPENDENT has an involuntary loss of other coverage (such as being laid off, fired, expiration of COBRA or someone who quit and isn't eligible to keep group coverage) or completely loses employer contribution for the other coverage. If the SUBSCRIBER'S DEPENDENT(s) lost other coverage or lost the entire employer contribution toward their coverage, the SUBSCRIBER may change from individual to family coverage within the specified time frame. Coverage becomes effective on the date the other coverage terminates.

Documentation supporting the loss of coverage or employer contribution is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846)* available at etf.wi.gov.

ETF requires documentation including the following items on letterhead from the previous insurer and/or the former employer dated and issued before or 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:

a) Who was covered (must list the name of the member who is requesting this special, late enrollment)

b) Name of Health Insurer

c) Subscriber name

d) Date coverage was terminated

e) Reason for the cancellation (that is voluntary such as due to non-payment of premium (including for COBRA) vs. involuntary such as being laid off, fired, expiration of COBRA or someone who quit and isn't eligible to keep group coverage)

Note: The EMPLOYEE should complete and apply as soon as possible, even if they have not received the required documentation. 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.

4) **Paternity Acknowledgment:** When an acknowledgment of paternity is filed within 60 days of the birth, and an application is received 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 the *Life Change Events and Documentation Requirements (ET-2846)* available on the ETF website.

5) **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.

If the EMPLOYEE is eligible, the EMPLOYER is required to enroll the child or children as instructed in the notice. However, the EMPLOYER must adhere to limitations imposed on withholding as mandated by withholding laws of the state where the EMPLOYEE is principally employed.
In addition to the NMSN (serving as required documentation), the employee must enroll online through My Insurance Benefits to add the children named in the order to coverage. See 506 E for details.

6) **Legal Custody Change:** When a court order lists custody either full, joint or a transfer, coverage for the DEPENDENT(s) will be effective on the date of the event if an application is received within 30 days of the event.

Documentation supporting the custody change is required as outlined in the Life Change Events and Documentation Requirements (ET-2846) online at etf.wi.gov.

7) Disabled Dependent (child age 26 or older): Coverage is effective the date the HEALTH PLAN approves the DEPENDENT'S disabled status.

The SUBSCRIBER must submit an application 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 *Life Change Events and Documentation Requirements (ET-2846) online*.

505 Changing from Family to Individual Coverage

An EMPLOYEE can change from family to individual coverage in several situations outside of the 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 life event. An EMPLOYEE can change from family to individual coverage if their PREMIUMS are deducted pre-tax and they experience a HIPAA qualifying life event or a status change such as a divorce, their last DEPENDENT becomes ineligible for other coverage, all DEPENDENTS become eligible for and enroll in other coverage, or their last eligible DEPENDENT becomes eligible for and enrolls in other coverage. If an EMPLOYEE'S PREMIUMS are deducted post-tax or they are an ANNUITANT, they may change to individual coverage at any time and typically, coverage will end the last day of the month. See below and subsection 508 for more information.

The SUBSCRIBER must go online to My Insurance Benefits to remove their dependent(s) using the "change family to individual coverage" reason from the drop-down listing.

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

505 A) Divorce: EMPLOYEES are required under the Patient Rights and Responsibilities section of health benefits materials, to promptly notify their EMPLOYER of a divorce in order to properly terminate coverage and have COBRA continuation offered to the former spouse. Refer to Chapter 9. (Retirees should notify ETF.) Claims paid for ineligible dependents may become the responsibility of the EMPLOYEE or retiree.

The EMPLOYEE or retiree must submit an application within 30 days of the divorce and individual coverage is effective the later of the first of the month:

(1) in which the COBRA vendor provides notification of continuation rights

or

(2) in which the date of entry of judgment of divorce is entered/final with the clerk of courts.

Documentation to support the divorce may be required as outlined in the *Life Change Events and Documentation Requirements (ET-2846) online*. The SUBSCRIBER, as well as the ex-spouse, has the opportunity to change HEALTH PLANS within 30 days of divorce 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.

If ETF receives a Domestic Relations Order (DRO or QDRO) for an EMPLOYEE and does not have a COBRA Notice on file for the ex-spouse, ETF will reach out to the employer by email and ask the employer to remove the ex-spouse and any dependents (if applicable) from the contract.

> **Note:** If a SUBSCRIBER would like to enroll a new spouse that is different from the previous spouse, the new spouse must wait six months from the date of divorce before being eligible for coverage.

505 B) Last Dependent Becomes Ineligible for Coverage: This occurs when the last covered DEPENDENT reaches age 26, if not disabled. The EMPLOYEE should notify the EMPLOYER within 60 days of the DEPENDENT losing eligibility. My Insurance Benefits automatically terminates the aging out DEPENDENT'S coverage 90 days prior to the last of the month in which they turn 26.

If the EMPLOYEE does not notify the EMPLOYER of the DEPENDENT'S loss of eligibility within 60 days, or the EMPLOYER does not 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 individual coverage (refer to section 212).

> **Example:** DEPENDENT ages out February 23; EMPLOYER is not notified or does not check My Insurance Benefits until July 14; EMPLOYER invoice can only be refunded for May, June, and July. The change to individual coverage will be retroactive to the end of the month the last DEPENDENT lost eligibility. In the example, individual 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.

505 C) All Dependents or Last Eligible Dependent Become(s) Eligible for and Enroll(s) in Other Coverage: This occurs when the EMPLOYEE'S DEPENDENTS all enroll in other group coverage, such as insurance through a spouse's employer, or their last DEPENDENT becomes eligible for other coverage. The application to change to individual 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 OPEN ENROLLMENT period to remove these DEPENDENTS. The new coverage will be effective the first of the month on or after the application is received.

Documentation to support the eligibility for the other coverage is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846) online*.

505 D) Employee's appointment changes from full time to less than half time resulting in significant change in employer contribution:
An EMPLOYEE whose appointment is changing from full time to less than half time may change from family to individual coverage. The application must be submitted no later than 30 days following the appointment change. Coverage will be effective the first of the month following date of position change (unless change date is the first of the month, then coverage is effective the first of the month).

506 Adding Dependents

DEPENDENTS can be added to an existing family contract outside the OPEN ENROLLMENT period for the following reasons. Several of these events also allow the EMPLOYEE to change HEALTH PLANS under Internal Revenue Code Section 125. A Social Security number or Individual Taxpayer Identification Number (ITIN) is required for any DEPENDENT over the age of one for tax purposes. If the DEPENDENT does not have an SSN or ITIN, an EMPLOYER developed affidavit should be completed by the PARTICIPANT or parent and submitted to the EMPLOYER.

If adding DEPENDENTS and documentation such as a marriage or birth certificate is not on file for previously covered dependents, it must be requested and provided (refer to subchapter 102A 3). Documentation to support the eligibility for the other coverage is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846) online*.

506 A) Marriage: When family coverage is already in place, the application to add a spouse and DEPENDENT children must be received within 30 days of the date of marriage, coverage for the new DEPENDENTS will be effective on the event date. If the application was not received within 30 days and the marriage was not reported, but family coverage was in place, the spouse and any of their minor DEPENDENT children will be added upon notice to ETF. Coverage will be effective the first of the month following receipt by the EMPLOYER. Refer to 506H "Eligible Dependent Left Off Original Application" below for exceptions.

The SUBSCRIBER also has the opportunity to change HEALTH PLANS within 30 days of the marriage, 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.

506 B) Birth or Adoption/Placement for Adoption / Establishment of Permanent Legal Guardianship: If family coverage is already in place, the application to add the DEPENDENT child(ren) or ward(s) must be received within 60 days after the event. (If the application is received after 60 days, contact EIU.)

Coverage will be effective the date of the event. If an application is not submitted within this time frame,

generally the EMPLOYEE cannot change from individual to family coverage until the OPEN ENROLLMENT period unless they have another life event occur and submit the application in a timely manner. Refer to 506H “Eligible Dependent Left Off Original Application” below for exceptions.

Documentation to support the adoption or placement for adoption or the establishment of permanent legal guardianship is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846)* available online.

Effective January 1, 2025, SUBSCRIBERS who want to cover DEPENDENTS must provide documentation supporting the birth, etc., for any newly added DEPENDENTS. This applies even if the SUBSCRIBER had previously insured the DEPENDENT(s). SUBSCRIBERS must cover all eligible DEPENDENTS.

The SUBSCRIBER 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 .

For EMPLOYEES who terminate after taking incomplete action to add a DEPENDENT child (lacking a birth certificate or other required documentation), the former EMPLOYEE will have 90 days to submit the documentation or the change to add the child will be deleted and coverage will not be effective.

506 C) Dependent Involuntary 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 an involuntary loss of other coverage (such as being laid off, fired, expiration of COBRA, someone who quit and isn’t eligible to keep group coverage or after divorce, DEPENDENTS who were insured as step-children by the former spouse) or completely loses employer contribution. Because an EMPLOYEE’S DEPENDENT(s) lost other coverage or the entire employer contribution toward coverage, the EMPLOYEE may add their DEPENDENT to the existing family coverage within the specified time frame (refer to subchapter 102A 3).

If an application is not submitted within this time frame, the EMPLOYEE cannot change to family coverage until the OPEN ENROLLMENT period unless another life event occurs in the interim. Refer to 506H “Eligible Dependent Left Off Original Application” below for exceptions.

Documentation supporting the loss of coverage or employer contribution is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846) online*. 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 name

(4) Date coverage was terminated

(5) Reason for the cancellation (that is voluntary such as due to non-payment of premium (including for COBRA) vs. involuntary such as being laid off, fired, expiration of COBRA or someone who quit and isn't eligible to keep group coverage)

506 D) 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 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 *Life Change Events and Documentation Requirements (ET-2846) online*.

506 E) National Medical Support Notice (NMSN): The NMSN is a federal requirement used to enforce medical support orders for minor children. It is to be used throughout the United States to enroll children in employment related health insurance coverage. 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 NMSN is a qualified medical child support order; therefore, the EMPLOYEE does not have a choice to not enroll children named in the NMSN. If health care coverage is available and the EMPLOYEE is eligible, the EMPLOYER is required to enroll the child or children as instructed in the notice. However, the EMPLOYER must adhere to limitations imposed on withholding as mandated by withholding laws of the state where the EMPLOYEE is principally employed. This is described in the following paragraph.

The EMPLOYEE is required to enroll their eligible children named in the NSMN in any medical insurance the EMPLOYER has available for them. When the EMPLOYER gets the NMSN, they will have to determine whether the amount of the EMPLOYEE'S child support order and the amount of the medical insurance premium, added together, will be more than the percent they are allowed to withhold from the EMPLOYEE'S paycheck under the federal Consumer Credit Protection Act. If the insurance and child support together equal more than this amount, the EMPLOYER will not enroll the EMPLOYEE'S child(ren) in medical insurance.

EMPLOYERS should make a copy of PART A of the NSMN (two pages), keep the original for your files and return the copy to the Issuing Agency with the response page completed.

If an EMPLOYEE chooses to object, the EMPLOYEE must contact the issuing local child support agency as instructed in the NMSN he/she received. The EMPLOYER must still comply with the NMSN regardless of whether an objection has been made by the EMPLOYEE. In addition to the NMSN (serving as required documentation), the EMPLOYEE must add the children named in the order to coverage using My Insurance Benefits online. The EMPLOYER must file an application on behalf of the EMPLOYEE if the EMPLOYEE fails to comply with the NMSN. If the EMPLOYEE refuses to sign the application, the EMPLOYER must indicate that.

506 F) Legal Custody Change If family coverage is already in place, coverage for the DEPENDENT(s) will be effective on the date of the event if an application is received within 30 days of the event.

Documentation supporting the custody change is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846) online.*

506 G) 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.

The SUBSCRIBER must submit an application or 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.

506 H) Eligible Dependent Left Off Original Application: If family coverage is already in place, spouses and minor children who were left off the original application can be added to coverage prospectively if the following requirements are fulfilled in compliance with this contract and statute (refer to subchapter 102A 3).

The relevant contract and statutory provisions follow:

> 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 403 A) 5.

506 I) 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.

507 Removing Dependents

DEPENDENTS can be removed from family coverage for a limited number of reasons outside the OPEN ENROLLMENT period. These include the following reasons:

507 A) Divorce: Upon divorce, an enrollment change 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 date the judgment of divorce is entered/final with the clerk of courts.

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 notice was provided by the COBRA vendor to the former dependents, whichever is later.

Documentation to support the coverage end date due to divorce may be required as outlined in the *Life Change Events and Documentation Requirements (ET-2846) online*.

507 B) Death of Dependent: In the event of a DEPENDENT death, An enrollment change reporting the death must be submitted. There is no limitation on how long the EMPLOYEE must report the death of a DEPENDENT; however, if the death results in the coverage level changing to individual, PREMIUMS for the difference in PREMIUM cost between family and individual 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. If the surviving spouse files an application to drop the stepchildren, proof of other insurance must be provided.

507 C) 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, documentation that the EMPLOYEE or their spouse are providing at least 50% of the child's support and maintenance (per IRS Publication 501 worksheet 2) and that the child is unmarried. If the dependent no longer meets these qualifications, they must be terminated and the COBRA vendor will send a COBRA notice.

507 D) Grandchild's Parent Turns 18: The EMPLOYER can pull a dependent census report monthly from **My Insurance Benefits** to determine if any EMPLOYEE'S grandchild(ren)'s parent turns 18 years old at the end of the month. Then the employer should use the 'Loss of Dependent Child Status' life event to remove the grandchild. The EMPLOYEE must submit an application and report that the grandchild is losing eligibility.

The EMPLOYEE will be sent a COBRA notice for the grandchild by the COBRA vendor within five days of the date coverage ends.

507 E) Minor Dependent No Longer a Permanent Legal Ward: When a court terminates the permanent legal 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 SUBSCRIBER 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.

A copy of the court order documenting the termination of the permanent guardianship is required. A COBRA notice for the ward will be sent by the COBRA vendor.

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.

507 F) Adult Dependent Child Eligible for Other Coverage: When a DEPENDENT child at or over the age of 19 becomes eligible for, and elects other coverage, the SUBSCRIBER must file an application to remove this DEPENDENT within 30 days of the event (enrollment in other coverage). For example, if a child marries but obtains coverage through their spouse at a later date such as an open enrollment period, the event is the start of other coverage, not the marriage. A DEPENDENT'S enrolling in Medicare does not qualify the SUBSCRIBER to terminate coverage for the adult child outside of OPEN ENROLLMENT.

Coverage will terminate at the end of the month following receipt of the application. If not received within 30 days, the SUBSCRIBER will not be able to remove their DEPENDENT until the OPEN ENROLLMENT period. This applies even if this would result in an EMPLOYEE dropping to individual coverage as they are their last eligible DEPENDENT.

Documentation to support the eligibility for the other coverage is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846) online.*

507 G) Adult Dependent Child gains a dependent: A DEPENDENT child at or over the age of 19

who is eligible for, and elects other coverage due to birth, adoption, paternity or National Medical Support Notice, may be removed as of the date their other coverage begins. If an application is not received within 30 days of the event or notice of the event, the EMPLOYEE will not be able to remove their DEPENDENT until the OPEN ENROLLMENT period, even if this would result in the EMPLOYEE dropping to individual coverage as they are their last eligible DEPENDENT.

Documentation to support the eligibility for the other coverage is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846) online*.

507 H) Adult Dependent requests to be dropped from Parent/Subscriber's coverage: When the SUBSCRIBER refuses to submit an application, and a DEPENDENT child at or over the age of 19 becomes eligible for, and elects other coverage; does not live with the SUBSCRIBER; and has concerns about private health insurance information being shared with the SUBSCRIBER; they may request to be removed from their parent's plan. The DEPENDENT must provide documentation of the preceding items. The effective date will be the end of the month following date of request.

507 I) Dependent No Longer covered under a National Medical Support Notice (NMSN): When a court terminates the NMSN of a DEPENDENT child, coverage for the DEPENDENT will end at the end of the month of the order terminating the NMSN.

A copy of the court order documenting the termination of the NMSN is required. A COBRA notice for the child will be sent by the COBRA vendor.

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.

