



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

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

Employer Communications Center  
1-877-533-5020

[etf.wi.gov](http://etf.wi.gov)

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

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**Manual**

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**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-1118](#)) 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 instructions relevant to the administrative and reporting practices of the group health insurance program. Wisconsin statutes, administrative code and group health contract language are reviewed on an ongoing basis. This contract and administrative manual will be updated regularly.

The Department of Employee Trust Funds 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-1118) contains examples relevant to the administration of the group health insurance program but may not cover every eventuality. Specific program questions and situations will be considered with regard to current statute, administrative code, 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-related questions or concerns. If questions remain, contact the Employer Communications Center in ETF's Employer Services Section (ESS). ESS provides a single point of contact to resolve issues regarding eligibility, enrollment, coverage and invoicing for ETF benefit programs. A central voice mail system handles calls when all ESS staff member lines are busy. The voice mail system is monitored on a regular basis and all calls are returned within 24 business hours. The ESS telephone is 1-877-533-5020 or email at [ETFMSBEmployerInsurance@etf.wi.gov](mailto:ETFMSBEmployerInsurance@etf.wi.gov).

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-1118), please contact ETF at 1-877-533-5020.

**Department of Employee Trust Funds  
State Agency Health Insurance Employer Standards,  
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### **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 retirees 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 Group Insurance Board (BOARD) sets policy and oversees administration of the group health, life, 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 this State of Wisconsin Group Health Insurance Program Agreement. 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](http://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 the *It's Your Choice* materials at [etf.wi.gov](http://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](http://etf.wi.gov)) and appears in the *It's Your Choice* materials online under *Federal/State Notifications*.

## 101 G) Patient Protection and Affordable Care Act

The Patient Protection and 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 employees and early (non-Medicare) retirees of the State of Wisconsin groups are considered MINIMUM ESSENTIAL COVERAGE.

For more detailed information about ACA provisions, visit [www.healthcare.gov](http://www.healthcare.gov) and [www.dol.gov/ebsa/healthreform/](http://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) Review original required documentation to validate births, marriages, divorces, deaths, and other life events. For births, marriages, divorces and deaths, send ETF the *Employer Attestation for Documentation Received* ([ET-1908](#)) form to verify your actions to benefit coverage eligibility. Employers should *not* send digital copies of vital records per Wis. Stat. § 69.21. See Life Change Events and Documentation Requirements ([ET-2846](#)).
- (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, 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) Run reports to determine eligibility for dependents turning age 26 including those who are disabled.
- (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 It's Your Choice materials online under *Contact Info for Health Plans*. (Employers only are also provided contacts for more specific areas such as claims and complaints. The *Health Plan and Vendor Contact List* ([ET-1728](#)) is updated twice a year and provided in an employer 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 Services Section, Retiree Health Insurance Unit.
- (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](http://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.



## 103 Employer Training and Support

### 103 A) Training

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

### 103 B) Group Health Plan Questions and Technical Support

Questions about group health plans or benefits should be directed to the Employer Services Section at 1-877-533-5020 or ETFSMBEmployerInsurance@etf.wi.gov.

## 104 myETF Benefits System

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

### 104 A) myETF Benefits Administrator application for Employers (via Online Network for Employers - ONE).

### 104 B) myETF Benefits application for Members (via Online Network for Members - ONM) if not an employee under STAR/Central Payroll, UW or UWHC.

- (1) The myETF Benefits Administrator Application for Employers allows employers to:
  - (a) Initially enroll new employees.
  - (b) View and update individual member health insurance eligibility
  - (c) Complete mass employee terminations.
  - (d) View and update health insurance enrollment data.
  - (e) Approve employee submitted changes to health insurance and demographic data.

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

- (2) The myETF Benefits Application for Members allows members and employers to:
  - (a) Initially enroll in the health insurance if the employer allows and has set up the employee on myMembers.
  - (b) View individual health insurance eligibility and demographic data.
  - (c) Update health insurance enrollment data.
  - (d) Update demographic information.

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

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

## 105 ETF Ombudsperson Services

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

ETF offers ombudsperson services to assist members who remain dissatisfied after first having contacted the health plan and/or the Employer Services Section regarding a problem or complaint. Employers should direct employees in this situation to email, write or telephone 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](mailto: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, 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 in the Benefits area of the [etf.wi.gov](http://etf.wi.gov) and searching Ombudsperson Services.

## 106 Employer Services Section, Insurance Unit (ESS) Contact Information

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

### 106 A) Employee Trust Funds

<b>Mailing Address</b>	P.O. Box 7931 Madison WI 53707-7931
<b>Shipping Address</b>	Department of Employee Trust Funds 4822 Madison Yards Way Madison WI 53705-9100
<b>Telephone</b>	1-877-533-5020 select option 2 (toll free)

<b>TTY</b>	711
<b>Fax</b>	1-608-267-4549
<b>Website</b>	<a href="http://etf.wi.gov">etf.wi.gov</a>
<b>Email</b>	<ul style="list-style-type: none"> <li>• Reach out to <a href="mailto:ETF SMBSTARInsurance@etf.wi.gov">ETF SMBSTARInsurance@etf.wi.gov</a> if the employee works for a Central Payroll Agency.</li> <li>• Reach out to <a href="mailto:ETF SMBUWandUWHCInsurance@etf.wi.gov">ETF SMBUWandUWHCInsurance@etf.wi.gov</a> if the employee works for the University of Wisconsin or the UW Hospital Authority</li> <li>• If the employee works for one not listed, contact <a href="mailto:ETF SMBEmployerInsurance@etf.wi.gov">ETF SMBEmployerInsurance@etf.wi.gov</a></li> </ul>

**Office Hours**

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

**106 B) Pharmacy Benefit Manager (PBM) Contact Information**

<b>Office Address</b>	Navitus Health Solutions,
<b>Mailing Address</b>	Navitus Health Solutions, LLC P.O. Box 999 Appleton, WI 54912-0999
<b>Telephone</b>	1-866-333-2757 (toll free)
<b>Website</b>	<a href="http://www.navitus.com">www.navitus.com</a>

**106 C) Wellness and Disease Management Program Administrator Contact Information**

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

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## **Chapter 2 — Health Plan and Program Requirements and Information**

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The State of Wisconsin Group Health Insurance Program consists of two types of plans: IYC health plans and the IYC ACCESS Plan. Effective January 1, 2015, ETF also offered a High Deductible Health Plan (HDHP) option for both types of plans. Eligible EMPLOYEES, ANNUITANTS (including those under Wis. Stat. § 40.51 (16)), 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 IYC Health Plans and HDHP (HMOs and PPOs)**

**201 A)** IYC health plans are health maintenance organizations (HMO) or preferred provider organizations (PPO)) that provide comprehensive benefits at a lower cost than the IYC ACCESS PPO Plan in exchange for some health care provider limitations. Most employees select an IYC health plan. PPOs may have different copayment and deductible schedules for out-of-plan providers, except in the case of emergency, urgent care or when the service is not reasonably available from a plan 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 *It's Your Choice* enrollment 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, quality of services, and

access to specific physicians or other health care providers.

While Uniform Benefit coverage levels are the same for IYC health plans, plans differ in other ways, namely overall premium amount, provider network, benefit determinations and administrative requirements. Uniform Benefits and premium amounts change on an annual basis. The latest 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 and the Certificates of Coverage and Schedules of Benefits (listed below) online are the most reliable resources for details.

<b>Form # ET-</b>	<b>Title of Certificate of Coverage or Schedule of Benefits</b>
2180	Uniform Benefits Certificate of Coverage [For Access Plans too]
2107sb	IYC Health Plan Schedule of Benefits
2112sb	Access Plan Schedule of Benefits
2107sbhd	High Deductible Health Plan (HDHP) Schedule of Benefits
2170sb	Access High Deductible Health Plan (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 *It's Your Choice* materials online.

Uniform Benefits and premium amounts change on an annual basis. The latest annual Health Benefits Decision Guide, available at [etf.wi.gov](http://etf.wi.gov) 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. These are the most reliable resources for current benefit details. **Note:** Benefits differ for retirees and their dependents enrolled in Medicare for example, deductibles do not apply.

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).
  - c. Effective January 1, 2024, retirees 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:* Upon determination that a SUBSCRIBER has enrolled in such a plan, 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. Employers should provide guidance to those participants that are interested in voluntarily delaying/disenrolling from Medicare and/or Social Security. **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 IYC 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 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 a plan provider. 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.

## **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 *It's Your Choice* 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. The Board reserves the right to make enrollment and eligibility decisions as necessary to implement this program, including whether to make a Tier 1 plan available in those counties in which otherwise no qualified health plan in Tier 1 exists and/or a Tier 2 plan available in any county. 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 (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 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 Health Savings Account 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 Health Savings Account contributions and the Health Insurance Opt-Out Stipend.

## **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 through their employer's payroll/benefit system or file a paper Group Health Insurance Application/Change ((ET-2301) available on the ETF website and updated annually) form during the health benefits open enrollment period or within 30 days of hire for an employee new to the WRS. The application includes an opt-out check box and an eligibility attestation statement.

Before paying any opt-out incentives, the employer will compare the employee to ETF's 2015 opt-out master list, which is compiled from myETF Benefits enrollment system data. ETF will also validate eligibility for employers by verifying that their employee applying for the opt-out incentive does not currently have active coverage under a spouse or parent. To have this eligibility verified the employer needs to contact ETF directly at [ETF SMBEmployerInsurance@etf.wi.gov](mailto:ETF SMBEmployerInsurance@etf.wi.gov) or contact their case manager. Larger employers with more frequent hires should submit their requests via email in a spreadsheet so ETF can process these eligibility checks as quickly as possible. Incentive payments will be spread out over all applicable pay periods in the year. For mid-year new hires, the employer shall prorate the \$2,000 stipend per the remaining number of pay periods in the calendar year in which the election is made. The incentive is considered taxable income and will appear on employees' W-2 statements. However, the incentive payment is not considered WRS earnings.

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.

More information, addressed to employees, appears in the It's Your Choice Frequently Asked Question section on the Opt-Out Incentive.

## **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 retirees 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 retirees will also have supplemental "Wrap" coverage that pays secondary to the Medicare Pharmacy Part D plan.

Retirees may choose to be enrolled in another Medicare Part D plan, but it is neither recommended nor required. Retirees who choose to enroll in another Medicare Part D plan will be disenrolled from the 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, retirees 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 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 benefit vendor addresses and general phone numbers are listed in the *It's Your Choice* materials online.