507 J) Dependent No Longer covered due to custody change: When a court orders custody of a minor DEPENDENT child to a different party, coverage for that DEPENDENT will end at the end of the month of the custody order changing where the child lives. A copy of the court order documenting the custody change of the DEPENDENT is required.

508 Considerations When Both Spouses Are Employed by the State, the University of Wisconsin, or One or Both Are Annuitants

If an EMPLOYEE'S spouse is an eligible state or University of Wisconsin EMPLOYEE or an ANNUITANT, one may select family coverage that will cover all eligible DEPENDENTS the EMPLOYEE chooses to cover.

If both an EMPLOYEE and their spouse are enrolled for individual coverage, PREMIUMS are being deducted on a ***pre-tax basis***, and they are not newly married, family coverage may only be elected effective at the beginning of the calendar year or when the EMPLOYEES have gained a DEPENDENT that necessitates family coverage.

If PREMIUMS are being deducted on a ***post-tax basis*** and the EMPLOYEE and spouse both have individual contracts, one of the individual contracts may be changed to a family plan at any time without restriction and the other single contract will be canceled. Family coverage will be effective the beginning of the month on or after receipt of an application, or a later date specified on the application. If PREMIUMS for family coverage are deducted ***pre-tax***, coverage can only be changed to individual coverage effective the beginning of the calendar year or when the last DEPENDENT becomes

ineligible for coverage or becomes eligible for and enrolled in other group coverage.

ANNUITANT PREMIUMS are deducted post-tax.

If PREMIUMS are deducted ***post-tax***, one family policy can be split into two individual plans with the same HEALTH PLAN effective the beginning of the month on or after receipt of an application, or a later date specified on the application from both spouses, provided both work for the state or are ANNUITANTS. A family policy may also be changed to one individual plan under either spouse.

509 Considerations When One Spouse is Employed by a Local Employer in the WPE Group Health Insurance Program or Other Non-State Employer

In addition to the information within subchapter 508, if the EMPLOYEE is insured under their spouse through a participating Wisconsin Public Employer or other non-state employer, and the EMPLOYEE dies, that EMPLOYEE'S sick leave credits will not be available for use by the surviving dependents. Under a state family plan, sick leave credits are preserved for the surviving DEPENDENTS regardless of who should die first.

510 Transfers of Employee from one State Employer to Another

When an EMPLOYEE changes employment from one State EMPLOYER to another, the EMPLOYER who has been paying EMPLOYER contribution toward PREMIUM will continue to pay until the new EMPLOYER becomes responsible for the PREMIUMs per 401 B.

Chapter 6 —Open Enrollment

601 Open Enrollment Eligibility

601 A) Establishing Open Enrollment

(1) The BOARD shall establish enrollment periods, called the OPEN ENROLLMENT, which shall permit eligible EMPLOYEES, ANNUITANTS and currently insured CONTINUANTS to enroll for or change coverage to any HEALTH PLAN offered by the BOARD as required by Wis. Stat. § 40.51. Unless otherwise provided by the BOARD, the OPEN ENROLLMENT period shall be held once annually in the fall of each year with coverage effective the following January 1.

(2) 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), transfer the coverage from one spouse EMPLOYEE to the other, transfer a DEPENDENT'S coverage from one divorced EMPLOYEE parent to another, or change from individual to family (refer to subchapter 102A 3) or family to individual coverage without limitations.

(3) If a SUBSCRIBER has not received an OPEN ENROLLMENT opportunity as determined by ETF, an enrollment opportunity may be offered prospectively.

(4) An EMPLOYEE who returns from leave of absence (as defined under Wis. Stat. § 40.02 (40)) during which coverage lapsed and which encompassed the entire previous OPEN ENROLLMENT period will be allowed an enrollment opportunity provided an application is filed during the 30-day period which begins on the date the EMPLOYEE returns to work following a leave of absence.

(5) An eligible EMPLOYEE who is insured as a DEPENDENT child on another policy in this program can enroll for coverage by submitting an application during OPEN ENROLLMENT for coverage effective the following January 1. Their parent must also submit an application to remove them from coverage during OPEN ENROLLMENT.

(6) A retired EMPLOYEE of the state who is receiving a retirement annuity or has received a lump sum payment which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1) and had been insured in the program when they terminated employment; or an EMPLOYEE of the state who terminates creditable service after attaining 20 years of creditable service, remains a participant in the WRS and is not eligible for an immediate annuity may enroll for coverage during OPEN ENROLLMENT.

601 B) Open Enrollment Period

The BOARD sets the OPEN ENROLLMENT period. Changes in coverage take effect January 1 of the following year.

601 C) Participation in the Open Enrollment Period

The following requirements must be met to make a change or enroll during OPEN ENROLLMENT:

(1) To enroll, the EMPLOYEE must be eligible for and enrolled in the WRS or be a currently employed UW graduate assistant. If making a change, the EMPLOYEE must be currently insured in the State of Wisconsin Group Health Insurance Program; ***and***

(2) If the EMPLOYEE is enrolling for family coverage for the first time they must provide documentation such as a marriage or birth certificate (refer to 102A 3) ***and***

(3) (a) EMPLOYEES must enter the change request online into My Insurance Benefits within the designated OPEN ENROLLMENT period.

(b) Applications from ANNUITANTS and CONTINUANTS changing plans during OPEN ENROLLMENT must be received by ETF postmarked no later than the last day of OPEN ENROLLMENT unless otherwise authorized by ETF. Members with duty disability are not eligible to newly enroll during OPEN ENROLLMENT.

601 D) Distribution of the annual *Insurance Benefits Decision Guide* and materials

The annual *Insurance Benefits Decision Guides,* available on the ETF website and updated annually (please see ET-2107 (EMPLOYEES) and ET-2108 (ANNUITANTS and CONTINUANTS)) provide information on what's changing, health insurance rates, uniform benefits and HEALTH PLAN availability for the plan year. The guides are forwarded to EMPLOYERS electronically prior to OPEN ENROLLMENT for distribution to all eligible EMPLOYEES, insured and uninsured (including those on leave of absence and layoff). ETF has guides mailed directly to ANNUITANTS and CONTINUANTS. There is a limited supply of paper annual *Insurance Benefits Decision Guides* available; EMPLOYERS are encouraged to direct EMPLOYEES to the electronic version found on ETF's website at etf.wi.gov. The annual *Insurance Benefits Decision Guides* must be distributed in a timely manner.

601 E) 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 online applications 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 HEATH PLAN or coverage type is selected effective January 1, and must have OPEN ENROLLMENT noted as the reason for submitting the application.

601 F) Employees who will retire during or after Open Enrollment:

Active EMPLOYEES who will retire between September and December should submit their OPEN ENROLLMENT elections directly to ETF as they will be a retiree effective January 1st of the following year. Applications can be submitted to ETF via Box, email, fax, or by mailing.

601 G) Employee's employment and/or health coverage ends after submitting an Open Enrollment election.

(1) If coverage ends on or prior to December 31, on the *Continuation - Conversion Notice (*ET-2311*),* list the health plan that coverage is with as of the coverage end date unless COBRA begins January 1. Then the open enrollment health plan election applies.

(2) List the *open enrollment* elected health plan on *Continuation - Conversion Notice* if current coverage ends after January 31.

601 H) Deferred Coverage Enrollment

(1) Any EMPLOYEE actively employed with the state who does not elect coverage during the enrollment period provided under section 401, 704 B, or who constructively waives coverage under section 211 C or who subsequently cancels coverage elected under chapter 4 or 502, 503, 603 B and 601 A (1), (3) (4) and 601 C (2) (b), may be insured only by electing coverage during the OPEN ENROLLMENT period as provided in section 601 A (1).

(2) An EMPLOYEE or ANNUITANT enrolled for individual coverage, though eligible for family coverage may only elect family coverage during the OPEN ENROLLMENT period, except as provided in chapter 4 or 502, 503, 603 B and 601 A (1), (3) (4) and 601 C (2) (b).

(3) An insured EMPLOYEE or ANNUITANT is permitted to change among HEALTH PLANS during an OPEN ENROLLMENT period offered under sections 502, 503, 603 B and 601 A (1), (3) (4) and 601 C (2) (b).

(4) A retired EMPLOYEE of the state may enroll for coverage during the OPEN ENROLLMENT period if he/she:

a) is receiving a retirement annuity (immediate annuity, disability retirement) or

b) has received a lump sum payment which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1) and had been insured in the program when they terminated employment or

c) is an EMPLOYEE of the state who terminates creditable service after attaining 20 years of creditable service, remains a participant in the WRS and is not eligible for an immediate annuity.

An immediate annuity means the annuity effective date is within 30 days of the termination date.

(5) An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40) who is not enrolled for coverage, may only enroll in the ACCESS PLAN 30 days prior to retirement for the purpose of escrowing their accumulated sick leave conversion credits per Wis. Stat. § 40.05 (4) (b). An EMPLOYEE is not allowed to enroll in the High Deductible Health Access Plan option as part of this provision. Beginning in January 1, 2019, retirees who elected the ACCESS PLAN 30 days prior to retirement may remain on this plan and use their sick leave credits to pay for coverage.

602 Withdrawing/Rescinding Health Benefits Open Enrollment Elections

When a SUBSCRIBER requests to withdraw/rescind an OPEN ENROLLMENT election in My Insurance Benefits, EMPLOYERS should refer to the Process Manual for information about the late OPEN ENROLLMENT process. SUBSCRIBERS may withdraw/rescind an OPEN ENROLLMENT election by notifying their EMPLOYER in writing (letter or email) prior to the

January 1 effective date.

No application or online 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 804) or prospectively through the late OPEN ENROLLMENT process (refer to subchapter 604).

603 When a Health Plan is not Available at Open Enrollment

When a HEALTH PLAN is no longer available for the upcoming year, SUBSCRIBERS enrolled in that plan **must** make a HEALTH PLAN change during the OPEN ENROLLMENT period. SUBSCRIBERS are notified by letter from the departing plan at the start of OPEN ENROLLMENT. Information on plans no longer available will also be included in the "What's Changing" section in the annual *Health Benefits Decision Guide*. SUBSCRIBERS who fail to select an available HEALTH PLAN during OPEN ENROLLMENT are deemed to have canceled coverage and must apply through the late OPEN ENROLLMENT process to select a new HEALTH PLAN to continue coverage. Coverage is usually effective the first day of the calendar month on or after the date ETF receives the application. EMPLOYERS should refer to the Process Manual for more information about the late OPEN ENROLLMENT process.

603 A) In some instances, such as a HEALTH PLAN service area merger, applications are not required and SUBSCRIBERS are switched automatically to a new HEALTH PLAN. In the event a new application is not required, the annual OPEN ENROLLMENT employer news (sent via ETF E-mail Updates), and the annual *Health Benefits Decision Guides* will include instructions. SUBSCRIBERS can still elect a different HEALTH PLAN during the OPEN ENROLLMENT period if they do not wish to remain with their merged plan.

603 B) If the HEALTH PLAN offers more than one network to PARTICIPANTS and the service areas of those networks change on January 1st, a SUBCRIBER who failed to make an OPEN ENROLLMENT election to change networks in order to maintain access to his or her current providers may still change to the appropriate network within that same HEALTH PLAN. The effective date of the change in networks is effective on January 1st or the first day of the month after the EMPLOYER receives the SUBSCRIBER'S request to change networks, whichever is later.

604 Late Health Benefits Open Enrollment Applications

EMPLOYEES or ANNUITANTS may request a review if they believe they were not offered an OPEN ENROLLMENT opportunity and they feel that their application should be accepted after the designated OPEN ENROLLMENT period. EMPLOYERS should refer to the Process Manual for more information about the late Open Enrollment process.

605 Late Health Benefits Open Enrollment Review Sample Letter

Below is a sample letter from the EMPLOYER informing an EMPLOYEE or ANNUITANT of the review process for a late OPEN ENROLLMENT application.

(DATE)
(EMPLOYER NAME AND ADDRESS IF NOT ON THE LETTERHEAD)
Dear (EMPLOYEE NAME):

Your open enrollment 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:

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

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

Chapter 7 — Leave of Absence

701 Definition of a Leave of Absence (LOA)

701 A) Under Wis. Stat. § 40.02(40), "Leave of absence (LOA)" 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.

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

701 C) An EMPLOYEE on LOA is subject to the same eligibility and enrollment provisions as an active EMPLOYEE.

702 Employer Contribution Toward Health Insurance Premium While on an Unpaid Leave of Absence

Wis. Stat. § 40.05(4)(a)3, requires that "[t]he employer shall continue to pay required employer contributions toward the health insurance premium of an insured employee while the insured employee is on a leave of absence, as follows:

(a) Only for the initial three months of the leave of absence, except as provided in subd. 3b.

(b) Unless otherwise provided in the compensation plan under s. 230.12, for the entire leave of absence if the insured employee is receiving temporary disability compensation under s. 102.43."

Note: EMPLOYEE also receives the EMPLOYER contribution toward health insurance PREMIUM that was prepaid prior to going out on a LOA in addition to receiving the EMPLOYER contribution for the initial three months following any prepaid month. For example, the EMPLOYEE goes on LOA effective September 5. The EMPLOYER and EMPLOYEE PREMIUM will be paid for September by the EMPLOYER on the 24th. The EMPLOYER share continues for October, November, and December. See also Section 708.

703 Coverage During an Unpaid Leave of Absence (Non-Military) - Coverage Does Not Lapse While on a Leave of Absence

703 A) Insured EMPLOYEEs on an unpaid leave of absence (LOA) choose whether to continue health insurance coverage during their LOA. After EMPLOYER contribution, the insured EMPLOYEE is responsible for payment of the full PREMIUM that must be paid in advance. Each payment must be received by the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid.

Retroactive EMPLOYER refunds resulting from termination for non-payment of PREMIUM by the EMPLOYEE are not allowed. For example:

- If the EMPLOYER has paid for May coverage, we do not let failure to collect the EMPLOYEE's share invalidate that month's coverage.
- If not collected, the following month's coverage (June) should be terminated due to failure to pay.

(1) If EMPLOYEE returns to active performance of duty and their LOA ends **within the first four months** after beginning a LOA, the following applies:

(a) No application is required upon resumption of active duty.

(b) EMPLOYER must track when the EMPLOYEE meets the criteria of a LOA ending under Wis. Stat. § 40.02(40) as described in 701.

(c) EMPLOYER must set the expectation with the EMPLOYEE regarding when a LOA ends and the use of leave time.

(d) EMPLOYEE cannot use leave time to satisfy the criteria ending a LOA under Wis. Stat. § 40.02(40).

(e) Leave time cannot be used to satisfy the 50% return to work criterion (see 701B), but this does not prevent an EMPLOYEE from using leave time to supplement their work schedule.

(f) EMPLOYER deducts EMPLOYEE-required PREMIUM contribution from EMPLOYEE's check.

Example:

i. EMPLOYEE goes out on a LOA January 15.

ii. If the EMPLOYER collects pre-paid PREMIUMS, the EMPLOYEE is eligible for EMPLOYER contribution toward the health insurance PREMIUM for the coverage month of February plus March, April and May under Wis. Stat. § 40.05(4)(a)3, *or*

iii. If the EMPLOYER collects PREMIUM for the month of coverage, and not pre-paid, the EMPLOYEE is eligible for EMPLOYER contribution for the health insurance PREMIUM for the coverage months of January plus February, March and April.

iv. EMPLOYEE returns to active performance of duty on April 1.

v. LOA ends May 1, upon completing the criteria under Wis. Stat. § 40.02 (40).

vi. EMPLOYEE continues to receive the EMPLOYER contribution toward the health insurance PREMIUM for the coverage month of May.

(2) If EMPLOYEE returns to active performance of duty and the LOA ends **more than four months** after beginning the LOA, the following applies:

(a) No application is required upon resumption of active duty.

(b) EMPLOYER must track when the EMPLOYEE meets the criteria of a LOA ending under Wis. Stat. § 40.02(40) as described in 701.

(c) EMPLOYER must set the expectation with the EMPLOYEE regarding when a LOA ends, the use of leave time, and when they will become eligible for the EMPLOYER contribution toward the health insurance PREMIUM.

(d) EMPLOYEE cannot use leave time to satisfy the requirements ending a LOA under Wis. Stat. § 40.02(40).

(e) Leave time cannot be used to satisfy the 50% return to work criterion (see 701B), but this does not prevent an EMPLOYEE from using leave time to supplement their work schedule.

(f) The EMPLOYEE becomes eligible for the EMPLOYER contribution toward the health insurance PREMIUM for the coverage month in which the LOA ended.

(g) EMPLOYER deducts or collects the full monthly PREMIUM from the EMPLOYEE until the LOA ends.

(h) EMPLOYEE receives a refund of any EMPLOYER contribution paid by the EMPLOYEE for the month in which the LOA ended.

Example:

i. EMPLOYEE goes out on a LOA October 2.

ii. If the EMPLOYER collects pre-paid PREMIUMS, EMPLOYEE is eligible for EMPLOYER contribution toward the health insurance PREMIUM for the coverage month of November plus December, January and February under Wis. Stat. § 40.05(4)(a)3, *or*

iii. If the EMPLOYER collects PREMIUMS for the month of coverage, and not pre-paid, the EMPLOYEE is eligible for EMPLOYER contribution for the health insurance PREMIUM for the coverage months of October plus November, December and January.

iv. EMPLOYEE pays full premium, no EMPLOYER contribution, beginning with the coverage month of March.

v. EMPLOYEE returns to active performance of duty on March 20.

vi. LOA ends April 19; Wis. Stat. § 40.02(40).

vii. EMPLOYEE is eligible for the EMPLOYER contribution toward the health insurance PREMIUM for the coverage month of April, the month the employee's LOA ends.

viii. Since the total PREMIUM has been paid by the EMPLOYEE prior to the coverage month of April, the EMPLOYEE is due a refund of the EMPLOYER contribution toward the health insurance PREMIUM.

(3) Additional information regarding EMPLOYEES continuing health insurance coverage during an

approved LOA follows.

(a) The maximum length of time coverage can be continued for an EMPLOYEE on LOA is 36 months per Wis. Stat. § 40.02(40). However, an EMPLOYEE on a union-service leave may continue coverage beyond 36 months until termination of the leave or the date that service with the labor organization ceases, whichever occurs first. After this, or upon termination (whichever occurs first), coverage may be continued under COBRA. (Refer to Chapter 9 for information about COBRA.)

(b) The State contribution toward PREMIUM payment continues for the initial three months of the LOA for which PREMIUMS have not already been deducted as of the date the LOA begins. This will result in a total of up to four months (after the LOA begins) of EMPLOYER contribution towards PREMIUMS. For the remaining months of the LOA, the EMPLOYEE must pay the entire PREMIUM; there is no EMPLOYER contribution after the initial three months. See 703A for more information on EMPLOYEE contribution.

(c) EMPLOYEES on LOA are included along with active EMPLOYEES on the EMPLOYER's monthly invoice. Any payments received from EMPLOYEES on LOA should be made payable to the EMPLOYER and included in the EMPLOYER's monthly invoice payment to ETF.

(d) EMPLOYERS must provide OPEN ENROLLMENT information to EMPLOYEES on LOA prior to the beginning of the designated OPEN ENROLLMENT period.

704 Coverage During an Unpaid Leave of Absence (Non-Military) - Coverage Lapses While on a Leave of Absence

704 A) Insured EMPLOYEES on an unpaid leave of absence (LOA) can choose to allow their health insurance coverage to lapse during their LOA by not paying the PREMIUM when due. If they do so, they may regain eligibility for coverage upon return to work.

If the EMPLOYEE files an application to cancel coverage they are not eligible to enroll upon return to work**.** This is considered a voluntary termination. EMPLOYEES who cancel coverage cannot re-enroll until the next OPEN ENROLLMENT period or when a life event occurs (e.g. marriage, birth, etc.), whichever occurs first. Refer to Chapter 5 for other enrollment opportunities.

If the EMPLOYEE's coverage was canceled while on a LOA, the EMPLOYEE is not eligible to re-enroll when their disability annuity is approved.

704 B) Any insured EMPLOYEE for whom coverage lapses, or who allows family coverage to lapse during the LOA but continues individual coverage (as a result of non-payment of PREMIUM), may reinstate coverage by filing an application with the EMPLOYER within 30 days after the return to work. Coverage is effective the 1st day of the month on or after the date the EMPLOYER receives the application. The EMPLOYEE becomes eligible for the EMPLOYER contribution toward PREMIUM for the coverage month the leave of absence ends.

If the EMPLOYEE's coverage lapsed while on a LOA, the EMPLOYEE is eligible to re-enroll when their disability annuity is approved.

704 C) If EMPLOYEE allowed their health insurance coverage to lapse while on LOA, the following applies upon returning to work and the EMPLOYEE chooses to reinstate coverage**:**

(1) EMPLOYEE must submit an application to the EMPLOYER within 30 days after resumption of active performance of duty to enroll in coverage. The coverage effective date is on or following the first of the month following receipt of the application by 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 that month. Otherwise, the entire

PREMIUM for that month is waived.

(a) The EMPLOYEE is limited to the same HEALTH PLAN and level of coverage they were enrolled in prior to their LOA. See (i), (ii) and (iii) that follow for exceptions to this requirement.

i. EMPLOYEE may change coverage level if a qualifying life event occurred during their LOA (e.g. marriage, birth, etc.). Refer to Chapter 4, subchapter 403 for information about other life event enrollment opportunities.

ii. EMPLOYEE who moved while on a LOA may change HEALTH PLANS upon return to work.

iii. EMPLOYEE who returns from a LOA that encompassed the entire previous 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.

(b) EMPLOYEE who did not file an application within 30 days of returning to work cannot re-enroll in coverage until the next OPEN ENROLLMENT period or when a qualifying life event occurs (e.g. marriage, birth, etc.), whichever occurs first. Refer to Chapter 4, subchapter 403 other enrollment opportunities.

(2) EMPLOYEE must indicate coverage to be effective either "As Soon As Possible" or "When the Employer Contributes toward Premium". Examples follow (6) below.

(a) If EMPLOYEE elects "As Soon As Possible" – coverage is effective the first of the month on or following the EMPLOYER application receive date.

i. EMPLOYEE becomes eligible for the EMPLOYER contribution toward the health insurance PREMIUM for the coverage month the LOA has ended.

ii. EMPLOYER will deduct or collect the full monthly PREMIUM from the EMPLOYEE until the LOA ends. EMPLOYEE receives a refund of any EMPLOYER contribution paid by the EMPLOYEE for the month in which the LOA ended.

(b) If EMPLOYEE elects "When the Employer Contributes toward Premium" – coverage is effective the first of the month on or following when the EMPLOYEE becomes eligible for the EMPLOYER contribution toward the monthly PREMIUM.

(3) EMPLOYER must track when the EMPLOYEE meets the criteria of a LOA ending under Wis. Stat. § 40.02(40) as described in 701.

(4) EMPLOYER must set the expectation with the EMPLOYEE regarding when a LOA ends, the use of leave time, and when they will become eligible for the EMPLOYER contribution toward the health insurance PREMIUM.

(5) EMPLOYEE cannot use leave time to satisfy the criteria ending a LOA under Wis. Stat. § 40.02(40).

(6) Leave time cannot be used to satisfy the 50% return to work criterion, but this does not prevent an EMPLOYEE from using leave time to supplement their work schedule.

Examples:

(a) EMPLOYEE elects coverage to be **effective as soon as possible**:

i. After coverage lapsed, EMPLOYEE returns to employment on February 1.

ii. EMPLOYEE submits an application to enroll in coverage that is received by the EMPLOYER on February 1. EMPLOYEE elects coverage to be effective as soon as possible.

iii. Coverage is effective February 1.

iv. LOA ends March 3 as EMPLOYEE meets return to work criterion under Wis. Stat. § 40.02 40).

v. EMPLOYEE must pay the entire premium for the coverage month of February.

vi. EMPLOYEE is eligible for the EMPLOYER contribution toward the health insurance PREMIUM for the coverage month of March since a full month's PREMIUM is due if coverage is effective before the 16th of that month.

vii. Since the total premium has been paid by the EMPLOYEE prior to the coverage month of March, the EMPLOYEE is due a refund of the EMPLOYER contribution toward the health insurance PREMIUM.

(b) EMPLOYEE elects coverage to be **effective when the EMPLOYER contributes** toward premium:

i. After coverage lapsed, EMPLOYEE returns to employment on February 1.

ii. EMPLOYEE submits an application to enroll in coverage that is received by the EMPLOYER on February 1. EMPLOYEE elects coverage to be effective when the EMPLOYER contributes toward PREMIUM.

iii. LOA ends March 3 as EMPLOYEE meets return to work criterion under Wis. Stat. § 40.02(40).

iv. EMPLOYEE becomes eligible for the EMPLOYER contribution toward PREMIUM on March 3.

v. Coverage is effective April 1, first of the month on or after becoming eligible for the EMPLOYER contribution toward PREMIUM.

vi. EMPLOYEE is only required to pay the required EMPLOYEE share of the monthly PREMIUMS for the coverage month of April going forward.

704 D) Additional information regarding EMPLOYEES whose health insurance coverage lapsed during an approved LOA follows:

(1) The EMPLOYEE may change level of coverage if a status change (e.g., marriage, birth, etc.) occurred during the LOA. (Refer to Chapter 4, subchapter 403 for information about other enrollment opportunities.)

(2) EMPLOYEES may change HEALTH PLANS if the change results from a move during the LOA.

(3) An EMPLOYEE who allows coverage to lapse and returns from a LOA that encompassed the entire previous 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.

(4) The coverage effective date for EMPLOYEES returning from Family Medical Leave of Absence (FMLA) in accordance with federal law, is the date the EMPLOYEE returns to work provided an application is filed with the EMPLOYER within 30 days of the EMPLOYEE's return to work. A full month's premium is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire premium for that month is waived.

The following are examples of situations of FMLA that may be encountered:

a) FMLA spans the end of one calendar year and continues into the next year (twelve weeks of one year ending December 31st and twelve weeks beginning January 1st of the next year): The effective date is the date the EMPLOYEE returns to work, as long as it is not beyond the allowable twelve

weeks for the current calendar year.

Note: FMLA is based on a calendar year and cannot exceed a twelve-week period in any given calendar year.

b) An EMPLOYEE on FMLA exceeds the twelve-week calendar year limit and elects to continue the leave using leave without pay: The effective date of the EMPLOYEE's reinstatement in the Group Health Insurance Program is the first of the month on or after the EMPLOYER's receipt of the EMPLOYEE's health insurance application after completing the return to work criterion described in 701.

(5) EMPLOYEES shall also have the life event enrollment opportunities if the EMPLOYEE or a DEPENDENT loses eligibility for another health insurance plan or the EMPLOYER's contribution toward it while on LOA. Other coverage may be as a member of the US Armed Forces, or as a citizen of a country with national health care coverage comparable to the ACCESS PLAN. EMPLOYEES must file an application and provide evidence satisfactory to ETF of the loss of eligibility.

705 Coverage During Military Leave

705 A) 2003 Wisconsin Act 162 (enacted March 17, 2004) provides a framework for insuring that certain EMPLOYEES serving in the uniformed services are treated, for purposes of pay and benefits, as though no interruption of service occurred. Under this act, EMPLOYEES may continue health insurance coverage while on military leave, if they so desire, including EMPLOYER-paid PREMIUMS and EMPLOYEE-paid PREMIUM payroll deductions.

EMPLOYEES not remaining on payroll while on military leave must make EMPLOYEE-paid PREMIUM share contributions directly to the EMPLOYER. Wis. Stat. § 230.315, created by Act 162, lists three criteria to be met by a state EMPLOYEE activated to serve on military duty in order to receive pay differential (meaning state salary less any military pay and housing allowances), accrue sick leave and paid annual leave, and receive other EMPLOYEE benefits as though no interruption of service occurred:

(1) Be activated to serve on military duty or in the U.S. Public Health Service, other than for training purposes, on or after January 1, 2003; and

(2) Serve as a member of the Wisconsin National Guard, a reserve component of U. S. armed forces, or recalled to active military duty from inactive reserve status; and

(3) Receive a military leave of absence under Wis. Stat. § 230.32(3)(a) or Wis. Stat. § 230.35(3), under a collective bargaining agreement, under rules promulgated by the Division of Personnel Management, or be eligible for reemployment under the provisions of Wis. Stat. § 45.50.

Eligible EMPLOYEES or their designated representative should elect, within 60 days after being activated, if they want their health insurance coverage to continue, lapse, or be canceled.

EMPLOYEES who prefer to rely solely on military provided health care and family health insurance may elect to lapse or cancel state coverage. Upon release from active duty, with return to employment and within 30 days of the loss of the military coverage—loss of coverage is defined as an "event"—the EMPLOYEE may reinstate their state health insurance coverage (same HEALTH PLAN and same coverage level) without prejudice.

The re-enrollment in coverage effective date is the day following the last day of the military coverage. EMPLOYEES who are not eligible for the EMPLOYER PREMIUM share when called to active duty, but who become eligible while on military leave, have 30 days from the date of their return to employment (sooner than return to work) to file an application.

705 B) For the purpose of this provision and in accordance with Wis. Stat. §40.05(4g), eligible EMPLOYEE includes National Guard and Military Reserve personnel on an unpaid military leave of absence for active duty for reasons other than for training. The EMPLOYEE must be receiving EMPLOYER contributions for health insurance on the date he or she is activated for duty. The 36 month limitation for continuing coverage, described in 706 below, does not apply.

The EMPLOYEE may elect to:

(1) Continue health insurance coverage and establish prepayment of PREMIUMS while on active duty; or

(2) Within 60 days of being activated for coverage, cancel or let his or her coverage lapse for nonpayment of PREMIUM after being activated for duty and reinstate coverage while on leave by filing a health insurance application; or

(3) Cancel or allow his or her coverage to lapse and reapply for coverage within 30 days of return to employment, provided the EMPLOYEE applies for re-employment within 90 days after release from active duty, and resumes employment within 180 days.

(4) An EMPLOYEE who is enrolled for individual coverage and becomes eligible for family coverage between the time of being called into active military service and the return to employment may elect family coverage within 30 days upon re-employment without penalty.

Note: Coverage is effective upon the date of re-employment. A full month's PREMIUM is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire PREMIUM for that month is waived.

706 Coverage During Layoff

706 A) Coverage may be continued during layoff with the following conditions:

1) The state contribution is available for the first three months of layoff for which PREMIUMS have not already been deducted. After that, the EMPLOYEE is responsible for the entire PREMIUM. See section 709.

2) EMPLOYEES on permanent LAYOFF may continue coverage for up to five years using converted sick leave to pay PREMIUMS until the sick leave credits are exhausted followed by 36 months under COBRA continuation provisions. In the event that sick leave conversion credits are used, the full amount of the required EMPLOYEE PREMIUMS is deducted from the credits until the credits are exhausted, the EMPLOYEE is re-employed, or five years elapse from the date of the LAYOFF.

   The use of sick leave during LAYOFF is the record-keeping responsibility of the EMPLOYER. The EMPLOYEE is reported to ETF the same as any other EMPLOYEE on LAYOFF who is continuing their coverage. For group health insurance purposes, a state EMPLOYEE whose employment is terminated due to permanent LAYOFF is to be treated as if terminated for retirement purposes or on a leave of absence per Wis. Stat. § 40.02(40) and Wis. Stat. § 40.05(4)(bm), meaning that upon termination due to permanent LAYOFF, health insurance coverage may be continued. (For more information on sick leave and payment options after LAYOFF, refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170). This includes retirement in lieu of LAYOFF.)

3) Any insured EMPLOYEE may continue coverage during any EMPLOYER approved leave of absence or LAYOFF for up to 36 months. Insurance coverage may be continued beyond 36 months if the approved leave is provided for union service leave under Wis. Stats. § 40.02(56) and Wis. Stats. § 40.03(6)(g) and/or under COBRA.

4) PREMIUMS must be paid in advance, either by deduction from the last paycheck or by direct payment to the EMPLOYER. Payments must be received by the EMPLOYER prior to the period of coverage.

5) EMPLOYEES on LAYOFF are reported along with your 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 remittance to ETF.