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](http://etf.wi.gov) under the *It's Your Choice* section. See the Certificates of Coverage (refer to 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 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., single 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 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. However, if the last dependent loses eligibility due to age, then retro adjustments to premiums may go back 6 months based upon the date the

EMPLOYEE files the application. Also see 801F.

## **214 Limited Premium and Claim Adjustments**

Except in cases of fraud, material misrepresentation, resolution of GIB 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 the office of the HEALTH PLAN, 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).

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

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## **Chapter 3—Eligibility**

- 301** [Employee, Annuitant and Continuant Eligibility](#)
- 302** [Dependent Coverage Eligibility](#)
- 303** [Employer Premium Contribution Eligibility](#)
- 304** [WRS Previous Service Check](#)
- 305** [Rehired Employee Coverage](#)

### **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 Continuant (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)** Single 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. 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 insurer 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 State 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 submit an application to remove the dependent. If the dependent(s) is to be newly covered by a subscriber that has single 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 State Group Health Insurance Program) contract. As permitted by Section 125 of the Internal Revenue Code, two single

contracts may be combined to one family contract, a family contract may be converted to two single contracts, or the family coverage may be changed from one spouse to the other without penalty effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application, or a later date as specified on the application. If the spouses have coverage with different HEALTH PLANS at the time of marriage or when two single contracts are combined to one family contract, they may elect family coverage with either HEALTH PLAN effective the first day of the calendar month which begins on or after the date the EMPLOYER receives the application. Should the spouses become divorced while carrying family coverage, the divorced spouse may elect coverage with any HEALTH PLAN without lapse if the EMPLOYER received the application within 30 days of the divorce.

- (2) 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 State 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 single 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 of 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 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) 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 Online Network for Employers (ONE) site at: <https://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 Services Section 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.

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## **Chapter 4 — Initial Enrollment**

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**403** [Enrollment Opportunities for Employees who Previously Declined or Canceled Coverage](#)

**404** [Applying for Coverage](#)

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### **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](#) for the program option(s) you offer,
- *Health Insurance Application/Change (ET-2301)* form, if requested or your employees are not able to enroll online, 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 on the ETF website and updated annually.

If the employee is a single parent (including divorced employees), they must provide documentation such as a birth certificate or paternity acknowledgement to add dependent children. If documentation is not on file for currently covered dependents, even if they were previously insured dependents, it will be requested and must be provided. 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 member or parent and submitted to the employer.

All eligible employees must either enroll online (with information electronically transferred to myETF Benefits System) or submit a completed Health Insurance Application/Change form, including those who do not wish to enroll and are choosing to waive/decline coverage (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 vendor 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 member 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 ETF application form is received by the EMPLOYER or an online enrollment through the employer's payroll system is received within 30 days of the date of hire, coverage to 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: An EMPLOYEE shall be insured if a completed ETF application form is received by the EMPLOYER or an online enrollment through the employer's payroll system is received within 30 days of the date of hire or prior to the date employer contributions begin, coverage to 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.*
- (3) For UW unclassified faculty/academic staff: A teacher who is a participating employee and who is employed by the University of Wisconsin for an expected duration of not fewer than six months with at least a one-third full time appointment (UW Faculty). UW Faculty members are eligible for the State premium contribution beginning on the date coverage begins.
- (4) For Graduate Assistants: If eligible, they may enroll for single or family coverage in any of the available non-high deductible health plans. Their benefits/payroll/personnel office must receive the application within 30 days of the date of first eligible appointment. Health insurance coverage will be effective as of the first day of the month that occurs on or following the date of hire. If this is not the grad assistant's first eligible appointment, they may still be eligible for the initial 30-day enrollment period if there was a 30-day employment break between appointments.

**Note:** If currently an active WRS participant, grad assistant positions are **not** eligible for coverage under the graduate assistant program. 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, a completed application requires the submission and acceptance of a Health Savings Account application to the third-party administrator. The Health Savings Account application must be submitted concurrently with the HIGH DEDUCTIBLE HEALTH PLAN 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 an individual in either or both the state and local group health insurance program is not permitted.

- (1) If their spouse is already enrolled with single coverage, the new employee may also elect single coverage or elect family coverage in which case the spouse would have to submit an



application to cancel their single coverage in order to go onto the new employee's family coverage.

- (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 complete (mark appropriate box declining coverage, sign, and date) a *Health Insurance Application/Change Form* (ET-2301) available on the ETF website and updated annually) or make a waive election in the employer's benefit/payroll 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 health benefits 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. 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 single 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 EMPLOYEE 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 a Health Savings Account (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 his 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 DEPENDENT. 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 health benefits open enrollment period for an effective date of January 1 of the following year or due to a qualifying life event. An EMPLOYEE who deferred coverage may enroll if he or she has a new DEPENDENT because of birth, adoption, placement for adoption or marriage, provided he or she submits an application within 60 days of the birth, adoption or placement for adoption, or within 30 days of the marriage. 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;
  - (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.

*A Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually), or online application via myETF Benefits or the employer's benefit/payroll system submitted electronically to ETF, and other information documenting the loss of coverage or employer premium contribution must be received by the employer within 30 days of the date the other coverage or the employer premium contribution ended. If all documentation is not readily available, submit the application and other 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 receipt of the application. 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. 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 plan 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 single 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.
- (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 30 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 hours increase to half-time or more. These employees may enroll in any plan without restriction and have 30 days from the date the employer contribution increases to file online via myETF Benefits, the employer’s benefit enrollment system or submit a *Health Insurance Application/Change Form* to the employer. Coverage is effective the first of the month following 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:** 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 IT'S YOUR-CHOICE 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 as of April 15, they need to be insured as an employee in the non-HDHP Access Plan as of April first, then their retiree 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. 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 Guide* and the *Health Insurance Application/Change Form* (ET-2301). 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. Inform the employee of the deadline for submitting the application. Employees may also submit their application online via myETF Benefits or their employer's payroll/benefit system within the same timeframe.

Employees should complete the application following the instructions included with the *Health Insurance Application/Change Form*. Each eligible employee must submit an application (paper or online) to the employer even if declining coverage (currently must submit paper form if declining coverage). It is important that there is written documentation indicating the employee declined coverage; employers should retain such documentation. UW staff using ebenefits to decline coverage need not complete this step.

(1) If employees are enrolling using the paper *Health Insurance Application/Change Form*, direct employees to the ETF website at [etf.wi.gov](http://etf.wi.gov).

(2) If employees are enrolling online via myETF Benefits, direct employees to the ETF website at [etf.wi.gov](http://etf.wi.gov). [Click on the Members tab, then select the myETF Benefits for Members link](#). The employee will need to have their Member ID (which the employer will need to share with the employee) and follow the steps outlined in the Instructions.

**404 C) After the employee submits their application (paper, the employer's benefit enrollment system or online via myETF Benefits) the employer will review:**

(1) If submitted via myETF Benefits, the employer will go to myETF Benefits, myMembers/myMembers Requests, review and approve the update(s) submitted by the employee under Request Status: Pending.

(2) If submitted via *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually), the employer must review the completed form before approving the application by completing the Employer Section as follows. **Note: the employee must sign the application. Failure to provide a signature is an incomplete application and will be rejected.**

- (a) Employer Identification Number (EIN)—The EIN given to employers, beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-0001-101).
- (b) Name of Employer
- (c) Payroll Representative E-mail

- (d) Five-digit Group Number—The five-digit number assigned to state agencies (e.g., 84535)
  - (e) Employee Type—Enter the appropriate code (refer to Appendix B).
  - (f) Coverage Type Code—Coverage code identifying single or family coverage (refer to Appendix B).
  - (g) Health Plan Name or Suffix—The full name or two-digit code identifying the health plan.
  - (h) Business Unit (if applicable)—For Central Payroll / Benefits
  - (i) Employment Status—Is the employee full-time, part-time, or LTE.
  - (j) Employee Deductions—Are the employee’s health insurance premiums deducted pre-tax or post-tax.
  - (k) Previous Service—Complete Information—Check the appropriate response for each question.
  - (l) Hire Date or WRS Eligible Employment or Graduate Assistant Appointment Began or Hire Date—The month, day and year the employee began WRS (or grad assistant) employment with the employer. For rehired employees, enter the rehire date.
  - (m) Employer Received Date—The date the employer received the completed application. It is important that this date be accurate to determine if the application was received timely.
  - (n) Event Date—The date the event took place (e.g., marriage date, birth date, loss of coverage date, etc.).
  - (o) Prospective Date of Coverage—The month, day and year the coverage should be effective.
  - (p) WRS Participating Employer (if applicable) – Local only
  - (q) Previous Service Check
  - (r) Source of Previous Service Check
  - (s) Did Employee Participate in WRS Prior to be Hired by You
  - (t) Payroll Representative Signature/Phone Number/Date Signed – The signature acknowledges the date the employer received the application and that an audit of the application has been completed and the phone number of that representative.
- (3) Upon completion of the Employer Section, make copies of the application:
- (a) Employer Copy—retain original for your records.
  - (b) Employee Copy—return a copy to the employee.
  - (c) ETF Copy—if requested, submit with copies of any required documentation (e.g., contract in “Waiting for ETF Approval” status).

## **405 Primary Care Provider or Primary Care Clinic**

In the event a SUBSCRIBER files an application during a prescribed enrollment period listing a plan and a primary physician, clinic or care system that is not available in the plan selected, the HEALTH PLAN shall immediately notify the EMPLOYER. The SUBSCRIBER shall be allowed to correct the plan selected 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. The application shall be effective the later of first of the month following receipt of the application or the EFFECTIVE DATE of the original application. The HEALTH PLAN may not simply reassign a primary physician or clinic.



## 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). Member identification numbers are different on each card. The eight-digit ID number appearing on the pharmacy ID card is the employee's myETF Benefits member ID.

Applications should be submitted/entered at least one month prior to the coverage effective date, whenever possible, to allow sufficient time for the health plan and 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 for the health plans and the PBM are listed in the online *It's Your Choice* materials under the *Resources* tab at [etf.wi.gov](http://etf.wi.gov).

Subscribers can contact the health plan directly to change the physician or clinic.

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## **Chapter 5 – Changing Coverage**

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- 504 [Changing from Single to Family Coverage](#)
- 505 [Changing from Family to Single Coverage](#)
- 506 [Adding Dependents](#)
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- 508 [Considerations When Both Spouses Are Employed by the State, the University of WI, or One or Both Are Annuitants](#)
- 509 [Considerations When One Spouse is Employed by a Local Employer in the WPE Group Health Insurance Program or Other Non-State Employer](#)

### **501 Life Event Changes**

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

Status change opportunities are provided via the It's Your Choice webpages on 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) Health benefits 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 in myETF Benefits requires the participant to submit a copy of the *Address/Name/Gender Change* form (ET-2815) to the employer or ETF. The member must submit the request for any dependent under the age of 18. ETF systems are currently only able to accept male and female for gender. ETF is typically able to process requests within 30 days of receipt.

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

a. **Active employees:**

- i. Submit the document to human resources or benefits person at work. The employer will submit the information to ETF for processing.
- ii. ETF may reach out to the employer to report the active employee gender change if the ET-2815 is received at ETF without indication that the employer has updated their own records.

b. **Active employees' dependents:**

- i. Submit the document to human resources or benefits person at work. The employer will submit the information to ETF for processing; or
- ii. Submit the documents directly to ETF following the instructions for retirees below.

c. **Retirees and dependents:** Submit the document directly to ETF using one of the methods below. or :

- i. Securely via Box through ETF's website
- ii. U.S. Postal Service: WI Dept of ETF, P.O. Box 7931, Madison WI 53707-7931
- iii. In Person: WI Dept of ETF, 4822 Madison Yards Way, Madison, WI 53705-9100
- iv. 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, 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 go online to myETF Benefits and submit a request to change health plans or submit a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) to their employer (ETF for annuitants) within 30 days before or after the move. If the employee 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 employee in myETF Benefits or the receipt of the *Health Insurance Application/Change Form* by the employer.

If the application to change plans is not received within 30 days before or after the move, the SUBSCRIBER cannot change health plans until the annual health benefits 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 SUBSCRIBER should still go online to myETF Benefits or their employer's payroll/benefit system and update their address or submit a *Health Insurance Application/Change Form* to their employer within 30 days before or after the move.

## 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 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 member 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 member'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 1<sup>st</sup> enrollment date, a paper Health Insurance Application/Change for Retirees (ET-2331) must be submitted to ETF prior to the effective date. Once Benefitplace is operational, if the member 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 member(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 member(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 member'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 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 1<sup>st</sup> enrollment date, a paper Health Insurance Application/Change for Retirees (ET-

2331) must be submitted to ETF prior to the effective date. Once Benefitplace is operational, if the member 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 Single 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.

One example is that the law requires SSNs to be reported on federal form 1095-B. Your health insurance company provides 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 members.

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 member 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 will be requested and must be provided.

**504 A)** An EMPLOYEE can change from single to family coverage in several situations outside of the annual health benefits 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 single to family coverage as your employer contribution continues as described in sections 1204, 1205 or 1206.)
- (10) Has a previously covered dependent older than age 26 who is newly disabled.
- (11) In accordance with Wis. Stat. § 40.51 (2), an EMPLOYEE who enrolls for single 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 single coverage who gains more EMPLOYER PREMIUM contribution may change to family coverage within 30 days following the increase in employer contribution.

The SUBSCRIBER must either go online to myETF Benefits or their employer's payroll/benefit system and add the new dependent(s) for the appropriate reason from the drop-down listing or submit a *Health Insurance Application/ Change Form* ((ET-2301) available on the ETF website and updated annually) to the employer. 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 as follows.

1) **Marriage:** Online enrollment or application must be submitted within 30 days from the event date. An employee with single coverage may change to family coverage provided the application is received within 30 days of the marriage.

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 single 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 individual in either or both the state and local group health insurance program is not permitted.

Cancellation of single coverage and the change to family coverage can be coordinated provided one of the applications is received timely. If the application to cancel the single coverage and/or the application to change to family coverage is not received timely, the change to family can only occur during the annual health benefits 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 to change health plans or the electronic submission of the request to change health plans.

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

If the application is received after 60 days, contact the Employer Services Section. Generally, a SUBSCRIBER with single coverage must submit the application to add a dependent and change to family coverage within a 60-day time frame to be effective on the event date. If an application is not submitted within this time frame, the SUBSCRIBER cannot change to family coverage until the annual health benefits open enrollment period unless another qualifying life event occurs in the interim.

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

Effective January 1, 2022, if the subscriber is single (including divorced), documentation supporting the birth and any newly added dependents is required as outlined in the Life Change Events and Documentation Requirements (ET-2846) online. This applies even if the subscriber had previously insured the dependent(s). For single mothers, this documentation is generally a birth certificate and will be required for any children. For single fathers, this documentation is generally a paternity acknowledgement or birth certificate. Documentation for single fathers has been required for many years. Note that single fathers may be required to provide documentation of dependent status for children covered upon request from ETF to the employer.

Documentation supporting the adoption, placement for adoption, the establishment of permanent legal guardianship is required as outlined in the *Life Change Events and Documentation Requirements (ET-2846)* available on the ETF website.

The SUBSCRIBER has the opportunity to change health plans within 30 days of birth, adoption or placement for adoption (not establishment of permanent legal guardianship), provided the application to do so is submitted within the 30-day time frame. The change in health plan will be effective the first of the month on or after receipt of the application or electronic submission of the request to change health plans.

**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 single to family coverage within the specified time frame.

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

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 or online enrollment performed within the 60-day time frame, family coverage is effective on the date of birth. Beyond the 60-day time frame, coverage is effective the first of the month on or after receipt of the application.

Documentation supporting the paternity acknowledgment is required as outlined in 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 also file a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) or enroll online through myETF or their employer's payroll/benefit system 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 or online enrollment performed 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.

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

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

## 505 Changing from Family to Single Coverage

An employee can change from family to single coverage in several situations outside of the annual health benefits 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 single 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 single coverage at any

time. See subsection 508 for more information.

The SUBSCRIBER must either go online to myETF Benefits or their employer's payroll/benefit system to remove their dependent(s) using the "change family to single coverage" reason from the drop-down listing or submit a *Health Insurance Application/ Change Form* ((ET-2301) available on the ETF website and updated annually) to their employer (annuitants to ETF).

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 the *It's Your Choice* materials, to promptly notify their employer of a divorce in order to properly terminate coverage and offer COBRA continuation to the former spouse. (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 single coverage is effective the later of the first of the month:

(1) in which the employer provides notification of continuation rights (*Continuation - Conversion Notice* [\[ET-2311\]](#)). (Refer also to subchapter 903.)

*or*

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

In the event of a divorce in conjunction with a change to single coverage, ETF does not require the submission of a *Continuation/Conversion Notice* ([ET-2311](#)) form but one must be provided to any dependents.

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 or the electronic submission of the request to change health plans.

If ETF receives a Domestic Relations Order (DRO or QDRO) for an employee and does not have a Continuation/Conversion Notice (ET-2311) form 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 and provide ETF a copy of the Continuation/Conversion Notice (ET-2311) form that was sent to them within 5 business days. If ETF does not received the Continuation/Conversion Notice (ET-2311) form within 5 business days, ETF will remove the ex-spouse and any dependents (if applicable) from the contract and issue the Continuation/Conversion Notice (ET-2311) form.

**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. ETF 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 utilize the 'Dependent Inquiry' available under 'Enrollment Reports' to track aging



out dependents, there are invoice consequences. The employer will be limited to two months of premium refund paid prior to the current month of coverage for the difference between family and single coverage (refer to section 212).

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

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

**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 single coverage must be submitted within 30 days of the date the dependent(s) enrolled in other coverage. If the application is not received within 30 days, the employee is limited to the annual health benefits open enrollment period to remove these dependents. The new coverage will be effective the first of the month 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 single coverage. The Health Insurance Application or electronic enrollment request 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 annual health benefits 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 member or parent and submitted to the employer.

If adding children and documentation such as a birth certificate is not on file for previously covered dependents, it will be requested and must be provided.

**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 children will be added upon notice to ETF. Coverage will be effective the first of the month following receipt by the employer. Refer to "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 or electronic submission of the request to change health plans.

**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 child(ren) or ward(s) must be received within 60 days after the event. If the application is received after 60 days, contact the Employer Services Section.

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 single to family coverage until the annual health benefits open enrollment period unless they have another qualifying life event occur and submit the application or online enrollment in a timely manner. Refer to “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 on the ETF website.

Effective January 1, 2022, if the subscriber is single (including divorced), documentation supporting the birth is required. This applies even if the subscriber had previously insured the dependent(s). For single mothers, this documentation is generally a birth certificate and will be required for any children. For single fathers, this documentation is generally a paternity acknowledgement or birth certificate. Documentation for single fathers has been required for many years. Note that single fathers may be required to provide documentation of dependent status for children covered upon request from ETF to the employer.

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 to change health plans or the electronic submission of the request to change health plans.

For employees who terminate after taking incomplete action to add a 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 or 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.

If an application is not submitted within this time frame, the employee cannot change to family coverage until the annual health benefits open enrollment period unless another qualifying life event occurs in the interim. Refer to “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 or online enrollment performed within 60 days of the birth. If more than 60 days have elapsed, coverage will be effective on the first of the month on or after receipt of the application.

Documentation supporting the paternity acknowledgment is required as outlined in the *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 also file a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) to add the children named in the order to coverage.

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 on the application.

**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 or online enrollment performed 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.

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 4.

**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 annual health benefits open enrollment period. These include the following reasons:

**507 A) Divorce:** Upon divorce, either a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) or an electronic enrollment 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 *Continuation-Conversion Notice* ([ET-2311](#)) was provided to the former dependents, whichever is later.

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

**507 B) Death of Dependent:** In the event of a dependent death, a *Health Insurance Application/Change Form* or report of the death online 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 single, premiums for the difference in premium cost between family and single coverage will only be refunded to the employer for a maximum of six months.

Covered stepchildren can remain covered at the discretion of the surviving spouse in the event of the employee's death. 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 and that the employee or their spouse are providing at least 50% of the child's support and maintenance. If the dependent no longer meets these qualifications, they must be sent a *Continuation Conversion Notice* by the employer.

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

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

**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 employee or their spouse will end at the end of the month of the order terminating the permanent guardianship. Expiration of legal guardianship due to the ward attaining age 18 does not necessitate the removal of the ward from coverage.