6) If an EMPLOYEE is on LAYOFF during an entire OPEN ENROLLMENT period, the EMPLOYEE must be given an OPEN ENROLLMENT opportunity. OPEN ENROLLMENT information should be sent to those EMPLOYEES who are on LAYOFF prior to the beginning of the designated OPEN ENROLLMENT period.

706 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. Return to work is defined in 701.

1) The EMPLOYEE must submit an application within 30 days of the EMPLOYEE's return to work. Coverage is effective the first of the month on or following the EMPLOYER's receipt of the completed application.

2) The EMPLOYEE is limited to the same HEALTH PLAN and level of coverage as before the LAYOFF. See a), b) and c) that follow for exceptions to this requirement.

   a) 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 life event enrollment opportunities.)

   b) EMPLOYEES moving during a LAYOFF may change HEALTH PLANS.

   c) An EMPLOYEE who returns from a LAYOFF that encompassed the entire previous 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.

3) EMPLOYEE who did not file an application within 30 days of returning to work cannot re-enroll in coverage until the next health benefits OPEN ENROLLMENT period or when a life event occurs (e.g. marriage, birth, etc.), whichever occurs first. Refer to Chapter 4, subchapter 403 other enrollment opportunities.

707 Coverage During Appeal of Discharge

707 A) An insured EMPLOYEE who has exercised a statutory or contractual right of appeal from removal or discharge from their position, or who within 30 days of discharge becomes a party to arbitration or to legal proceedings to obtain judicial review of the legality of the discharge, may continue to be insured from the date of the contested discharge until a final decision has been reached.

707 B) 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:

(1) The EMPLOYER must receive the first PREMIUM payment within 30 days of discharge.
(2) Future PREMIUM payments (where the EMPLOYER collects pre-paid PREMIUMS) must be made through the EMPLOYER and must be received in advance of the coverage month *or*
(3) Future premium payments (where the EMPLOYER collects PREMIUMS in the month of coverage) must be made through the EMPLOYER and must be received in the coverage month.
(4) The EMPLOYEE must pay both the EMPLOYEE and EMPLOYER share of PREMIUM due each month until the appeal is resolved.
(5) 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.

707 C) 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.

707 D) 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. This may include by expiration without appeal of the time within which an appeal might have been perfected, or by final affirmation on appeal.

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 only 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.)

708 Examples for Contribution upon return from a Leave of Absence

EMPLOYEES on LOA become eligible for the EMPLOYER contribution when the LOA is ended as defined in Wis. Stat. § 40.02(40). The LOA is deemed ended when the EMPLOYEE has returned to work, that means the EMPLOYEE has resumed active performance of duty for 30 consecutive calendar days for at least 50% of what is considered his or her normal work time with that EMPLOYER.

An EMPLOYEE who is on LOA is not eligible for EMPLOYER contribution toward PREMIUM simply because they receive earnings at some point during the payroll cycle for a given month.

Example 1: John is receiving Income Continuation Insurance (ICI) benefits for five months. He has used up his sick leave but has sabbatical leave that his EMPLOYER is allowing him to use during his period of

disability. John is using one day of paid leave during each pay period. Although receipt of the sabbatical pay keeps John on payroll, he is not eligible for EMPLOYER contribution toward health insurance past the maximum of three months (plus one if pre-paid) because he has taken at least one day of unpaid leave and has not returned to work for 50% of his regular work schedule for 30 days. Therefore, John has not met the statutory requirement for return to work and is not entitled to EMPLOYER contributions toward his health insurance until he does so.

Example 2: Jackie has received Income Continuation Insurance (ICI) benefits for seven months. She returns to work for two half days per week during the sixth month. Although Jackie's earnings place her on payroll, she is not eligible for EMPLOYER contribution toward health insurance beyond the 4 (if contributions were pre-paid) or 3 months (if contributions were paid month of coverage), because she has taken at least one day of unpaid leave and has not returned to work for 50% of her regular work schedule for 30 days. Therefore, Jackie has not met the statutory requirement for return to work and is not entitled to EMPLOYER contributions toward her health insurance until she does so.

Unpaid Leave of Absence:

Length of Coverage Availability	Payment of Premiums	Employee-Required Contributions	Employer-Required Contributions
An additional 3 months of employer contribution toward premium. Thereafter, employee may continue for up to 36 months under continuation provisions, and then another 36 months of COBRA, by paying the full premium after the employer contribution ends.	Premiums should be collected as described in 707B 2 and 3 by payroll deduction or personal check. See 703A for termination timeframes.	After the 3 initial months supplemented by employer contribution toward premium, employees still on leave can continue coverage by paying the entire share of premium to their employer in advance.	First 3 months (in addition to any prepaid months at time of termination) after employee is on leave.

709 Examples for Contribution upon return from a Temporary Layoff

Temporary LAYOFF is defined under the applicable contract or administrative code and may include, for example, seasonal layoffs, school-year summer layoffs, etc.

Length of Coverage Availability	Payment of Premiums	Employee-Required Contributions	Employer-Required Contributions
An additional 3 months of employer contribution toward premium. Thereafter, employee may continue for up to 36 months under continuation provisions, by paying the full premium after the employer contribution ends. Then COBRA coverage after the 36-month continuation period ends.	Premiums should be collected as described in 707B 2 and 3 by payroll deduction or personal check. See 703A for termination timeframes.	After the 3 initial months supplemented by employer contribution toward premium, employees still on leave can continue coverage by paying the entire share of premium to their employer in advance.	First 3 months (in addition to any prepaid months at time of termination) after employee is laid off.

Chapter 8 —Cancellation and Termination of Coverage

801 Individual Termination of Coverage

ETF offers a resource to help EMPLOYERS advise EMPLOYEES who are terminating employment, including ANNUITANTS. It is the Termination Checklist for State Employees (ET-2500s).

801 A) A PARTICIPANT'S coverage shall terminate at the end of the month on the earliest of the following dates:

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

(2) The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due.

Note: As required by federal law, if timely payment is made in an amount that is not significantly less than amount due, that amount is deemed to satisfy the HEALTH PLAN'S requirement for the amount that must be paid. The HEALTH PLAN may notify the PARTICIPANT of the amount of the deficiency and grant a reasonable time period for payment of that amount. Thirty days after the notice is given is considered a reasonable time period.

(3) The expiration of the 36 months for which the SUBSCRIBER can continue coverage while on a leave of absence or LAYOFF, as provided in sections 701, 702, 704 B and C, 705 B, 706 A and 403 E.

(4) The end of the month in which a notice of cancellation of coverage or sick leave escrow application is received by the EMPLOYER or by ETF in the case of an ANNUITANT or CONTINUANT, or a later date as specified on the cancellation of coverage notice or sick leave escrow application. If the ANNUITANT or CONTINUANT contacts the HEALTH PLAN directly to cancel coverage, the HEALTH PLAN is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to ETF.

(5) The definition of PARTICIPANT no longer applies (such as for a divorced spouse, an overage DEPENDENT child who marries, etc.). As required by Wis. Stat. §632.897, if family coverage remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification

of continuation of coverage rights occurs (see 901A). The EMPLOYER may collect PREMIUM retroactively from the SUBSCRIBER if the divorce was not reported in a timely manner and there were no other eligible DEPENDENTS for family coverage to remain in effect. The ACA requires that a PARTICIPANT receive a full month of coverage before coverage is terminated unless there is fraud or gross misconduct in order for the PARTICIPANT to find other coverage.

(6) The expiration of the continuation period for which the PARTICIPANT can continue under 801 C) below, as required by state and federal law.

(7) The effective date of coverage gained from another employer's group health plan for a PARTICIPANT who continues under 801 C) below. Terminations due to enrollment in medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or TRICARE may be retroactive to the effective date of coverage upon request by the SUBSCRIBER and determination by ETF.

(8) The earliest date federal or state continuation provisions permit termination of coverage for any reason.

(9) The end of the month in which the SUBSCRIBER terminates employment.

(10) Upon date of death. No refund of PREMIUM may be granted for the month in which the coverage ends. If deceased SUBSCRIBER has covered DEPENDENTS, see 1302 A) and C) regarding continued coverage of surviving DEPENDENTS.

(11) Upon a significant reduction in EMPLOYER's contribution toward health insurance (full time to less than ½ time). An EMPLOYEE whose EMPLOYER contribution is lowering due to a job appointment change may cancel coverage. The event is the first of the month on or following the appointment change. The application must be submitted no later than 30 days following the appointment change.

Note: If the EMPLOYEE's spouse is an eligible State or Local EMPLOYEE, the couple may change the listed SUBSCRIBER to the spouse who is getting a greater share of employer contribution.

801 B) No refund of any PREMIUM under 801 A) (5) may be made unless the EMPLOYER, or ETF if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month of coverage. Except that when coverage ends because of termination of employment, refunds shall be made back to the end of the month in which employment terminates.

801 C) A PARTICIPANT who ceases to meet the definition of EMPLOYEE, ANNUITANT, or DEPENDENT may elect to continue group coverage as required by state and federal law. Application must be postmarked within 60 days of the date the PARTICIPANT is notified of the right to continue or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for the required PREMIUM.

801 D) No person other than a PARTICIPANT is eligible for health insurance BENEFITS. The SUBSCRIBER'S rights to group health insurance coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. For example, this may apply if there is a late reported divorce. In cases of fraud, coverage terminates the beginning of

the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and their coverage is limited to the ACCESS PLAN. Subsequently, a change to a different HEALTH PLAN is available during a regular OPEN ENROLLMENT period, as long as it begins a minimum of 12 months after the disenrollment date.

ETF may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

801 E) In situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with their primary care physician, disenrollment efforts may be initiated by the HEALTH PLAN or the BOARD. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. Coverage may be transferred to the ACCESS PLAN only, with options to enroll in a different HEALTH PLANS during subsequent OPEN ENROLLMENT periods. Re-enrollment in the HEALTH PLAN is available during a regular OPEN ENROLLMENT period, as long as it begins a minimum of 12 months after the disenrollment date.

801 F) Except in cases of fraud or where an individual makes an intentional misrepresentation of material fact, under federal law, an EMPLOYER must not retroactively cancel (rescind) coverage, except to the extent attributable to a failure to pay timely PREMIUMS towards coverage. This rule also applies to ANNUITANTS. It is not considered a rescission where, due to administrative delay in record-keeping, the EMPLOYER retroactively cancels coverage back to the date of termination of employment as limited by section 212.

801 G) If it is found that a PARTICIPANT has enrolled in disqualifying coverage for the HSA and the SUBSCRIBER is no longer eligible for the HIGH DEDUCTIBLE HEALTH PLAN (HDHP), coverage shall change to the non-HDHP Uniform Benefit with the same HEALTH PLAN to be effective either:

1. The effective date of the other disqualifying coverage in the current plan year, or
2. January 1 of the current plan year if the coverage began to be effective in the previous plan year.

As needed, PREMIUMS and claims shall be retroactively adjusted. See 201B 3 for more information.

802 Ending Coverage

The coverage end date for the EMPLOYEE is entered by the EMPLOYER in My Insurance Benefits.

Active coverage may be ended for an EMPLOYEE because of one of the following reasons:

- complete a spouse to spouse transfer,
- death of the SUBSCRIBER,
- disability approval (non-ICI),
- retirement,
- 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 14 regarding instructions and information on the Monthly Employer Invoice.)

Reason	Coverage End Date	Comments
Cancel Coverage	Refer to subchapter 804	EMPLOYEE is voluntarily ending coverage. Refer to subchapter 804 regarding Internal Revenue Code (IRC) Section 125 pre-tax and post-tax requirements. For example, when SUBSCRIBER and all eligible DEPENDENTS are newly eligible for, and enrolled in, other coverage or the EMPLOYEEPREMIUM share has increased significantly. If EMPLOYEE does not pay required PREMIUM 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, going on an unpaid LOA or on permanent LAYOFF, but is not starting an immediate annuity, refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170) regarding reporting sick leave.
Termination of Employment prior to EFFECTIVE DATE of coverage	The application is void and any PREMIUMS paid or deducted will be refunded.	N/A
Cancel Spouse to Spouse Employment	Refer to subchapter 804	EMPLOYEE voluntarily ending coverage. Cannot complete a cancellation mid-year without an allowable status change under the plan language (contract) or HIPAA qualifying life event if PREMIUMS are deducted pre-tax.

Reason	Coverage End Date	Comments
Disability Approval (Non-ICI)	Coverage is continued as an ANNUITANT without lapse upon approval of a disability benefit.	This is an EMPLOYER entry in the ETA. 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 803. Also, refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170) for reporting sick leave.
Retirement	Coverage is continued as an ANNUITANT without lapse upon retirement if an EMPLOYEE retires with an immediate annuity.	Requires an EMPLOYER entry in the ETA. No application 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 803. Also, refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170) for reporting sick leave.
Death of Subscriber with Individual 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 was deducted.	Do not refund any PREMIUMS unless authorized by ETF. Refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170) for reporting sick leave. Refund may be due if coverage was paid for the next month. Coverage automatically continues for survivors.

803 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)

(1) EMPLOYEE receives an immediate annuity upon retirement (monthly or lump sum benefit), WRS disability retirement, or duty disability benefits.

(2) 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 send the termination of employment in the ETA (see 104 A). They must also complete a sick leave certificate and the required entry in the Accumulated Sick Leave system (AcSL) (Refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170)). ANNUITANTS without sick leave credits who wish to continue coverage may make PREMIUM payments through their annuity or with payments directly to the HEALTH PLAN.

804 Voluntary Cancelation of Coverage

When an EMPLOYEE wishes to cancel coverage for any of the reasons listed in subchapter 801, they cannot complete their request mid-year without an eligible life event 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 canceled at any time throughout the calendar year. Coverage end date for a cancelation is the end of a month following receipt of the request.

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
A. Pre-Tax EMPLOYEE Terminating Employment	Application 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 or the event date, whichever is later.	The coverage end date for a cancelation request is always the end of a month. Retroactive cancelations are not allowed.

Event	Eligibility Requirements	Coverage End Dates	Comments
B. Pre-Tax EMPLOYEE Going on an Unpaid LOA	Application must be submitted no later than the month EMPLOYEE goes on a LOA. The event date is the date EMPLOYEE begins a LOA. An affirmative choice to cancel coverage by submitting an application invalidates the right to re-enroll at upon return to work after the LOA. 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. No application is required and none should be requested for a lapse.	End of the month following receipt of the application or the event date, whichever is later. For lapses, coverage termination should be entered at the time payment is not received from the EMPLOYEE. Coverage ends the end of the month for which payment was received.	An EMPLOYEE who continued coverage during a LOA is eligible to receive the EMPLOYER share of the monthly PREMIUM for the current coverage month premium 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, but this invalidates the right to re-enroll upon return to work after the from LOA. Coverage end date for a cancelation request is always the end of a month. Retroactive cancelations are not allowed.

Event	Eligibility Requirements	Coverage End Dates	Comments
C. Pre-Tax Family Life Event Status Change (e.g., spouse to spouse)	An allowed family status change under the plan language (contract) or a HIPAA qualifying life event must occur, for example, to allow cancellation in order to enroll under spouse's coverage as an EMPLOYEE. Application must be submitted within 30 days of the IRC Section 125 status change, the event.	End of the month following receipt of an application or the event date, whichever is later.	Refer to Chapter 5 for life event status changes allowed under the plan language (contract) and HIPAA qualifying life events. Documentation may be required. 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. Coverage end date for a cancelation request is always the end of a month. Retroactive cancellations are not allowed.
D. Pre-Tax EMPLOYEE PREMIUM Contribution Has Increased Significantly	Application must be submitted within 30 days of the date PREMIUMS significantly increased, the event date.	End of the month following receipt of an application or the event date, whichever is later.	Coverage end date for a cancelation request is always the end of a month. Retroactive cancelations are not allowed.