A copy of the court order documenting the termination of the permanent guardianship is required. A *Continuation Conversion Notice* for the ward must be sent.

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

**507 F) Adult Dependent Child Eligible for Other Coverage:** A dependent child over the age of 19 who becomes eligible for, and elects other coverage, requires that an application to remove this dependent be submitted within 30 days of the event (enrollment in other coverage). 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 electronic request or paper application. If not received within 30 days, the employee will not be able to remove their dependent until the annual health benefits open enrollment period, even if this would result in the employee dropping to single coverage as they are their last eligible dependent.

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

**507 G) Adult Dependent Child gains a dependent:** For effective dates beginning January 1, 2021. Adult Dependent Eligible for Other Coverage due to gaining a Dependent: A dependent child 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 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 annual health benefits open enrollment period, even if this would result in the employee dropping to single coverage as they are their last eligible dependent.

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

**507 H) Adult Dependent requests to be dropped from Parent/Subscriber's coverage:** For effective dates beginning January 1, 2021 when the subscriber refuses to submit application. A dependent child over the age of 19 who becomes eligible for, and elects other coverage, who does not live with the subscriber, and has concerns about private health insurance information being shared with the subscriber may request to be removed from their parent's plan. The child 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 child, coverage for the child 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 *Continuation Conversion Notice (ET-2311)* for the child must be sent.

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

**507 J) Dependent No Longer covered due to custody change:** When a court orders custody of a minor 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 tax dependents and any eligible non-tax dependents the employee chooses to cover.

If both an employee and their spouse are enrolled for single 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 single contracts, one of the single 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 electronic or paper application, or a later date specified on the application. Annuitant premiums are deducted post-tax if premiums for family coverage are deducted **pre-tax**, coverage can only be changed to single 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.

If premiums are deducted **post-tax**, one family policy can be split into two single plans with the same carrier effective the beginning of the month on or after receipt of an electronic or paper 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 single 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 individual'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.



**Department of Employee Trust Funds  
State Agency Health Insurance Employer Standards,  
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## **Chapter 6 — Health Benefits Open Enrollment**

**601** [Health Benefits Open Enrollment Eligibility](#)

**602** [Withdrawing/Rescinding It's Your Choice Enrollment Elections](#)

**603** [When a Health Plan is not Available at Open Enrollment](#)

**604** [Late It's Your Choice Open Enrollment Applications](#)

### **601 It's Your Choice Open Enrollment Eligibility**

#### **601 A) Establishing Health Benefits Open Enrollment**

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

(2) Health benefits 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 to the other, transfer a dependent's coverage from one divorced employee parent to another, or change from single to family or family to single coverage without limitations.

(3) If a SUBSCRIBER has not received an health benefits 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 IT'S YOUR CHOICE enrollment period will be allowed an health benefits enrollment provided an application is filed during the 30-day period which begins on the date the EMPLOYEE returns from 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 the annual health benefits enrollment for coverage effective the following January 1. Their parent must submit an application to remove them from coverage during the annual health benefits 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 the IT'S YOUR CHOICE enrollment period.

## **601 B) Health Benefits Open Enrollment Period**

The Board sets the health benefits open enrollment period, normally a four-week period in October. Changes in coverage take effect January 1 of the following year.

## **601 C) Participation in the Health Benefits Open Enrollment Period**

Two 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 the first time and a single parent (including divorced employees), they must provide documentation such as a birth certificate or paternity acknowledgement to add dependent children (if documentation is not on file for currently covered dependents, even if they were previously insured dependents, it will be requested and must be provided) **and**
- (3) (a) Employees who work for non-STAR/UW/UWHC employers must enter the change request online into the myETF Benefits system or provide the *Group Health Insurance Application* ((ET-2301) available on the ETF website and updated annually) to the employer within the designated health benefits open enrollment period. STAR/UW/UWHC Employer Agency employees must enter any It's Your Choice changes in the appropriate payroll/benefits system.  
  
(b) Applications from ANNUITANTS and CONTINUANTS changing plans during the IT'S YOUR-CHOICE enrollment period must be received by ETF postmarked no later than the last day of the IT'S YOUR-CHOICE enrollment period, unless otherwise authorized by ETF. Members with duty disability are not eligible to newly enroll during open enrollment.

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

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. The guides are forwarded to state agencies electronically prior to the health benefits open enrollment period 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 *Health Benefits Decision Guides* available; employers are encouraged to direct employees to the electronic version found on ETF's website at [etf.wi.gov](http://etf.wi.gov). The annual *Health 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 or *Group Health Insurance Application/Change Forms* during their regular enrollment period. The first application will cover the period from the date of initial coverage through December 31. The second application will change to whatever health plan or coverage type is selected effective January 1, and must have Annual health benefits enrollment box checked 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 It's Your Choice 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 It's Your Choice health plan election applies.
- (2) List the *It's Your Choice* 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 IYC HEALTH PLANS during a 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 who is receiving a retirement annuity (immediate annuity, disability retirement) 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 the open enrollment period. 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

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

**602 A)** If the employee submitted their It's Your Choice election on a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) or online, upon receipt of the written request to withdraw/ rescind:

- (1) Either forward one copy of the application with "Rescind" written across the top or a copy of the employee's written request to withdraw/rescind the application to ETF.
- (2) Retain the original copy of the rescinded application for the employer's records.
- (3) ETF will update myETF Benefits by deleting the initial It's Your Choice request and reinstating the employee's coverage that was to end on December 31.

**Note:** No application or on-line request for coverage may be withdrawn/rescinded on or after the effective date of coverage. After the coverage effective date, the subscriber can only cancel coverage prospectively if premiums are paid with post-tax dollars (refer to subchapter 804) or submit a late IT'S YOUR CHOICE election request (refer to subchapter 604).

## 603 When a Health Plan is not Available at Open Enrollment

When a plan is no longer available for the upcoming year, subscribers enrolled in that plan **must** make an It's Your Choice change online **or** submit a *Group Health Insurance Application* ((ET-2301) available on the ETF website and updated annually) during the open enrollment period to enroll in a new plan. Subscribers are notified by letter from the departing plan at the start of It's Your Choice. Information on plans no longer available will also be included in the "What's Changing" section in the annual *Health Benefits Decision Guide*.

**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 plan. In the event a new application is not required, annual It's Your Choice employer news 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 IT'S YOUR CHOICE 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 SUBSCRIBER who failed to make an IT'S YOUR CHOICE 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.

Subscribers whose plan will no longer be available and who fail to submit an application selecting an available plan during the open enrollment period must apply through the late It's Your Choice application 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.

## 604 Late Health Benefits Open Enrollment Applications

SUBSCRIBERS may request a review if they believe they were not offered an open enrollment opportunity and they feel that their *Group Health Insurance Application* ((ET-2301) available on the ETF website and updated annually) should be accepted after the designated It's Your Choice Open Enrollment period. Employers may key late open enrollment requests as long as the open enrollment reason remains available in myETF Benefits without submitting to ETF for review. Please note that a late It's Your Choice application does not guarantee approval. The steps included in this process are as follows:

- (1) Employee submits application after the end of the open enrollment period.
- (2) Employer rejects and returns late application to employee with instructions on requesting review. A sample letter informing an employee of this process is found in subchapter 605.
- (3) Employee submits a written request (letter or email) for ETF review to the employer no later than April 15 following the open enrollment period. Approved requests prior to January 31st will be retroactively effective to January 1. Requests approved after January 31st will be effective prospectively to the first of the following month.
- (4) Employee includes in the letter or email the facts or circumstances regarding the reason(s) their application is being filed late and the remedy being sought.
- (5) After January 1, the employer develops a cover memo, letter or email addressed to ETF detailing the process used to distribute health benefits materials and information to employees, the date of receipt of the employee's health benefits application, and any pertinent facts that either supports or does not support the employee's request.
- (6) Employer sends a copy of the employee's late *Group Health Insurance Application*, the original employee's letter or email requesting a review, and the employer cover memo, letter or email to:

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

These materials and information can also be faxed to (608) 267-4549 or scanned and emailed using encryption to: [ETFSMBEmployerInsurance@etf.wi.gov](mailto:ETFSMBEmployerInsurance@etf.wi.gov). The cover sheet or subject line should be titled "Late Health Benefits Open Enrollment Application".

- (7) ETF reviews the materials submitted and issues a letter within 30-60 days to the employee, copying the employer, that the request was either approved or denied. Generally, coverage will be prospective if approved.

## 605 Late Health Benefits Open Enrollment Review Sample Letter

Below is a sample letter from the employer informing an employee of the review process for a Late *health benefits 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).



**Department of Employee Trust Funds  
State Agency Health Insurance Employer Standards,**

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**Guidelines and Administration Manual**

## **Chapter 7 — Leave of Absence**

- 701 [Definition of a Leave of Absence](#)
- 702 [Employer Contribution Toward Health Insurance Premium While on an Unpaid Leave of Absence](#)
- 703 [During an Unpaid Leave of Absence \(Non-Military\) - Coverage Does Not Lapse While on a Leave of Absence](#)
- 704 [Coverage During an Unpaid Leave of Absence \(Non-Military\)- Coverage Lapses While on a Leave of Absence](#)
- 705 [Coverage During Military Leave of Absence](#)
- 706 [Coverage During Layoff](#)
- 707 [Coverage During Appeal of Discharge](#)
- 708 [Examples for Contribution upon return from a Leave of Absence](#)

### **701 Definition of a Leave of Absence (LOA)**

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

**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 24<sup>th</sup>. The employer share continues for October, November, and December. See also Section 708 and [the Sick Leave Conversion Program Employer Manual \(ET-1170\)](#).

## **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.
  - If the employer pays the month before coverage starts and they have not been able to collect the employee's contribution in advance of coverage, coverage should cancel for the first full month they received no payment from the member.
- (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 § 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 § 40.02 (40).
  - (e) 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.
  - (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 § 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 § 40.02 (40).
- (e) 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.
- (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 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 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. An employee may choose to allow their coverage to lapse 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 complete and 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” on the application. 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 § 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 § 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 premium 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 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 by completing the *Health Insurance Election for Military Service Personnel* ([ET-2350](#)). The employer must receive this form within 60 days after the employee is activated.

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 by filing



a *Group Health Insurance Application* ((ET-2301) available on the ETF website and updated annually).

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 a health insurance 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 thirty-six 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 § 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 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 a *Group Health Insurance Application* ((ET-2301) available on the ETF website and updated annually). The application must be received 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 *Group Health Insurance 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 his or her 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.) A *Continuation-Conversion Notice* ([ET-2311](#)) must be provided to the employee using the original discharge date.

## **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.

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

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## **Chapter 8 —Cancellation and Termination of Coverage**

- 801** [Individual Termination of Coverage](#)
- 802** [Ending Coverage](#)
- 803** [Changing From Active to Annuitant Coverage](#)
- 804** [Voluntary Cancellation of Coverage](#)

### **801 Individual Termination of Coverage**

ETF offers a resource to help employers advise employees who are terminating employment, including retirees. 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 a DEPENDENT child's marriage, divorced spouse, etc.). As required by Wis. Stat. §632.897, if family coverage remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs (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 an employee receive a full month of coverage before coverage is terminated unless there is fraud or gross misconduct in order for the employee 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 obtained with another employer group health plan of 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 1402 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 Health Insurance Application or electronic enrollment request 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. This event does not permit a change of health plans.

**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. 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 is limited to the ACCESS PLAN.

Change to an IYC HEALTH PLAN is available during a regular IT'S YOUR CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date.

ETF 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 IYC HEALTH PLANS during subsequent IT's YOUR CHOICE enrollment periods. Re-enrollment in the HEALTH PLAN is available during a regular IT's YOUR CHOICE enrollment period, which 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 (also called 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)** Upon determination that a SUBSCRIBER is ineligible 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 for more information.

## **802 Ending Coverage**

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

Active coverage may be ended for an employee based upon an employee's request to:

- complete a spouse-to-spouse transfer,
- death of the subscriber,
- disability approval (non-ICI),
- 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	<p>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 employee premium share has increased significantly.</p> <p>If employee does not pay required premiums while out on a leave of absence (LOA), this is a cancellation, voluntarily ending coverage.</p>
Termination of Employment	End of the calendar month in which the employee terminates employment.	<p>Employee's coverage is an involuntary loss of coverage.</p> <p>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 <i>Sick Leave Conversion Program Employer Manual (ET-1170)</i> regarding reporting sick leave.</p>
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	<p>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.</p>

Reason	Coverage End Date	Comments
Disability Approval (Non-ICI)	Coverage is continued as an annuitant without lapse upon approval of a disability benefit.	<p>This is an employer entry in myETF Benefits. No application to end coverage is required from employee.</p> <p>ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs.</p> <p>Refer to subchapter 803. Also, refer to the <i>Sick Leave Conversion Program Employer Manual</i> (ET-1170) for reporting sick leave.</p>
Retirement	Coverage is continued as an annuitant without lapse upon retirement if an employee retires with an immediate annuity.	<p>Requires an employer entry in myETF Benefits. No application is required from employee. Enter the number of available sick leave hours and pay rate for the member terminating coverage.</p> <p>ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs.</p> <p>Refer to subchapter 803. Also, refer to the <i>Sick Leave Conversion Program Employer Manual</i> (ET-1170) for reporting sick leave.</p>
Death of Subscriber with Single Coverage	End of the calendar month in which the death occurred.	Refund any premiums paid in advance for coverage beyond the end of the month in which death occurred.
Death of Subscriber with Family Coverage	Coverage under the employee's contract continues through the last day of the month for which the premium was deducted.	<p>Do not refund any premiums unless authorized by ETF.</p> <p>Refer to the <i>Sick Leave Conversion Program Employer Manual</i> (ET-1170) for reporting sick leave. Refund may be due if coverage was paid for the next month. Coverage automatically continues for survivors.</p>

### 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 end their coverage in myETF Benefits. They must also complete the required entry in the Accumulated Sick Leave system (AcSL) in myETF Benefits (Refer to the *Sick Leave Conversion Program Employer Manual (ET-1170)*). Retirees without sick leave credits who wish to continue coverage may make premium payments through their annuity or with payments directly to the plan

**804 Voluntary Cancellation 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 family status change that is allowed under the plan language (contract) or a HIPAA qualifying life event 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. 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
Pre-Tax Employee Terminating Employment	<i>Health Insurance Application</i> or electronic enrollment request must be submitted no later than the month employment terminates. The event date is the date employee terminates employment.	End of the month following receipt of the application/electronic request or the event date, whichever is later.	The coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.

Event	Eligibility Requirements	Coverage End Dates	Comments
Pre-Tax Employee Going on an Unpaid LOA	<p><i>Health Insurance Application</i> or electronic enrollment request must be submitted no later than the month employee goes on a LOA.</p> <p>The event date is the date employee begins a LOA.</p>	<p>End of the month following receipt of the application/electronic enrollment Benefits request or the event date, whichever is later.</p>	<p>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/request. Coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.</p>



Event	Eligibility Requirements	Coverage End Dates	Comments
Pre-Tax Family Status Change	<p>An allowed family status change under the plan language (contract) or a HIPAA qualifying life event must occur.</p> <p><i>Health Insurance Application/ Change Form</i> or myETF electronic enrollment request must be submitted within 30 days of the IRC Section 125 status change, the event.</p>	End of the month following receipt of an application/request or the event date, whichever is later.	<p>Refer to Chapter 5 for 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 cancellation request is always the end of a month. Retroactive cancellations are not allowed.</p>
Premiums Deducted Post Tax	<p><i>Health Insurance Application</i> or myETF Electronic enrollment request must be submitted.</p>	Coverage end date is the end of the month following the application received date or the myETF Electronic request date. If the application received date or the myETF electronic request date is the last day of a month, coverage ends on the receipt/request date.	<p>An application can be submitted requesting a future cancellation date other than the end of the month following receipt of the application. Coverage can be canceled mid-year. Coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.</p>

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## **Chapter 9 – COBRA, Continuation and Conversion**

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### **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 GIB 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 spouse (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 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 parent/stepparent. 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 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 a 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 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.

**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 ETF is not notified within 60 days of the:

1) event that caused the loss of coverage, or

2) 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 employer provides the notice of the right to continue coverage (*Continuation – Conversion Notice* ([ET-2311](#))) to the ex-spouse and any stepchildren or children of minor stepchildren. In this situation, employers must check with ETF on the length of continuation coverage that is available.

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

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:

- 1) Submitting the *Continuation – Conversion Notice* ([ET-2311](#)) and the *Group Health Insurance Application* (([ET-2301](#)) available on the ETF website and updated annually) to ETF. Both forms (an employee need only submit a *Continuation – Conversion Notice* unless requesting a change in coverage) must be sent to ETF (that is, postmarked) no later than 60 days from the termination of their coverage or within 60 days of the date they were notified by their employer, whichever is later. 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.
- 2) Paying premium to the health plan when billed by the health plan.
- 3) 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.

4) 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:

- a) **prior to or on** the effective date of COBRA coverage, they are eligible for Medicare reduced rates.
- b) **after** COBRA coverage begins, COBRA coverage ends for the subscriber or dependent when they enroll in Medicare Parts A and B.
  - i) Qualified beneficiaries not eligible for Medicare remain eligible for COBRA coverage.
  - ii) 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 myETF Benefits for the employee's coverage or the end date for any specific dependent on the employee's contract through 'Remove Dependent', enter an end date that is the end of the month following the event. There is an exception to this when removing the subscriber's spouse due to divorce (refer to subchapter 903).

## 906 Notice Requirement Illustration Chart

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

Event	Occurs	Coverage Continues Until	Employee or Beneficiary Must Notify Employer By	Employer Must Provide Continuation Notice By	To Elect Continuation, Application Must Be Submitted To ETF By
Child (or stepchild, DP's dependent) turns 26 and is not disabled.	3/15	3/31	N/A*	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues <a href="#">ET-2311</a> .
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 <a href="#">ET-2311</a> .

\* 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 <a href="#">ET-2311</a> .

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 <a href="#">ET-2311</a> .
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 <a href="#">ET-2311</a> .

## 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.

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## **Chapter 10 — Retirement or Disability**

**1001** [Coverage – Requirements to Continue](#)

**1002** [Coverage for Former State Employees Whose Coverage Lapsed](#)

**1003** [Medicare Enrollment](#)

**1004** [Premium Payment](#)

### **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 member is required to be enrolled in Medicare. The amount of the monthly premium will be reduced accordingly. Retrospective adjustments to premiums are limited to the shortest retroactive enrollment limit set by Medicare (90 days), in accordance with the 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 member'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 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 terminate the employee's health insurance contract using the Retirement option in myETF Benefits to ensure their coverage continues automatically. See C-6 in Appendix C for more info about terminating coverage.

### **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 health insurance program.

This provision does not apply if the employee files a *Group Health Insurance 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 and a *Group Health Insurance Application/Change for Retirees & COBRA Continuant*s ((ET-2331) available on the ETF website and updated annually) 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) and a *Group Health Insurance Application* 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 *It's Your Choice* 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. A sample of the statement appears at the end of this subchapter. 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.



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## **Chapter 11 — Rehired Annuitants**

**1101** [Eligibility](#)

**1102** [Coverage](#)

**1103** [Disability 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 retiree 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 are deducted one month in advance, insurance is paid for one month beyond the annuity suspension date. Premiums paid through the annuitant's accumulated sick leave conversion account are also paid one month beyond the annuity suspension date. ETF will assist the employer in determining the date the rehired annuitant should be added to active coverage on the monthly additions report. A *Group Health Insurance Application* ((ET-2301) available on the ETF website and updated annually) 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 with a Health Insurance Application/Change ((ET-2301) available on the ETF website and updated annually) form.

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.](#)

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## 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) myETF Benefits:

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

The employer can enter the information into myETF Benefits. If the employer enters it, please have the employee provide a *Health Insurance Application (ET-2301)* available on the ETF website and updated annually) or enter the information into the employer's payroll and benefit administration system.

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.

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

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

#### 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 coverage types of Medicare Single, Medicare Family - Some and Medicare Family - All are not listed for active employees because they are not eligible for the Medicare reduced rates, as 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 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 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 retirees.

**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 IV., A., 11., b. (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 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 IV., A., 11., b. 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 (i.e. a Medicare Family 1 contract) 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 members multiple times a year. The VDSA has eliminated the need for most Medicare Data Match activities.