E. Pre-Tax EMPLOYEE (and all DEPENDENTS, if applicable) Became Eligible for and Enrolled in Other Group Coverage	Application must be submitted within 30 days of the date the other coverage becomes effective.	End of the month following receipt of an application or the event date, whichever is later.	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 which shows the effective date of coverage. Coverage end date for a cancelation request is always the end of a month. Retroactive cancellation is not allowed.
F. Pre-Tax Annual OPEN ENROLLMENT Period	Application must be submitted during the OPEN ENROLLMENT period.	Coverage end date is December 31.	Based on plan language (contract), coverage can be canceled at the end of a calendar year regardless if employee premiums are deducted pre-tax or post-tax.
G. PREMIUMS Deducted Post Tax	Application must be submitted.	Coverage end date is the end of the month following the application received date. If the application received date is the last day of a month, coverage ends on the receipt/request date.	An application can be submitted requesting a future cancellation date. Coverage can be canceled mid-year. Coverage end date for a cancelation request is always the end of a month. Retroactive cancellations are not allowed.

Chapter 9 – COBRA, Continuation and Conversion

901 Overview of COBRA, Continuation, and Conversion

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), PARTICIPANTS and their eligible DEPENDENTS covered under the State 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 State 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 life events" (refer to subchapter 902). The following provides an overview of continuation
and conversion.

901 A) 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 BOARD to reinforce and broaden continuation rights under certain circumstances.

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. 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.

For example: If divorce is more than 36 months in the past, the ex-spouse must still be offered 18 months of continuation coverage.

If the PARTICIPANT does not reside in a county listing a primary physician for the SUBSCRIBER'S HEALTH PLAN at the time continuation coverage is elected, the PARTICIPANT may elect a participating plan in the

county where the PARTICIPANT resides (Also see Chapter 5).

901 B) Conversion:

Conversion coverage is available to PARTICIPANTS who have been covered under the State Group Health Insurance Program under terms negotiated with the HEALTH PLAN. PARTICIPANTS may elect to convert to Marketplace or 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.

Such PARTICIPANT may also elect to convert to individual coverage or a Marketplace plan without underwriting if application is made directly to the HEALTH PLAN within 30 days after termination of group coverage as provided under Wis. Stat. §632.897. The PARTICIPANT shall be eligible to apply for the direct pay conversion contract then being issued provided coverage is continuous and the PREMIUMS then in effect for the conversion contract are paid without lapse.

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 life event,” EMPLOYEES and their covered DEPENDENTS become “qualified beneficiaries” and must be offered continuation coverage (refer to subchapter 905 for EMPLOYER responsibilities).

Qualified beneficiaries must be treated the same as "similarly situated active EMPLOYEES." That means qualified beneficiaries are entitled to the same benefits, choices, and services as active EMPLOYEES. For example, the EMPLOYEE’S spouse may elect COBRA even if the EMPLOYEE does not. COBRA may be elected for only one, several, or all DEPENDENT children who are qualified beneficiaries. A parent may elect continuation coverage on behalf of any DEPENDENT children. The EMPLOYEE or the EMPLOYEE’S spouse (if the spouse is a qualified beneficiary) can elect continuation coverage on behalf of all qualified beneficiaries.

902 A) Employees must be offered continuation coverage in the event coverage is lost due to either of the following events:

1) 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).
2) Completion of the maximum prepayment periods of 36 months while on a leave of absence or layoff (Refer to Chapter 7).

902 B) The spouse of an employee with family coverage in the State Group Health Insurance Program becomes a qualified beneficiary as a result of any of the following qualifying life events:

1) Death of EMPLOYEE. EMPLOYERS do not need to provide a *Continuation - Conversion Notice* [ET-2311] as the survivor’s coverage will automatically continue (Refer to Chapter 13 on EMPLOYEE Death).
2) Divorce. Coverage as a DEPENDENT spouse continues until the later of:
    a) The end of the month in which the EMPLOYER provides notification of continuation rights (*Continuation - Conversion Notice* [ET-2311]) (Refer to subchapter 903).
    or

b) The end of the month in which the date of entry of judgment of divorce is entered/final with the clerk of courts.

3) Spouse (EMPLOYEE) loses coverage for reasons listed above under section 902 A.

902 C) Each eligible dependent child of an employee with family coverage in the State Group Health Insurance Program becomes a qualified beneficiary as a result of any of the following qualifying life events:

1) Death of EMPLOYEE. EMPLOYERS do not need to provide a *Continuation - Conversion Notice* [ET-2311] as the survivor's coverage will automatically continue (EMPLOYEE; refer to Chapter 13 on EMPLOYEE Death).

2) DEPENDENT eligibility status ceases under the State Group Health Insurance Program (Refer to the chart in subchapter 906 for examples)

3) Parents become divorced resulting in loss of eligibility.

4) Parent (EMPLOYEE) loses coverage for reasons listed above in section 902 A.

902 D) An eligible DEPENDENT of a minor DEPENDENT of an EMPLOYEE with family coverage in the State Group Health Insurance Program becomes a qualified beneficiary when losing eligibility as a result of the minor DEPENDENT 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.

902 E) An eligible disabled DEPENDENT, over age 26, of an EMPLOYEE with family coverage in the State 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.

902 F) If an EMPLOYEE, within the initial 18 months of COBRA coverage, is granted an SSA disability, they may be eligible for an extension of COBRA for up to 29 months. The EMPLOYEE must provide ETF with a copy of the SSA letter that states they have been found to be disabled, within 60 days of the date of the letter.

902 G) In the event an EMPLOYEE is hired, WRS eligible, and elected insurance coverage is in force, and the EMPLOYEE terminates before completion of 30 days of service the insurance remains in force and the EMPLOYEE **must** be offered COBRA. Coverage as an active EMPLOYEE will end as of the end of the month of termination.

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 (refer to subchapter 902) are responsible for informing the EMPLOYER of a qualifying life event in which a DEPENDENT loses eligibility for coverage under the State Group Health Insurance Program. Qualified beneficiaries should notify ETF of these changes.

Applications must be received by ETF postmarked within 60 days of the date the PARTICIPANT is notified by the EMPLOYER of the right to continue, or 60 days from the date coverage ceases, whichever is later. The HEALTH PLAN shall bill the continuing PARTICIPANT directly for required PREMIUMS. COBRA continuation coverage ends when coverage is canceled, PREMIUMS are not paid when due, or coverage is terminated as permitted by state or federal law.

Under federal COBRA law, if the EMPLOYER or Voya is not notified within 60 days of theevent 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 the ex-spouse and 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 Voya 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, Voya 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.

CONTINUANTS may not add (to their family coverage or change from single to family) persons who were not originally insured when group health insurance ended, unless a child was born or adopted (or placed for adoption) while the EMPLOYEE is continuing group coverage. A CONTINUANT with single coverage must elect family coverage within 60 days of the birth or adoption.

COBRA coverage ends for all qualified beneficiaries when the maximum COBRA duration has been met.

Note: If a CONTINUANT is enrolled in family coverage and gets married, the new spouse is not eligible to be added to the family contract.

904 Qualified Beneficiary Responsibilities

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

A) Submitting an online application through Voya 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. No lapse or gap in coverage is allowed. If qualified beneficiaries do not elect continuation coverage within the 60-day period, they lose eligibility to enroll under continuation.

B) Paying PREMIUM to the HEALTH PLAN when billed by the HEALTH PLAN.

C) 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.

D) 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:

1. ***prior to or on*** the effective date of COBRA coverage, they are eligible for Medicare reduced rates.
2. ***after*** COBRA coverage begins, COBRA coverage ends for the SUBSCRIBER or DEPENDENT when they enroll in Medicare Parts A and B.
   a. Qualified beneficiaries not eligible for Medicare remain eligible for COBRA coverage.
   b. 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

905 A) Within five days of being notified of the "qualifying life 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:

1) *Continuation - Conversion Notice* (ET-2311), with the employer sections completed.
2) *Group Health Insurance Application* (ET-2301) available on the ETF website and updated annually). 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*.

> **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 life event was not provided to the employer within the required time period. (Refer to subchapter 906 for information on providing notice.)
>
> In the case of divorce, confirm the address of all qualifying beneficiaries.

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

1) If electing continuation coverage, the completed *Continuation - Conversion Notice* and *Group 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.
2) If electing continuation coverage, the HEALTH PLAN will bill the CONTINUANT(S) directly.
3) If electing continuation coverage and the CONTINUANTS are moving 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.
4) See section 503 for other reasons to change coverage.

> **Note:** When entering a coverage end date in My Insurance 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	N/A*	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 Eligibility Ends as Dependent turns 18	03/15	03/31	N/A*	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.

* EMPLOYER must check for aging out DEPENDENTS monthly. See Appendix.

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	05/30	5 days after receipt of disability status change letter Status change letter	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	05/30 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	N/A	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 unless another life event occurs at the same time. 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 SUBSCRIBER'S HEALTH PLAN is available in the qualified beneficiary's county. CONTINUANTS can change HEALTH PLANS during the annual OPEN ENROLLMENT period or following a residential move.

Continuation coverage may be in effect for up to 18 months following termination of employment (36 for divorce, death, and DEPENDENT loss of eligibility). However, continuation coverage will be terminated early and cannot be reinstated for any of the following reasons:

1) The PREMIUM for continuation coverage is not paid when due.
2) The SUBSCRIBER becomes covered under another group HEALTH PLAN; a SUBSCRIBER who refuses health insurance offered by another EMPLOYER will not be affected.
3) A member who was not eligible for Medicare when continuation began, becomes eligible for and enrolled Medicare.
4) A spouse is divorced from a covered EMPLOYEE and subsequently remarries and is covered through the new spouse's group HEALTH PLAN.
5) Qualified beneficiary voluntarily cancels continuation coverage.

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 set forth in Wis. Stat. §632.897 and/or Marketplace plan as provided by the HEALTH PLAN.

Chapter 10 — Retirement or Disability

1001 Coverage – Requirements to Continue

WRS-covered state EMPLOYEES insured under our group health insurance program, are entitled to continue the insurance for life when they receive a WRS retirement or disability benefit. This excludes Income Continuation Insurance (ICI). 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 PARTICIPANT 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 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.

1001 A) Retirement Benefit

Group health insurance coverage will automatically be continued if the EMPLOYEE retires with an *immediate annuity* under Wis. Stat. § 40.02 (38). 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. Note: A separation benefit is not considered an annuity. (Refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170) regarding the Accumulated Sick Leave Conversion Credit program.)

Health insurance coverage automatically continues for state 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 SUBSCRIBERS's signature or email with electronic signature PRIOR to their active EMPLOYEE coverage ending.*** Note: Canceling coverage will forfeit any sick certified by the EMPLOYER. If the retiring EMPLOYEE wishes to escrow/bank their unused sick leave credits upon retirement, they should contact ETF for information and a *Sick Leave Escrow Application* (ET-4305).

A person who is eligible and applies for an immediate annuity under Wis. Stat. § 40.02 (38) may have their State group health insurance coverage reinstated even if, during any period

preceding retirement:

1) insurance has not been in effect while no earnings were received, or
2) insurance has been continued under COBRA continuation through the State's group health insurance program.

An application for health insurance must be received by ETF within 30 days after the date of ETF's notification of eligibility for health insurance. Coverage shall be effective the first day of the calendar month which occurs on or after the date the application for health insurance has been received.

Note: EMPLOYERS should send the EMPLOYEE's termination of employment in the ETA (see 104 A) using the Retirement reason. The EMPLOYEE's coverage will be set up to continue by ETF as part of their retirement process.

1001 B) Disability Benefit

Coverage for an insured EMPLOYEE shall be continued if the EMPLOYEE:

1) Receives a disability annuity (disability retirement) under Wis. Stat. §40.63 and remains continuously covered under the group. This EMPLOYEE is considered to have met the requirements for an immediate annuity for health insurance purposes. If the disability annuity terminates and the PARTICIPANT continues to meet the definition of eligible EMPLOYEE under Wis. Stat. § 40.02 (25), the individual is eligible to continue using accumulated leave credits until exhausted under Wis. Stat. § 40.05 (4) (b).

2) Receives a duty disability benefit under Wis. Stat. §40.65 and remains continuously covered under the group. Members with duty disability are not eligible to newly enroll during OPEN ENROLLMENT.

Insured EMPLOYEES applying for a WRS disability retirement or duty disability benefit must pre-pay PREMIUMS through their EMPLOYERS until their disability benefit is approved by ETF, or else coverage will lapse.

EMPLOYEES on an unpaid leave of absence immediately prior to termination, who are eligible for WRS disability retirement under Wis. Stat. §40.63, or duty disability benefits under Wis. Stat. § 40.65, may have their coverage reinstated even if, during the period preceding the benefit approval:

1) no insurance was in effect while no earnings were received, or
2) insurance has been continued under COBRA continuation through the State's group health insurance program.

This provision does not apply if the employee files an application to terminate health insurance coverage.

Once the WRS disability retirement or duty disability benefit is approved, the previously insured EMPLOYEE whose coverage lapsed or who was covered under COBRA will be offered a new opportunity to enroll and may use sick leave to pay premiums. ETF will notify the EMPLOYER of the disability retirement or duty disability benefit. (Refer to Chapter 8.) ETF also will send the EMPLOYEE a letter offering lifetime coverage under the State Group Health Insurance Program. The application for health insurance must be received by ETF within 30 days after the date of ETF's notification of eligibility for health insurance. Coverage shall be effective the first day of the calendar on or after the date the application for health insurance has been received.

1001 C) 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 *Group Health Insurance Program Continuation Application* (ET-2155) to ETF within 90 days of the termination of employment if the terminated EMPLOYEE does not take an immediate annuity.

1001 D) Termination before Minimum Retirement Age with 20 Years of Service

Insured state EMPLOYEES leaving state service before reaching minimum retirement age (therefore, not eligible for an immediate annuity) with at least 20 years of WRS creditable service who do not close their WRS account may continue coverage under the State Group Health Insurance Plan indefinitely. These EMPLOYEES are required to pay the full PREMIUMS. They cannot use sick leave credits to pay PREMIUMS or apply to escrow their sick leave credits until they later apply for their retirement annuity. At the time of termination, the EMPLOYER certifies the retiring EMPLOYEE's sick leave, but it is "preserved" until an application for retirement (refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170)) is submitted, at which point it can be escrowed or the ANNUITANT can enroll in the State Group Health Insurance Program.

The EMPLOYEE must complete a *Group Health Insurance Program Continuation Application (ET-2155)* if they wish to continue coverage until they formally retire.

For additional information, see the *Group Health Insurance* (ET-4112) booklet for retired state EMPLOYEES with 20 years of service who terminate employment and surviving spouses and DEPENDENTS of insured EMPLOYEES.

1002 Coverage for Former State Employees Whose Coverage Lapsed

Former state EMPLOYEES whose coverage has lapsed may be eligible to apply for coverage under the State Group Health Insurance Program if they meet one of the following conditions:

1) Currently receiving a monthly annuity or took a lump sum annuity payment from the WRS (which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1)) and had been insured in the program when they terminated employment. An immediate annuity means the annuity effective date is within 30 days of the termination date.
2) Terminated state employment before reaching their minimum retirement age of 55 (50 for protective category EMPLOYEES) with at least 20 years of WRS creditable service.

For additional information, see the online FAQ regarding eligibility for retired state EMPLOYEES, state EMPLOYEES with 20 years of service who terminate employment, and surviving spouses and DEPENDENTS of insured EMPLOYEES.

1003 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.

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

1004 Premium Payment

ANNUITANT PREMIUM payments are made through one of the following methods:

1) **Sick leave credits -** From sick leave credits until exhausted, Wis. Stat. § 40.05 (4) (b). Sick leave credits may be escrowed at the time of retirement if the EMPLOYEE is covered under comparable non-state health coverage. The EMPLOYEE should contact ETF for information and a *Sick Leave Escrow Application* (ET-4305).

2) **Annuity Deduction -** PREMIUMS are paid from a monthly retirement or disability retirement benefit annuity under Wis. Stat. §40.63 if the annuity is sufficient to cover the entire PREMIUM.

3) **Direct Pay -** When the annuity is not sufficient to cover the entire PREMIUM or the member only receives duty disability or Long-Term Disability Insurance (LTDI) benefits, the HEALTH PLAN will directly bill the SUBSCRIBER, and the SUBSCRIBER will pay PREMIUMS directly to the HEALTH PLAN.

4) **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).

ETF may authorize PREMIUM payments to be made directly to the HEALTH PLAN where circumstances require such without member notification. Failure to make required PREMIUM payments by the due dates established by the HEALTH PLAN and approved by ETF shall cause the health care coverage to be canceled.