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*)  
Arlene Larson, ETF

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## **Chapter 13 — Employee Death**

**1301** [How to Report an Employee Death](#)

**1302** [Surviving Spouse and Dependents](#)

**1303** [Surviving Spouse who is also an Employee Eligible for Coverage](#)

### **1301 Report an Employee Death to ETF Immediately**

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

The employer is responsible for determining and entering the health insurance coverage end date in myETF Benefits. For both single 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 1402 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. Should the surviving spouse (or retiree) and dependent(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 through the Accumulated Sick Leave System (AcSL) 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 dependent(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/ to the health plan.

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## Chapter 14 — Invoicing

1401 [Viewing Your Invoice](#)

1402 [Reconciling Your Invoice](#)

1403 [Accepting and Paying Your Invoice \(Wismart and Automated Clearing House \(ACH\)\)](#)

1404 [Late Interest Charge](#)

1405 [Who to Contact for Assistance](#)

### 1401 Viewing Your Invoice

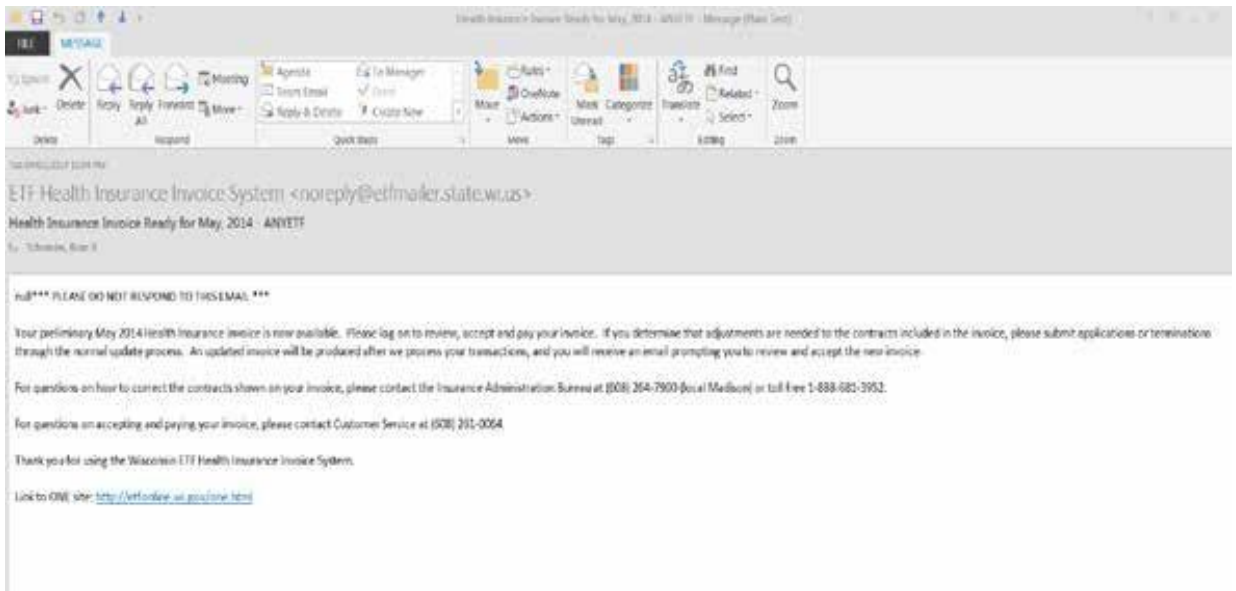
Reports and remittances from employers required in the administration of the group health insurance program shall be submitted to ETF no later than the 24<sup>th</sup> day of the calendar month for the current month's coverage. The remittance by the employer shall be the amount invoiced by ETF.

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

<b>CURRENT PROCESS (2017)</b>					
	<b>Coverage Month</b>	<b>ETF Generates Employer Invoices</b>	<b>Premiums due from Employers to ETF</b>		
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

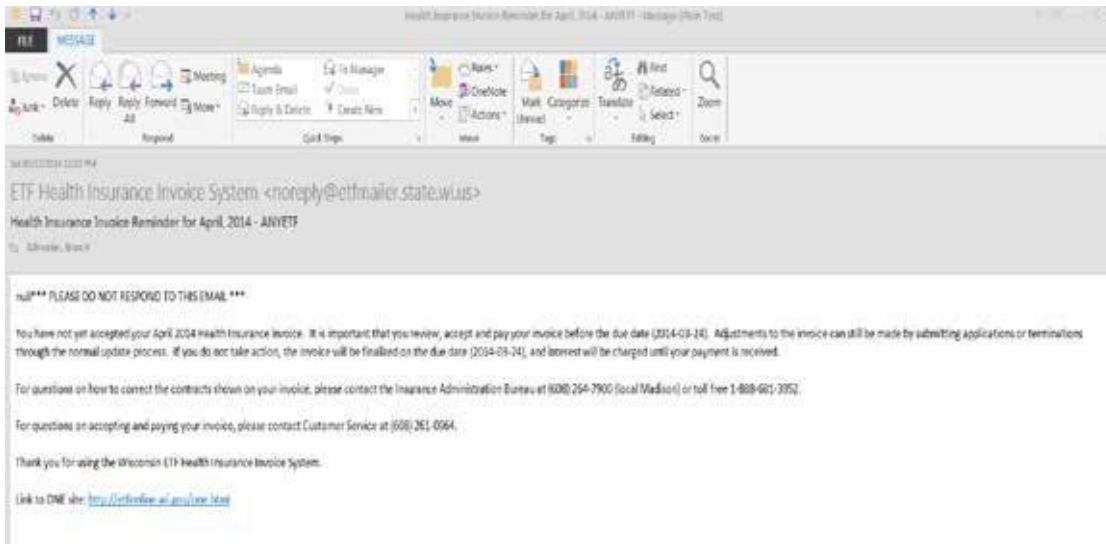
During the evening on the first day of every month, the myETF Benefits system initially generates an invoice for health insurance premiums for all state employers. This invoice is generated in a locked status, meaning any enrollment information received after this date appears on the following month's 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.

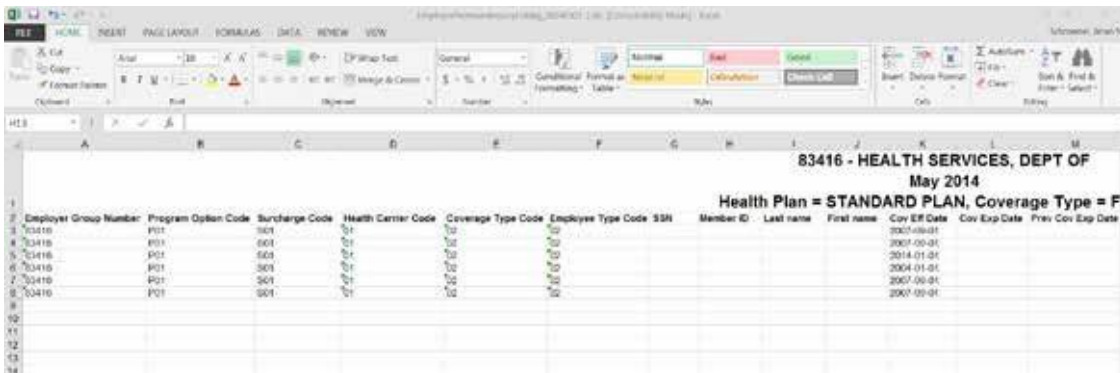


The following illustrates the results once the search filters are set and the user clicks *'Display'*. The results being displayed will provide the specific details of the employees for whom you are being billed or refunds are being generated on that coverage month's invoice by health plan and coverage 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.

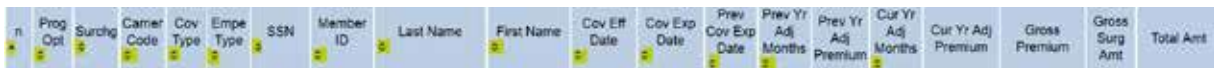
The user can click on *'Clear'* and set new filters from the drop-downs, then click *'Display'*. The user can also go directly to the drop-downs, select new filters, then

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.

Health Plan	Employee Type	Coverage Type	Number of contracts by carrier/coverage type	Premium amount	Total premiums for coverage type and number of contracts	Prior month adjustments by carrier/coverage type	Premiums total by carrier/coverage type
12 2014 HEALTH PLAN	STATE EMPLOYEES - REGULAR	FULL	1	1,014.76	1,014.76	0.00	1,014.76
	Health Plan Fee		1		1,014.76	0.00	1,014.76
18 DAC-RIP	STATE EMPLOYEES - REGULAR	SMALL	1	816.10	816.10	0.00	816.10
	Health Plan Fee		1		816.10	0.00	816.10
12 2014 US HEALTH	STATE EMPLOYEES - ELECTIVE	SMALL	1	887.22	887.22	0.00	887.22
	Health Plan Fee		1		887.22	0.00	887.22
12 2014 US HEALTH	STATE EMPLOYEES - REGULAR	SMALL	1	1,081.40	1,081.40	0.00	1,081.40
	Health Plan Fee		1		1,081.40	0.00	1,081.40
<b>Group Total</b>			<b>4</b>		<b>4,802.48</b>	<b>0.00</b>	<b>4,802.48</b>
Group Fee			0		4,802.48	0.00	4,802.48
Employee Reimbursement Accounts Administrative Fee			0	0.00	0.00	-	0.00
<b>Total Invoice</b>					<b>4,802.48</b>	<b>0.00</b>	<b>4,802.48</b>

## 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.

The screenshot shows a web interface for an electronic payment system. At the top left is the logo for 'ABC Co.' and at the top right is the slogan 'Make life simple'. Below this is a navigation bar with an 'Exit' link. The main content area is titled 'Welcome to the Electronic Payment System' and contains the instruction 'Please enter your User ID and Password and click Log In.' There are two input fields: 'User ID' and 'Password'. To the right of the 'User ID' field is a link 'Forgot Your User ID?'. To the right of the 'Password' field is a link 'Forgot Your Password?'. Below the input fields is a red 'Log In' button. Underneath the button are three links: 'Register', 'Pay Without Registering', and 'Log In'. At the bottom left is the 'powered by usbank' logo. At the bottom right are four links: 'Customer Service', 'Help', 'Privacy Policy', and 'Security'.

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

ABC Co. Make life simple Exit

Your last visit was Thu 10/03/2013 11:23 AM CDT Make a Payment My Account

## Make a Payment

My Payment

**Payment for Your Organization**

Amount Due \$45.00  
Due Date 10/15/2013  
Account Number 3214568

Payment Information

Frequency One Time  
Payment Amount \$45.00  
Payment Date  Pay now  Pay on a future date

Payment Method

Saved Payment Methods Select [Use a new payment account](#)  
Email Address test.user@corp.com

Continue Cancel

This will have 3 sections.

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

### Contact Information

First Name	Test
Last Name	User
Company	(Optional)
Address 1	123 S. Main
Address 2	Apt. 24
City	Springfield
State	IL
Zip Code	12345 (Optional)
Phone Number	1231231234
Email Address	test.user@corp.com

[Become a Registered User](#)

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

Payment Method **Checking or Savings**

Sample Check 1215  
123 Main St.  
Anytown, MO 12345 DATE: \_\_\_\_\_  
PAY TO THE ORDER OF \$ \_\_\_\_\_ DOLLARS  
MEMO: \_\_\_\_\_  
⑆123456789⑆ 888 11111111⑆ 001215⑆  
Bank Routing Number Bank Account Number Check Number

[Personal Check](#) | [Business Check](#)

Bank Routing Number \_\_\_\_\_

Bank Account Number \_\_\_\_\_

Bank Account Type  Checking  Savings  
 This is a business account  
 Save this payment account for future use

Email Address test.user@corp.com

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

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

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

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

## Review Payment

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

**Payment Details**

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


**Payment Method**

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

**Billing Address**

<b>Address 1</b>	123 S. Main
<b>Address 2</b>	Apt. 24
<b>City</b>	Springfield
<b>State</b>	IL
<b>Zip Code</b>	12345

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

powered by 

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

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

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

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

## Confirmation

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

Confirmation Number **KATARC00001543**

**Payment Details**


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

**Payment Method**

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

**Billing Address**

<b>Address 1</b>	123 S. Main
<b>Address 2</b>	Apt. 24
<b>City</b>	Springfield
<b>State</b>	IL
<b>Zip Code</b>	12345

powered by 

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

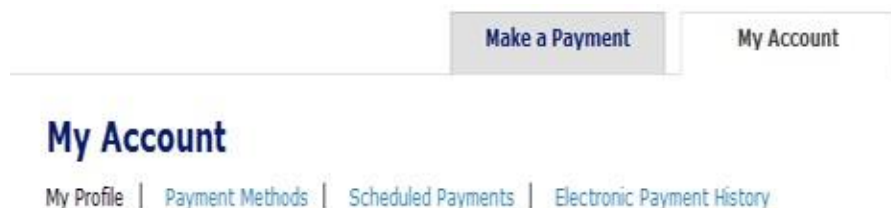
Upon successful completion, the payment will post to the employer's invoice at 11:00 a.m. on the payment date selected.

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

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

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

The screenshot displays the 'My Account' interface. At the top, there are navigation links: 'My Profile', 'Payment Methods', 'Scheduled Payments', and 'Electronic Payment History'. Below this is the 'My Contact Information' section, which contains several input fields: 'First Name' (Test), 'Last Name' (User), 'Company' (Optional), 'Address 1' (123 S. Main), 'Address 2' (Apt. 24), 'City' (Springfield), 'State' (IL), 'Zip Code' (12345, Optional), 'Phone Number' ((123)123-1234), and 'Email Address' (test.user@corp.com). Below the contact information is the 'Login Details' section, which includes: 'User ID' (krtest1), 'Password' (masked with \*\*\*\* and a 'Change my Password' link), three 'Security Question' dropdown menus with corresponding 'Answer' fields. The questions are: 'What was the name of your childhood best friend?' (Answer: Sue), 'What is your favorite sports team?' (Answer: Spartans), and 'What is your mother's maiden name?' (Answer: Lynn). At the bottom of the form are 'Save' and 'Cancel' buttons.

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

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

**My Account**

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

Saved Payment Methods [Add a Payment Method](#)

Nickname	Method	Type	Number	Actions
Test Visa	Credit	Visa	*1111	<a href="#">Edit</a>   <a href="#">Delete</a>

**My Account**

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

Electronic Payment History

Show  entries Search Filter:

Confirmation Number	Payment Date	Amount	Payment Method	Status
KATABC000001537	09/11/2013	\$45.00	*1111	PROCESSED
KATABC000001530	08/27/2013	\$45.00	*1111	PROCESSED
KATCON000001528	08/27/2013	\$60.20	*1111	PROCESSED
KATCON000001525	08/19/2013	\$60.20	*1111	PROCESSED
KATABC000001521	08/15/2013	\$45.00	*1111	PROCESSED

Showing 1 to 5 of 5 entries [First](#) [Previous](#) [1](#) [Next](#) [Last](#)

## 1405 Who to Contact for Assistance

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

**Laura Vang:** 1-608 261-0064 or [laura.vang@etf.wi.gov](mailto:laura.vang@etf.wi.gov).

**Rolanda Franklin:** 1-608-266-0781 or [rolanda.franklin@etf.wi.gov](mailto:rolanda.franklin@etf.wi.gov).

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

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## **Chapter 15 —Glossary of Definitions**

**"ACCESS PLAN"** means the nationwide health care 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 as described in Article 2.9.

**"CONTRACT"** means this document which includes all attachments, supplements, endorsements or riders.

**"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 403 D.

**"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 this CONTRACT.

**"EMPLOYEE"** means a person who is working for pay as an eligible EMPLOYEE of the State of Wisconsin 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 State of Wisconsin Group Health Insurance Program to provide BENEFITS and services to PARTICIPANTS.

**"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 Group Health Insurance Program BENEFITS. Eligible EMPLOYEES and ANNUITANTS under Wis. Stat. § 40.51 (16) to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51. The dates for this time period are set each year by ETF and the Group Insurance Board.

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

**"PREMIUM"** means the rates shown on Attachment A plus the pharmacy rate and administration fees required by the BOARD. Those rates may be revised by the HEALTH PLAN 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, or his or her surviving DEPENDENTS, who have been specified by ETF to the HEALTH PLAN for enrollment and who is entitled to BENEFITS.

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**Appendix A — Forms and Brochures**

Document name	Form number	Link
WRS Administration Manual	ET-1127	<a href="http://etf.wi.gov/resource/wisconsin-retirement-system-administration-manual">etf.wi.gov/resource/wisconsin-retirement-system-administration-manual</a>
State of Wisconsin Group Health Insurance Program Agreement	ET-1136	<a href="http://etf.wi.gov/resource/2022-state-wisconsin-group-health-insurance-program-agreement">etf.wi.gov/resource/2022-state-wisconsin-group-health-insurance-program-agreement</a>
Group Health Insurance Application	ET-2301	<a href="http://etf.wi.gov/publications/et2301.pdf">etf.wi.gov/publications/et2301.pdf</a>
Health Insurance Application/Change for Retirees & COBRA Continuants	ET-2331	<a href="http://etf.wi.gov/publications/et2331.pdf">etf.wi.gov/publications/et2331.pdf</a>
COBRA Continuation Conversion Notice	ET-2311	<a href="http://etf.wi.gov/publications/et2311.docx">etf.wi.gov/publications/et2311.docx</a>
Rehired Annuitant Form	ET-2319	<a href="http://etf.wi.gov/publications/et2319.pdf">etf.wi.gov/publications/et2319.pdf</a>
Converting Your Group Life Insurance to Pay for Health Insurance or Long Term Care Insurance Premiums	ET-2325	<a href="http://etf.wi.gov/publications/et2325.pdf">etf.wi.gov/publications/et2325.pdf</a>
Group Health Insurance	ET-4112	<a href="http://etf.wi.gov/publications/et4112.pdf">etf.wi.gov/publications/et4112.pdf</a>
Sick Leave Conversion Credit Brochure	ET-4132	<a href="http://etf.wi.gov/publications/et4132.pdf">etf.wi.gov/publications/et4132.pdf</a>
Sick Leave Escrow Application	ET-4305	<a href="http://etf.wi.gov/publications/et4305.pdf">etf.wi.gov/publications/et4305.pdf</a>
Medicare Eligibility Statement	ET-4307	<a href="http://etf.wi.gov/publications/et4307.pdf">etf.wi.gov/publications/et4307.pdf</a>



**Department of Employee Trust Funds  
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## Appendix B — Codes

1. [Employee Type Codes](#)
2. [Coverage Type Codes](#)
3. [Individual Relationship Codes](#)
4. [Health Plan Codes](#)

### 1) Employee Type Codes

Code	Employee Coverage	Description
01	State-elected	Legislators, state constitutional officers, circuit, supreme court, or appeals judges, chief clerk or Sergeant-at-Arms of the Senate or Assembly
02	Regular State	State Employee
03	UW Classified	UW other than faculty.
04	UW Unclassified	UW Faculty
05	Beyond Vision (aka WISCRAFT)	For use by Beyond Vision (aka WISCRAFT) only - for blind employees.
07	State Annuitant	Retired employee who is eligible for health insurance.
08	State Surviving Spouse/Dependent	Used for survivors of currently insured subscriber who dies while carrying family health insurance coverage.
10	State Continuant	ETF Use Only - Continuant
11	State Participant – 1991 WI Act 152	Terminated State Employee with at least 20 years of creditable service.
12	Graduate Assistant	Graduate Assistants, employees in training, short-term academic staff, fellows, and scholars.
13	Continuant- Graduate Assistant	ETF Use Only - Graduate Assistant Continuant.
17	LTE	Limited term employees.
19	State Fallen Officer Survivor	Survivors of Fallen Officers receiving health insurance
21	State Annuitant Split	Retired employee who is eligible for health insurance and has selected two health plans.
23	State Surviving Spouse/Dep Split	Used for survivors of currently insured subscriber who dies while carrying family health insurance coverage and has selected two health plans.
26	State Continuant Split	Continuant who has selected two health plans.
28	State Cont. Grad Assistant Split	Graduate Assistant Continuant who has selected two health plans.
29	State Participant – 1991 WI Act 152 Split	Terminated State Employee with at least 20 years of creditable service who has selected two health plans.