Chapter 11 — Rehired Annuitants

1101 Eligibility

A Wisconsin Retirement System (WRS) ANNUITANT's return to **non-WRS** employment does not affect their WRS annuity or health insurance benefits, if any. Eligibility under this Chapter assumes 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 a **WRS-eligible** position, as either an EMPLOYEE or an independent contractor.

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).

In the event a rehired ANNUITANT elects to return to active WRS coverage or is statutorily required to return to active WRS coverage, the annuity is suspended effective the first of the month following ETF's receipt of the *Rehired Annuitant Form* (for ANNUITANTS electing coverage) or the first of the month following the rehire date (for ANNUITANTS with WRS termination dates on or after July 2, 2013) until the EMPLOYEE again retires and reapplies for an annuity. Under either scenario, ANNUITANTS returning to active WRS participation are immediately eligible to apply for health insurance coverage through the state agency. Coverage typically begins the first of the month after the retiree is rehired and WRS eligible.

Any retiree health insurance the ANNUITANT had through the State of Wisconsin group health insurance program is terminated based upon the date the annuity ends. Any remaining accumulated sick leave conversion credits are suspended until the EMPLOYEE subsequently retires again. Additional sick leave earned from state employment after the EMPLOYEE returns to work is only available for conversion to pay for health insurance premiums if the EMPLOYEE is an active participant (participating EMPLOYEE) in the WRS. The additional earned sick leave will be added to their existing sick leave balance when retiring again. Sick leave hours earned as a non-participant EMPLOYEE are not convertible on re-retirement because no EMPLOYER contributions have been paid on sick leave earned in non-participant status.

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 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 insurance 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, 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, then will notify both the ANNUITANT and EMPLOYER. For an EMPLOYEE who was insured as an ANNUITANT, health insurance coverage through the active EMPLOYER becomes effective the day after the 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 or sick leave are deducted for the month of coverage, insurance ends at the annuity suspension date. ETF will assist the EMPLOYER in determining the date the rehired ANNUITANT should be added to active coverage on the monthly additions report. An application electing coverage must be received by the EMPLOYER within 30 days following the WRS participation begin date. When the EMPLOYEE retires again, refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170) 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.

1103 Disability Annuitants

Participants Under Normal Retirement Age
A WRS participant who is receiving a disability retirement benefit under Wis. Stat. §40.63 and who has not reached normal retirement age 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, if the participant is re-employed, their disability annuity will be suspended if they earn more than a set “earnings limit” during a calendar year. 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 can 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 the opportunity to apply online.

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.

Participants Over Normal Retirement Age

A WRS participant who is receiving a disability retirement benefit under Wis. Stat. 40.63 and who is over their normal retirement age will have their disability annuity suspended if they are re-employed in a WRS eligible position. They must complete a *Rehired Annuitant Form* (ET-2319). See 1101 and 1102 for more information about the process.

Chapter 12 - Medicare

1201 Overview of Medicare

1201 A) 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 when they sign up for their social security benefit.

1201 B) My Insurance Benefits:
If your agency allows, you and your EMPLOYEES may see whether or not ETF has Medicare eligibility information for them and their DEPENDENTS. For active EMPLOYEES, ETF collects this information for coordination of benefits with Medicare. Please ask EMPLOYEES older than age 65 to provide the information.

The EMPLOYEE can enter the information into My Insurance Benefits.

Medicare eligibility information may also be provided to ETF by the Centers for Medicare & Medicaid Services (CMS) through CMS' and ETF's Voluntary Data Sharing Agreement (VDSA), ETF, or the HEALTH PLAN. If your EMPLOYEES have concerns about the accuracy of the data, first carefully verify all fields with them, including effective and expiration dates, then contact ETF.

1201 C) Premium Rates:

1) Active EMPLOYEES (non-annuitants) 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. The Group Health Insurance Program pays primary on claims for these EMPLOYEES.

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

   The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the PARTICIPANT is eligible for the Medicare hospital and medical care benefits (Parts A and B) as the primary payor and coverage is provided under an ANNUITANT sponsor or group number. See also 1301 F.

1201 D) Employees aged 65 and older may be automatically enrolled in Medicare Part A coverage. This can happen when an EMPLOYEE signs up to receive social security benefits. Enrollment under the federal plans for hospital and medical care for the aged (Medicare) by SUBSCRIBERS and their DEPENDENTS who are eligible for those programs is waived if the SUBSCRIBER remains covered as

an active EMPLOYEE of the state. The reduction in PREMIUM is available only when the coverage is provided under an ANNUITANT sponsor or group number.

Enrollment in Medicare Part B is required for the EMPLOYEE or DEPENDENTS at the first Medicare enrollment period after active employment ceases. If an ANNUITANT, or an ANNUITANT'S spouse is covered under an active employee's group health insurance policy with another employer and that policy is the primary payor, the ANNUITANT or the ANNUITANT'S spouse covered under that policy may also defer enrollment in Medicare Part B (to the extent allowed by federal law) under this provision and shall pay the Medicare reduced PREMIUM for coverage under this program.

If an active EMPLOYEE over the age of 65 defers enrollment, they have a special enrollment period for Medicare Part B that starts when their employment ends. The Social Security Administration (SSA) may ask for verification of their employment and health insurance coverage. SSA will provide form #L564 to the EMPLOYEE and it is the EMPLOYER's responsibility to complete the form.

See also 1003 for information about deferring Medicare Enrollment.

1201 E) 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. Medicare reduced rates are only available for ANNUITANTS.

1201 F) Annuitants:

1) ANNUITANTS and 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 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, in accordance with Uniform Benefits Certificate of Coverage (ET-2180) 5., A., 16., a. (As-If Contract) However, retrospective adjustments to PREMIUM or claims for coverage not validly in force shall be limited to the shortest retroactive enrollment limit set by Medicare for either medical or prescription drug claims, not to exceed 90 days. They must enroll in Medicare Part B at the next available opportunity.

   In the event that a PARTICIPANT is enrolled in regular (non-Medicare coordinated) coverage, ETF will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits Certificate of Coverage (ET-2180) 5., A., 16., a. In such cases, the HEALTH PLAN will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.

2) Enrollment under the federal plans for hospital care (Medicare Part A) by EMPLOYEES, ANNUITANTS and their DEPENDENTS who are eligible for those programs is waived if the insured EMPLOYEE, ANNUITANT or DEPENDENT is required to pay a premium to enroll in the hospital portion of Medicare (Part A). However, if Part A is not elected, the reduced PREMIUM rate is not available.

3) If a Medicare coordinated family PREMIUM category has been established for a family, and one

or more family members enrolled in both parts of Medicare dies, the family PREMIUM category in effect shall not change to a higher premium rate solely as a result of the death.

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

4) U.S. residents, retired EMPLOYEES and their spouses and/or DEPENDENTS participating in the State Group Health Insurance Program who are Medicare enrolled, will be automatically enrolled in the Medicare Pharmacy Part D 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 ETF's Medicare Pharmacy Part D 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.

1201 G) Medicare Data Match:

The Medicare Secondary Payer (MSP) provisions of the Social Security Act state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. The Medicare Data Match Project is a federal program administered by Coordination of Benefits & Recovery (COB&R), that requires EMPLOYERS and HEALTH PLANS provide information about specific current or former EMPLOYEES covered under the EMPLOYER's health insurance program.

ETF has established a Voluntary Data Sharing Agreement (VDSA) with Medicare that transfers Medicare information on insured PARTICIPANTS multiple times a year. The VDSA has eliminated the need for most Medicare Data Match activities.

If Medicare paid a claim(s) as the primary carrier, when in fact, the EMPLOYER's group HEALTH PLAN was the primary carrier, the HEALTH PLAN is responsible for reimbursing Medicare for the claim(s) and COB&R will contact the HEALTH PLAN and EMPLOYER. If these inquiries are not handled timely, EMPLOYERS may receive collection notices issued by the Department of Treasury (Treasury) or an entity at the direction of the Treasury for repayment of claims.

EMPLOYERS may need to submit information to COB&R or another entity regarding the employment status of the EMPLOYEE or former EMPLOYEE. The HEALTH PLAN is responsible for resolving discrepancies in claims payments for all Medicare Data Match inquiries. In certain situations, HEALTH PLANs may inform COB&R or another entity that they are not responsible for payment under the terms of their contract. Occasionally the EMPLOYER or HEALTH PLAN may not have been specific enough in their explanation, resulting in Medicare or another entity pursuing the EMPLOYER for repayment of a benefit paid. You should receive documentation of any HEALTH PLAN's response to Medicare.

ETF strongly recommends keeping full documentation of any correspondence with COB&R or another entity regarding Medicare Data Match requests. It is the EMPLOYER's responsibility to keep complete records, including copies of the HEALTH PLAN's response to Medicare.

Medicare does have the right under federal law to collect the money paid in error from the EMPLOYER. However, it is our view that the EMPLOYER should not have to pay the amount owed if the matter is properly referred to and handled by the appropriate HEALTH PLAN. Reasons the EMPLOYER should not have to pay include:

1) The claim has already been paid
2) The claim is the responsibility of the HEALTH PLAN
3) Medicare is the primary payer

If you receive a letter from a Medicare intermediary or a collection agency on behalf of the Treasury, indicating that money is due and/or that money will be taken from your agency's federal funding, please follow these steps:

1) Verify that the EMPLOYEE was identified to COB&R or other entity through a data match request and review your records concerning each individual to make sure that you have all the documentation and copies of the documentation from the HEALTH PLAN. *HEALTH PLANs are to respond to COB&R or other entity following the federal procedures.*
2) Contact the HEALTH PLAN's representative to reach their current Coordination of Benefits (COB) person. Make sure that COB person has a copy of the documents and they are working on this with Treasury as a priority. Follow up with the HEALTH PLAN if the matter is not resolved in a timely manner.
3) Contact your legal counsel for assistance.
4) You may need to prepare a letter to the requestor. Talk about this with the HEALTH PLAN's COB person. You may use the attached Sample Letter.

Sample Letter

I am writing regarding Debt Identification Number _____, which is addressed in the enclosed copy of your letter, dated _____.

I challenge the assertion that the (*EMPLOYER Name*) owes Medicare $. It is my belief that all claims are payable, or have been paid, by (*HEALTH PLAN's name*), the health plan with whom (*EMPLOYEE's name*) had health insurance coverage, or, the claims are not covered as a primary benefit under the State of Wisconsin group health plan.

(*Name of individual and HEALTH PLAN*), is processing all appropriate claims. You may contact (*him/her*) at:

(*Health Plan Contact Name*
Plan Name
Plan Address)

(*Name of Plan Contact*)'s phone number is (*plan contact's phone number*). If you have any questions, please contact (*Plan contact's name*); otherwise, she/he will respond, as soon as is practicable, to specific requirements in your (*date*) letter.

Sincerely,

Enclosure

cc: (*Plan Contact Name/Plan*)
Phil Borden, ETF

Chapter 13 — Employee Death

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 our website at etf.wi.gov, go to the Contact Us tab, and send a secure email by clicking on the "WRS Employer" button.

The employer is responsible for determining and entering the health insurance coverage end date in My Insurance Benefits. For both individual coverage and family coverage, the end date is the end of the month of the EMPLOYEE's death. A payroll refund may be required.

EMPLOYERS must pay health insurance PREMIUMS for insured, eligible survivors of a law enforcement officer, as defined in Wis. Stat. § 66.0137(1)(am), who dies in the line of duty, per 2019 Wisconsin Act 19. If such an EMPLOYEE dies, contact ETF for assistance.

1302 Surviving Spouse and Dependents

1302 A) In the event an EMPLOYEE or ANNUITANT with family health coverage dies, the surviving spouse and/or eligible dependents will continue coverage as required by Wis. Adm. Code § ETF 40.01, except as provided for in 1302 D. Coverage shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT. The surviving spouse may continue coverage indefinitely; DEPENDENT children (as defined in 302) may continue coverage as long as they remain eligible under the program.

1302 B) When employment ends for a state EMPLOYEE due to death and family coverage is in place, the deceased state EMPLOYEE's family coverage continues through the end of the month that PREMIUMS have been deducted. All insured surviving DEPENDENTS remain covered on the family contract. PREMIUMS deducted from the deceased EMPLOYEE's pay are not refunded. There will be no other EMPLOYER contribution towards the monthly premium, except as provided for in 1302 D.

1302 C) If the surviving spouse and DEPENDENTS do not wish to continue coverage, ETF must receive a signed written request indicating this. Should the surviving spouse (or ANNUITANT) and DEPDENDENT(s) not elect to continue coverage, coverage will end at 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 and use of sick leave credits to pay health insurance PREMIUMS. 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 accumulated sick leave conversion credits or any WRS annuity the DEPENDENT may

be receiving. If there is no sick leave or 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:
1) the individual was previously insured under the contract of the deceased EMPLOYEE and regains eligibility or
2) a child of the EMPLOYEE or ANNUITANT who was in the process of being adopted by the deceased EMPLOYEE or ANNUITANT prior to death and is subsequently adopted by the surviving spouse or
3) a child born within nine months after the death of the EMPLOYEE or ANNUITANT.

These DEPENDENTS will be eligible for coverage under the survivor's contract until such time that they are no longer eligible.

If an active state EMPLOYEE is covered under a spouse's insurance plan outside of the State Group Health Insurance Program (through a private employer or a participating local employer) and the state EMPLOYEE dies, the surviving spouse does not have access to the deceased state EMPLOYEE's accumulated sick leave.

Note: The EMPLOYER must promptly certify accumulated and supplemental sick leave credits upon the death of an employee (refer to the *Sick Leave Conversion Program Employer Manual* (ET-1170).

1302 D) In the event a law enforcement officer EMPLOYEE with family health coverage dies in the line of duty, the EMPLOYER must continue to pay health insurance PREMIUMS for the surviving spouse and/or eligible DEPENDENTS as required by 2019 Wisconsin Act 19. Contact ETF for assistance.

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

When an EMPLOYEE with family coverage dies, and the surviving spouse 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.

    a. If the surviving spouse and/or DEPENDENTS(s) are already covered under the State Group Health Insurance Program, the decedent's sick leave credits will automatically be banked for use.
    b. Once the decedent's sick leave credits are banked, the surviving spouse and/or DEPENDENT(s) may use the banked sick leave credits when one of the following occurs:
        i. An involuntary loss of health insurance coverage (e.g., terminating employment).
        ii. A retirement: In order to use the deceased EMPLOYEE's inactivated sick leave credits, the spouse must meet the eligibility requirements upon retirement as stated in Chapter 10, subchapter 1001.

2) Enroll as the surviving spouse and retain coverage indefinitely as indicated in subchapter 1302. PREMIUMS will be paid through accumulated sick leave conversion credits, WRS annuity, or directly by the surviving spouse/DEPENDENTS to the HEALTH PLAN.

Chapter 14 — Invoicing

1401 Viewing Your Invoice

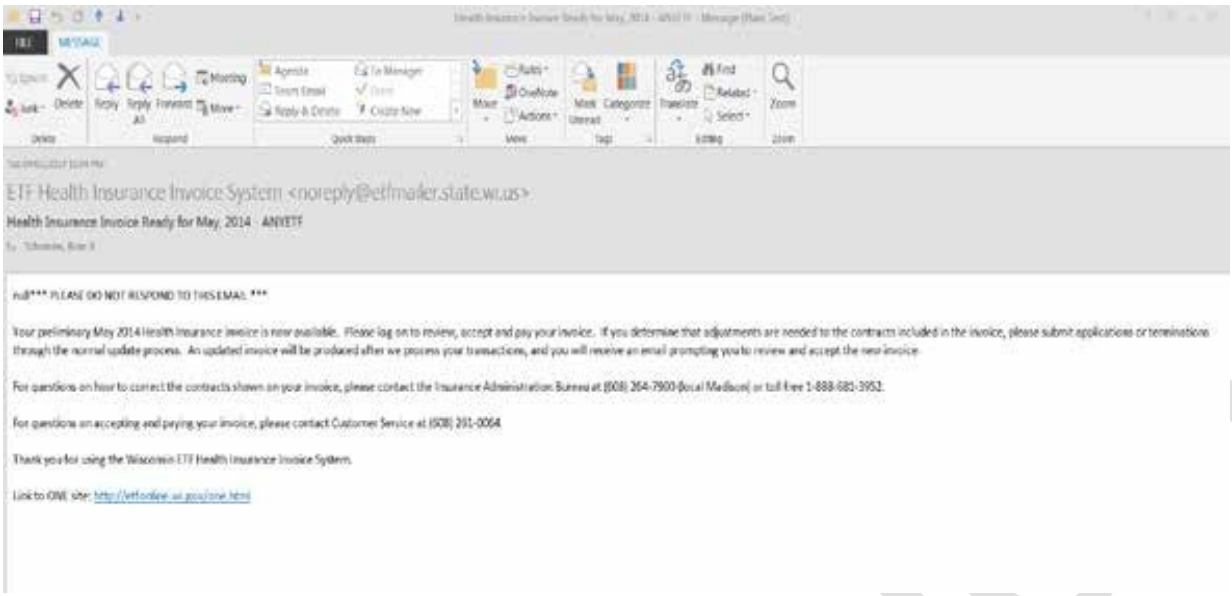
Reports and remittances from employers required in the administration of the group health insurance program shall be submitted to ETF no later than the 24th day of the calendar month for the current month's coverage. The remittance by the employer shall be the amount invoiced by ETF.

Each month, ETF invoices employers for coverage for the current month based on all active health insurance contracts in My Insurance Benefits. 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 OnLine Network for Employers (ONE).

CURRENT PROCESS (2017)					
	Coverage Month	**ETF Generates Employer Invoices**	**Premiums due from Employers to ETF**		
State Active	January 2017	January 1, 2017	January 24, 2017		
State Annuitants	January 2017	December 1-10, 2016	December 27, 2016		

1401 A) Invoice Generation

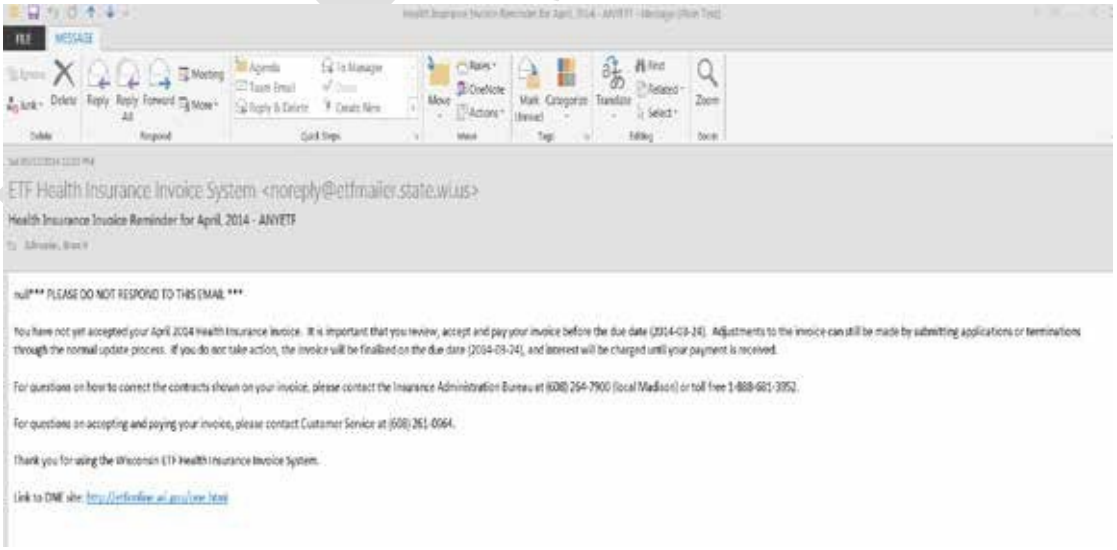
During the evening on the first day of every month, the myETF Benefits system initially generates an invoice for health insurance premiums for all state employers. This invoice is generated in a locked status, meaning any enrollment information received after this date appears on the following month's invoice. An email is sent to all employer's authorized agent and insurance contacts to alert them that an invoice is available for their review. An example of such an email is below:



The email 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 current calendar month on all health insurance contracts that are active in that month.

1401 B) 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 email to the person authorized to accept the invoice to remind them that the employer invoice has not been accepted. An example of such an email 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. See Section 1503 for more information on accepting and paying the monthly invoice and due dates.

1401 C) 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 email contact information by clicking on the *employer email address update* link. If the user is not updating their email 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, accept date, accepted by, employee share field, initial payment late indicator, and interest amount. The employee share field is a field the employer is **required** to make an entry in 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 are used in reconciling the invoice and 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.

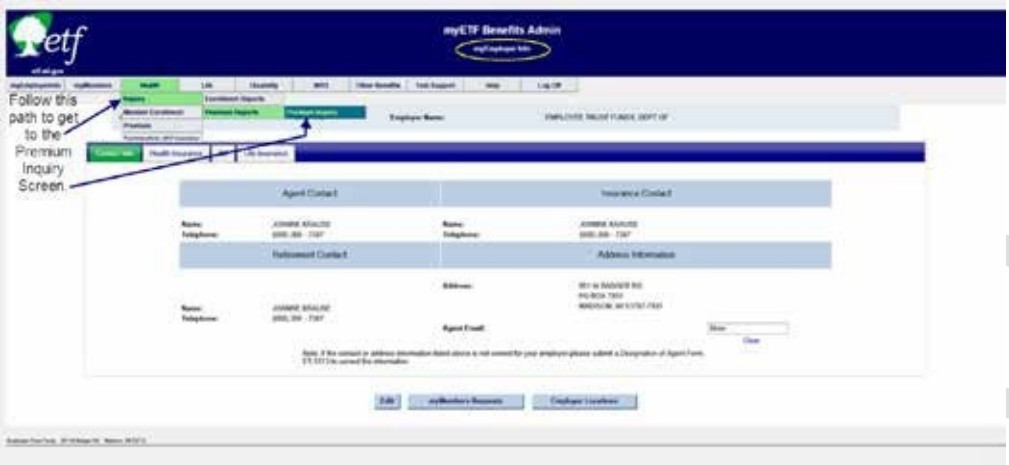
1402 Reconciling Your Invoice

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 available to them the "Invoice Detail" and "Contract Activity" applications. In addition, employers have access to two reports to utilize in their reconciliation effort, the "Enrollment Report" and "Premium Report".

1402 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

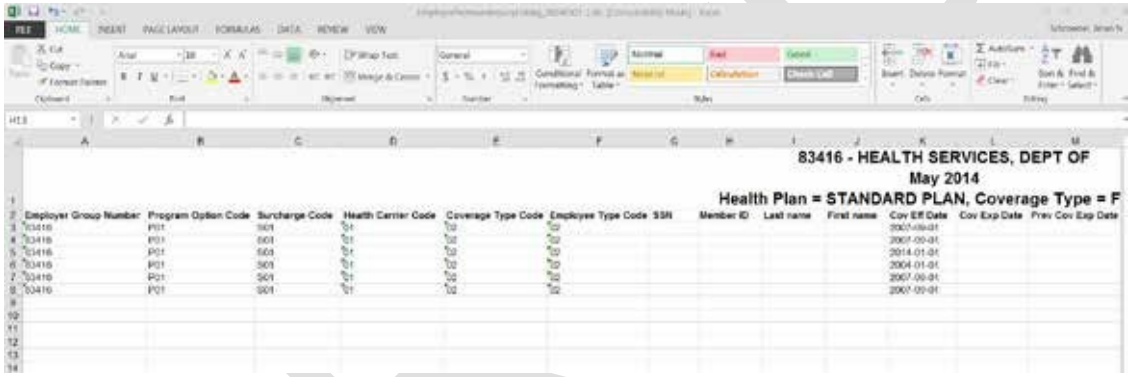
must set the search filters for coverage month and year, health plan and coverage type.

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.

1) 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.

The information displayed is the total number of contracts being billed on the invoice. The information is broken down by health plan, employee type and coverage level.

The application totals the contracts into one group total and assesses the Employee Reimbursement Accounts Administrative Fee that is added to the total invoice amount. This application does not provide specific employee information for whom the employer is being billed.

1402 B) Contract Activity

Access to the Contract Activity application is gained through the Health Insurance Invoice Summary screen. Click on the *'Contract Activity'* 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.

1402 C) 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. These reports are useful for tasks and employer needs to track, but not useful for reconciliation of your invoice. 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 Dependent Inquiry allows an employer to obtain a list of dependents, including spouses, stepchildren, grandchildren, children, and legal wards. This assists the employer in determining which dependents will be aging out (turning 26) and who will need to receive COBRA applications as well as if the subscriber's contract needs to be changed to single because the dependent aging out was the last dependent on the contract. This should be viewed for dependents up to 90 days out to have the earliest warning that a dependent will be aging out of coverage. ETF populates the termination date of adult dependents 90 days in advance of their age out. So, if we are in the invoice month for May, an employer can pull the July invoice dependent report to view those dependents who will be aging out between the current invoice and the July invoice.

The Address Inquiry provides a listing of address changes made for employees within the last 30, 60 or 90 days. Larger employers should refrain from requesting this information for more than 30 days as there could be a delay in results due to the volume of staff the employer has.

All of these reports can be exported by clicking Save As and then can be sorted as an Excel document to assist the employer with their various coverage and eligibility reconciliations, but not invoice reconciliation.

1403 Accepting and Paying Your Invoice

Wismart

Automated Clearing House (ACH)

1403 A) 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.

   On the next screen, review the invoice details and if everything is okay, click *'Confirm'.* Employers will then receive an email acknowledging the acceptance of the invoice. 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 email 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.

   Note: To reduce timing related issues with acceptance of invoices, please do not accept invoices between the hours of 5:40pm and 8:15pm.

   ETF may lock your invoice while making changes to it.

1403 B) 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.

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

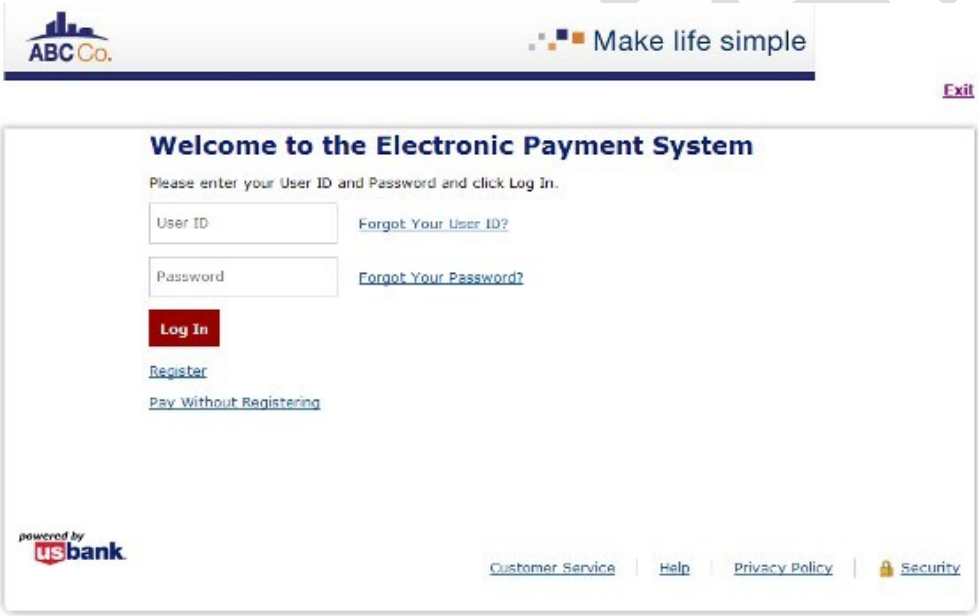
1403 C) Automated Clearing House (ACH):

For state employers paying by ACH, 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.

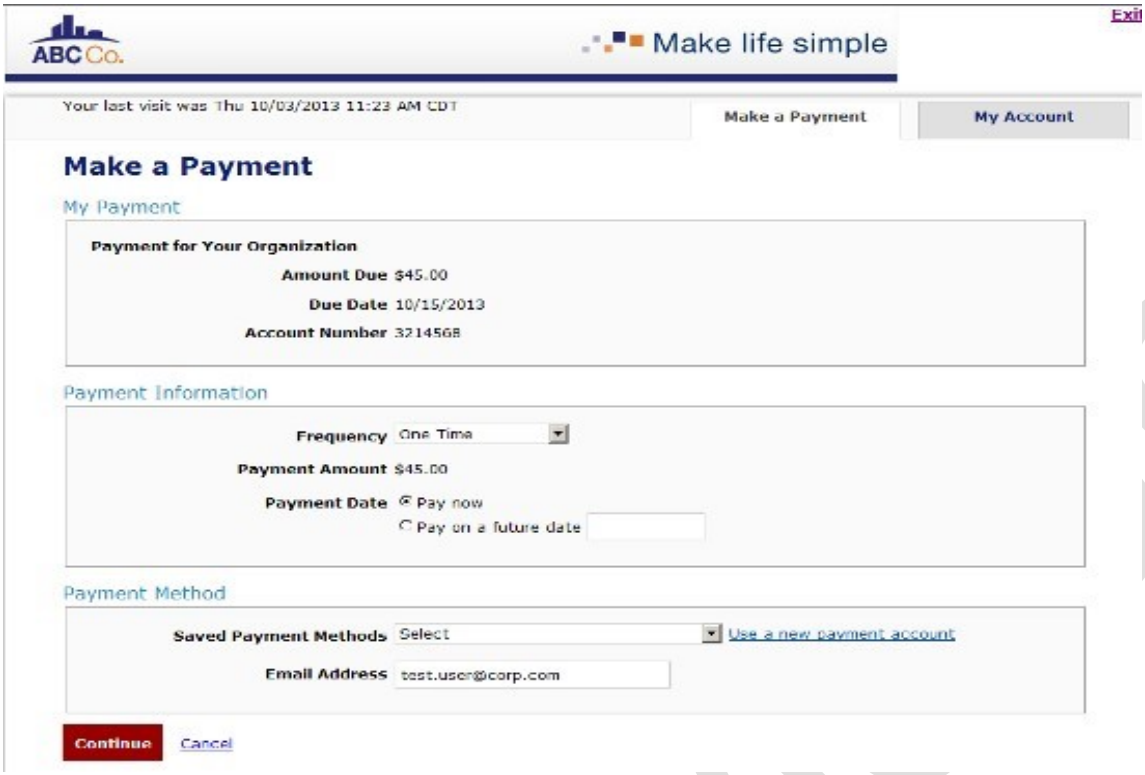
Log In – User should select this option if they have already registered for an account. This is separate from ETF's Online Network for Employers (ONE) or myETF Benefits and uses a different User ID & Password.

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.

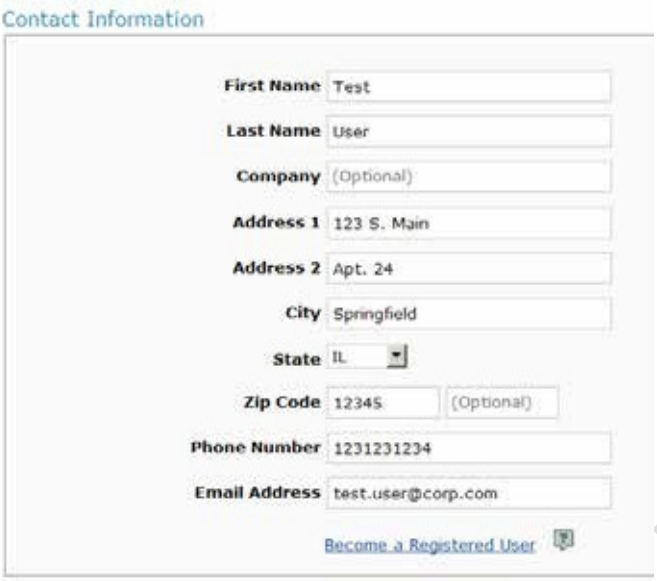


Next will be the **Make a Payment** screen.



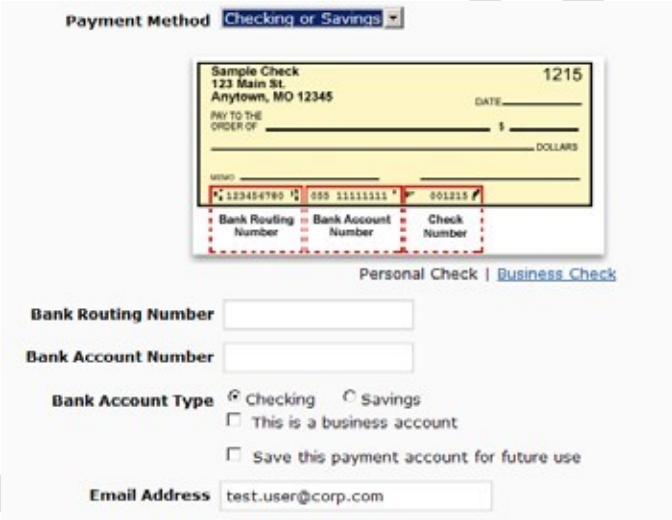
This will have 3 sections.

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.
            a. If the user is not using a registered account, the user will get a Contact Information Section to fill out.



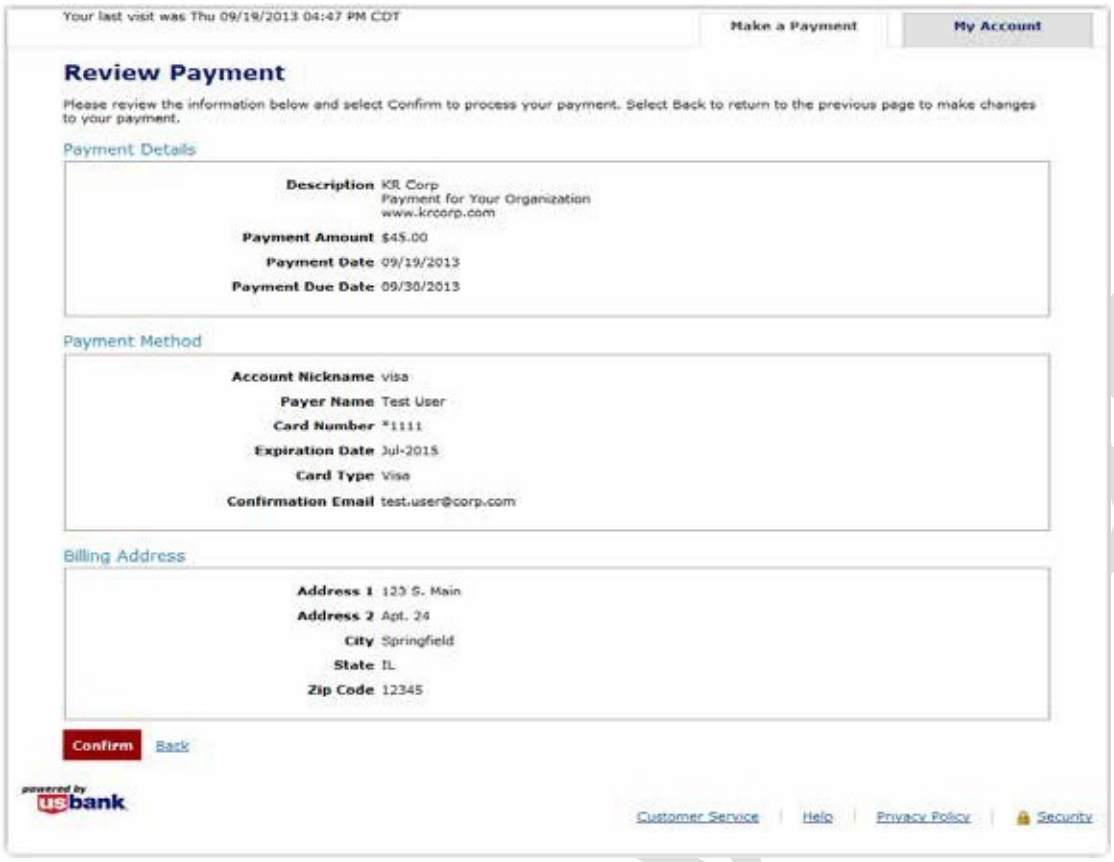
3) **Payment Method** – If a user is registered this will be the saved banking account.

a) If a user is paying without registering, the user will need to fill in the banking
information.

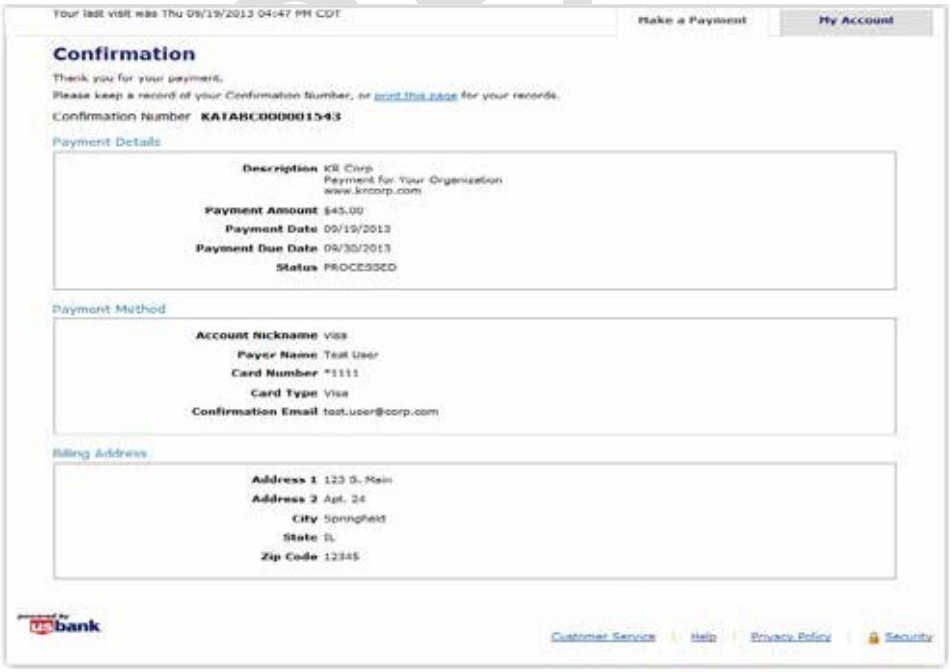


Once all 3 sections are complete, click '*Continue'*.

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



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



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:

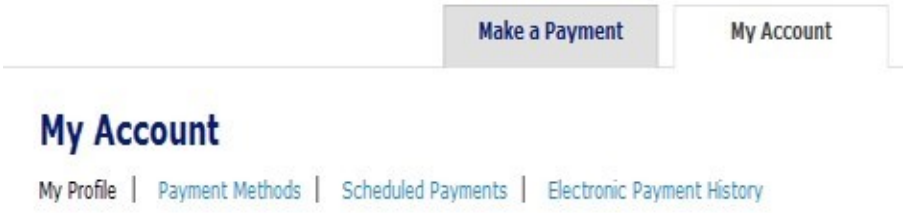
1) Check for print out of E-Payment Confirmation Page.

2) Check emails – Employers would have received an email 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 to the US Bank E-Payment Service and Log In if they are a registered user.

    a) Click on the '*My Account'* tab.



    i) Go to ***Scheduled Payments*** – This will list any pending payments. It will remain here as pending until the payment date.
        1) If there is a pending payment, no further action is needed and the user can logout.
        2) 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:

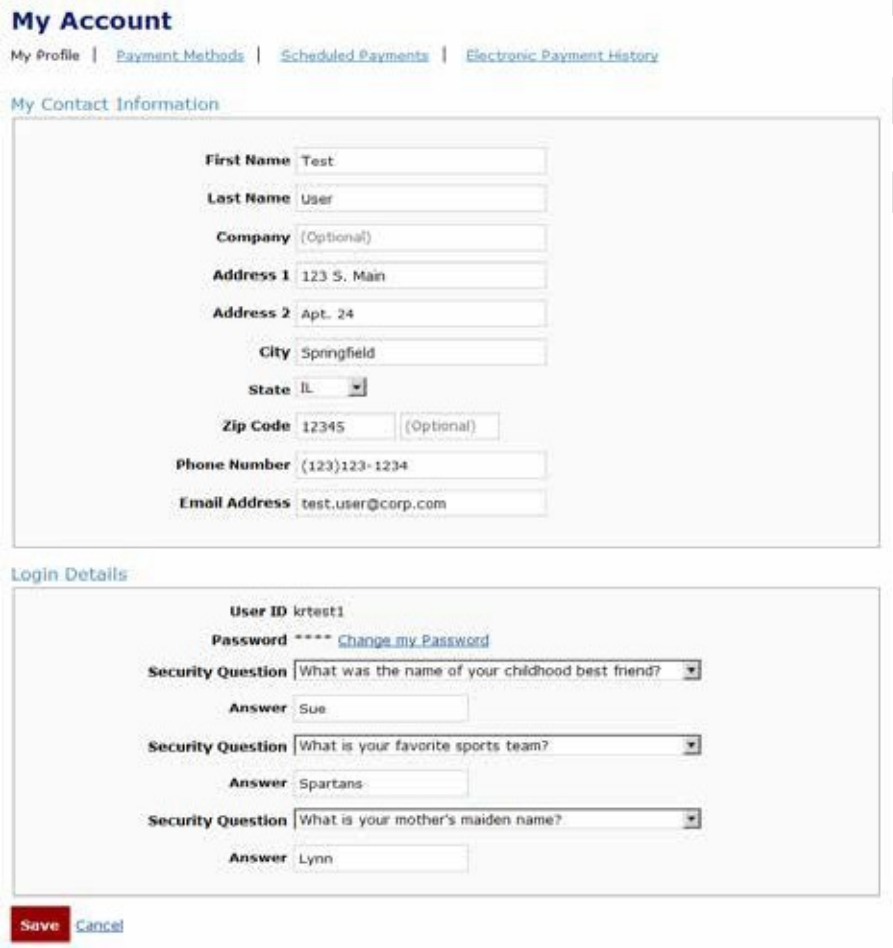
Interest Charge = Invoice Premium Due x Number of days late x 0.04%

The interest charge will be assessed after the payment has been submitted and should be paid as soon as possible. Employer's paying by ACH must 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 can 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.



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.

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.

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.

Chapter 15 —Glossary of Definitions

“ACCESS PLAN" means the nationwide preferred provider organization (PPO) benefit plan available to all PARTICIPANTS offered by the BOARD as provided by § 40.52 (1).

"ANNUITANT" means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System, a currently insured recipient of a long-term disability benefit under Wis. Adm. Code § ETF 50.40, a currently insured recipient of a disability benefit under Wis. Stat. § 40.65; or a terminated EMPLOYEE with 20 years of creditable service.

"BENEFITS" means the services that are paid for as a part of your coverage under the State of Wisconsin Group Health Insurance Program.

"BOARD" means the Group Insurance Board.

“CONTINUANT” means any SUBSCRIBER enrolled under the federal or state continuation provisions.

"CONTRACT" means the State of Wisconsin Group Health Insurance Program Agreement (ET-1136) and all appendices, exhibits and attachments.

"DEPENDENT" means, as provided herein, the SUBSCRIBER’S:

1) Spouse.
2) Child.
3) Legal ward who becomes a permanent legal ward of the SUBSCRIBER or SUBSCRIBER’S spouse prior to age 19.
4) Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
5) Stepchild.
6) Grandchild if the parent is a DEPENDENT child.

    a) A grandchild ceases to be a DEPENDENT at the end of the month in which the DEPENDENT child (parent) turns age 18.

    b) A spouse and a stepchild cease to be DEPENDENTS at the end of the month in which a marriage is terminated by divorce or annulment.

    c) All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except that:

        i. An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is dependent on the SUBSCRIBER (or the other parent) for at least 50% of the child’s support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER should decease, the disabled adult DEPENDENT must still meet the remaining disabled criteria and be

incapable of self-support. The HEALTH PLAN will monitor eligibility annually, notifying the EMPLOYER and ETF when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The HEALTH PLAN will assist the ETF in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination.

ii. After attaining age 26, as required by Wis. Stat. § 632.885, a DEPENDENT includes a child that is a full-time student, regardless of age, who was called to federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

d) A child born outside of marriage becomes a DEPENDENT of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name. The EFFECTIVE DATE of coverage will be the date of birth if a statement or court order of paternity is filed within 60 days of the birth.

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

f) 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 506H.

"EFFECTIVE DATE" means the date, as certified by ETF (or as shown on the records of the HEALTH PLAN for PARTICIPANTS who pay premium directly to the HEALTH PLAN), on which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in the CONTRACT.

"EMPLOYEE" means a person who is working for pay as an eligible EMPLOYEE of the State of Wisconsin, the University of Wisconsin, or UW Hospitals and Clinics as defined under Wis. Stat. § 40.02 (25) (a), 1., 2., or (b), 1m., 2., 2g., or 8.

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

"ETF" means the Department of Employee Trust Funds.

"FAMILY SUBSCRIBER" means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

"HEALTH PLAN" means the licensed insurer that is under CONTRACT with the BOARD to provide BENEFITS and services to PARTICIPANTS of the State of Wisconsin Group Health Insurance Program.

"INDIVIDUAL SUBSCRIBER" means a SUBSCRIBER who is enrolled for personal coverage only and whose DEPENDENTS, if any, are thus not eligible for BENEFITS.

"INPATIENT" means a PARTICIPANT admitted as a bed patient to a health care facility or in 24-hour home care.

"IT'S YOUR CHOICE" see OPEN ENROLLMENT.

"LAYOFF" means the same as "leave of absence" as defined under Wis. Stat. § 40.02 (40).

“MINIMUM ESSENTIAL COVERAGE” means an insurance plan that meets the Affordable Care Act requirement for having health coverage. Minimum essential coverage is sometimes called qualifying health coverage.

“OPEN ENROLLMENT” means the yearly period referred to in ETF materials where all members may make changes to their HEALTH PLAN. Eligible EMPLOYEES and ANNUITANTS may enroll for or transfer coverage to any HEALTH PLAN offered by the BOARD. The dates for this time period are set each year by ETF and the BOARD.

"PARTICIPANT" means the SUBSCRIBER or any of the SUBSCRIBER'S DEPENDENTS who have been specified by ETF for enrollment in the HEALTH PLAN and are entitled to BENEFITS.

"PREMIUM" means the rates shown in the Group Health Insurance Program print and web materials published by ETF that includes the medical, pharmacy, and dental (when applicable) components, and administration fees required by the BOARD.. Those rates may be revised annually, effective on each succeeding January 1 following the effective date of this CONTRACT. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

"SUBSCRIBER" means an EMPLOYEE, ANNUITANT, his or her surviving DEPENDENTS, or CONTINUANT who have been specified by ETF to the HEALTH PLAN for enrollment and who is entitled to BENEFITS

Appendix A — Forms and Brochures

Document name	Form number	Link
WRS Administration Manual	ET-1127	etf.wi.gov/resource/wisconsin-retirement-system-administration-manual
State of Wisconsin Group Health Insurance Program Agreement	ET-1136	etf.wi.gov/resource/2022-state-wisconsin-group-health-insurance-program-agreement
Group Health Insurance Application	ET-2301	https://etf.wi.gov/resource/health-insurance-applicationchange-form
Health Insurance Application/Change for Retirees & COBRA Continuants	ET-2331	etf.wi.gov/resource/health-insurance-applicationchange-retirees
COBRA Continuation Conversion Notice	ET-2311	etf.wi.gov/resource/cobra-continuation-conversion-notice
Rehired Annuitant Form	ET-2319	etf.wi.gov/resource/rehired-annuitant
Converting Your Group Life Insurance to Pay for Health Insurance or Long Term Care Insurance Premiums	ET-2325	etf.wi.gov/resource/converting-your-group-life-insurance-pay-health-or-long-term-care-insurance-premiums
Group Health Insurance	ET-4112	etf.wi.gov/resource/group-health-insurance
Sick Leave Conversion Credit Brochure	ET-4132	etf.wi.gov/resource/sick-leave-credit-conversion-program-brochure
Sick Leave Escrow Application	ET-4305	etf.wi.gov/resource/sick-leave-escrow-application
Medicare Eligibility Statement	ET-4307	etf.wi.gov/resource/medicare-eligibility-statement