## 2) Coverage Type Codes

Code	Type of Coverage	Description
01	Single	Coverage is for the subscriber (employee) only.
02	Family	Coverage is for the subscriber (employee) and eligible dependent(s).
03	Graduate Assistants - Single	Coverage is for the subscriber Graduate Assistant (employee) only.
04	Graduate Assistants - Family	Coverage is for the subscriber Graduate Assistant (employee) and eligible dependent(s).
05	Medicare - Single	Single coverage for annuitant or continuant subscriber with Medicare.
06	Medicare Family - Some–Health Plan Med	Family coverage for annuitant or continuant subscriber; one or more persons with Medicare.
07	Medicare Family - All	Family coverage for annuitant or continuant subscriber, subscriber and all dependents with Medicare.
12	Medicare Family Some – Med Advantage	Family coverage for annuitant or continuant subscriber; one or more persons with Medicare. Two health plans selected and the Medicare plan is Medicare Advantage.
22	Medicare Family Some – Med Plus	Family coverage for annuitant or continuant subscriber; one or more persons with Medicare. Two health plans selected and the Medicare plan is Medicare Plus.

## 3) Individual Relationship Codes

Code	Definition
01	Spouse
03	Parent of Minor Dependent
15	Legal Ward
17	Stepson or Stepdaughter
18	Self
19	Child
24	Dependent of a Minor Dependent

#### 4) Health Plan Codes

### 2024 CARRIER CODES FOR HEALTH INSURANCE

HMO Dental (Y)	HMO Dental (N) (LAHP)	HDHP Dental (Y)	HDHP Dental (N)	HEALTH CARRIER NAME
04	OL	JL	XL	IYC ACCESS HP - DEAN
07	OO	JO	XO	SMP - DEAN
08	OP	JP	XP	MEDICARE PLUS - UHC

38	OS	JS	XS	COMMON GROUND
15	NC	HC	WC	DEAN HEALTH PLAN
17	ND	HD	WD	DEAN HP PREVEA360 EAST
24	OR	JR	XR	DEAN HP PREVEA360 WEST
18	OG	JG	XG	UHC MEDICARE ADVANTAGE
30	NG	HG	WG	GHC EC GREATER WI
31	OT	JT	XT	GHC EC RIVER REGION
35	NH	HH	WH	GHC-SCW DANE CHOICE
36	OX	JX	XX	GHC-SCW NEIGHBORS
63	NN	HN	WN	MEDICAL ASSOCIATES HEALTH PLAN
64	NO	HO	WO	MERCYCARE HEALTH PLAN
70	NP	HP	WP	NETWORK HEALTH
79	OV	JV	XV	SECURITY
85	NS	HS	WS	HEALTHPARTNERS WEST
19	OW	JW	XW	HEALTHPARTNERS SOUTHEAST
96	OC	JC	XC	QUARTZ-UW HEALTH
98	OH	JH	XH	ROBIN WITH HEALTHPARTNERS
25	OI	JI	XI	ASPIRUS HEALTH PLAN
91	OJ	JJ	XJ	QUARTZ CENTRAL
99	OK	JK	XK	QUARTZ WEST

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

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**Appendix C — myETF Benefits**

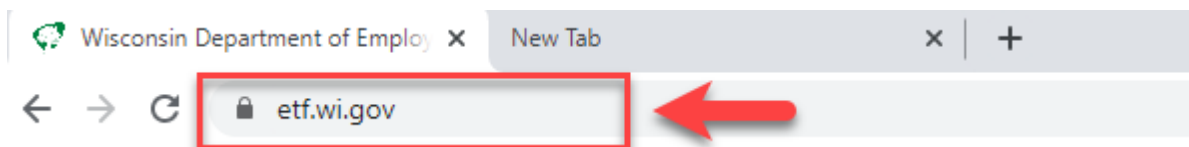
- C-1 [How to Log Into myETF Benefits](#)
- C-2 [Add Coverage](#)
- C-3 [Add Dependent](#)
- C-4 [Remove Dependent](#)
- C-5 [Change Health Plans](#)
- C-6 [Termination of Coverage](#)
- C-7 [Pending Transactions](#)
- C-8 [Enrollment Inquiry](#)
- C-9 [Dependent Inquiry](#)
- C-10 [Address Inquiry](#)
- C-11 [Running Reports](#)

**C-1. How to Log into myETF Benefits**

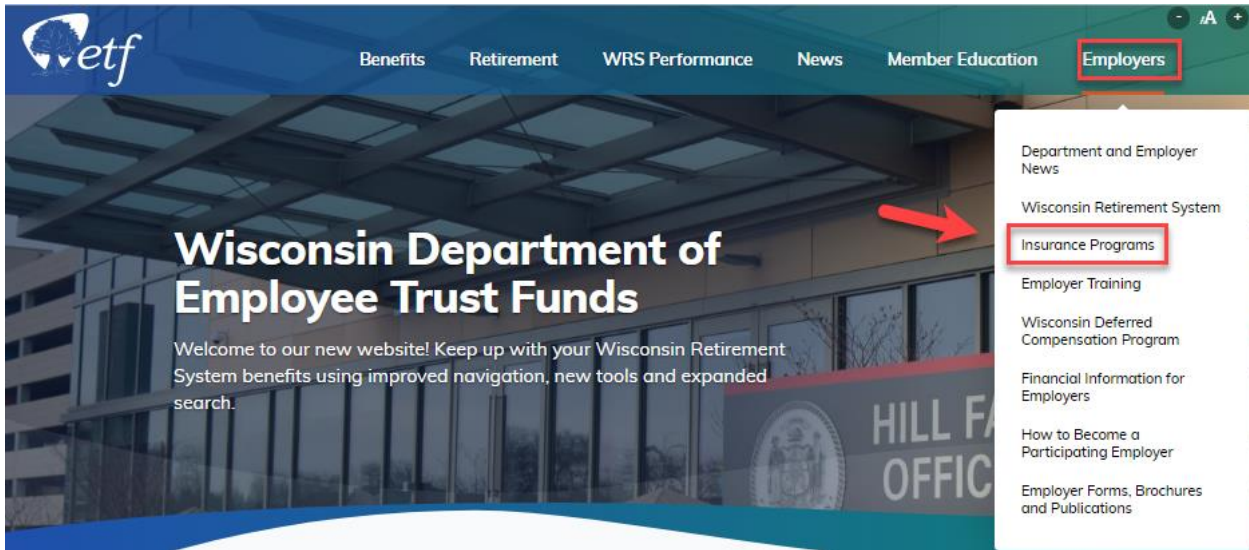
To get started in myETF Benefits you must first obtain access to the system by completing and submitting an *Online Network for Employers Security Agreement* ([ET-8928](#)) to ETF. Use this form to request access to myETF Benefits for administrators for the following areas:

1. Health Eligibility Inquiry
2. Health Eligibility Update
3. Health Premium Inquiry
4. Health Premium Payment

1. Once access has been granted, go to [etf.wi.gov](http://etf.wi.gov).



2. Under the Employers tab, choose Insurance Programs.



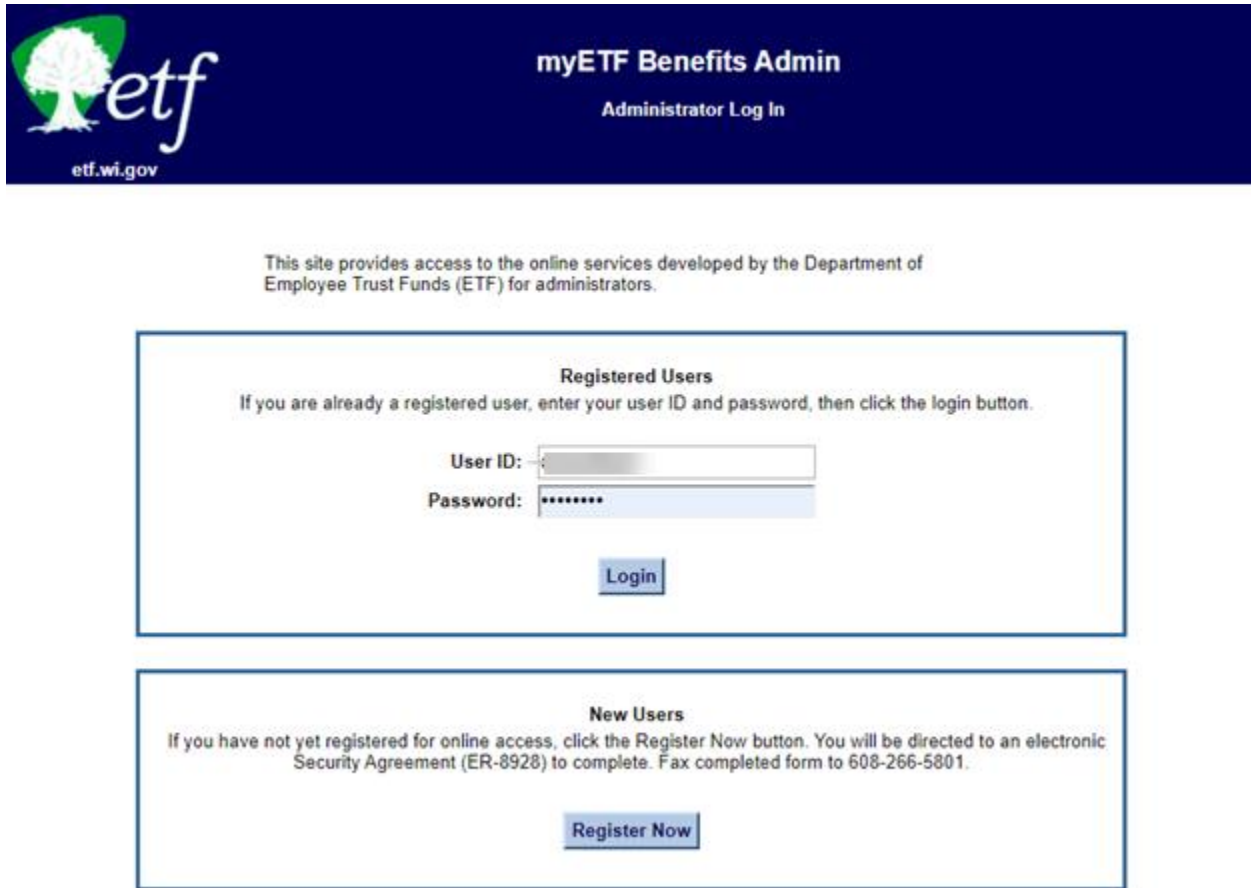
3. Click on MyETF Benefits Administrator.

## myETF Benefits Administrator

The myETF Benefits Administrator (mEBS) Application for Employers allows employers to execute benefits transactions. These include, but are not limited to, viewing and updating individual member health insurance eligibility and demographic data, completing mass employee terminations, adding and deleting a dependent or domestic partner and updating health insurance enrollment data and personal contact information.

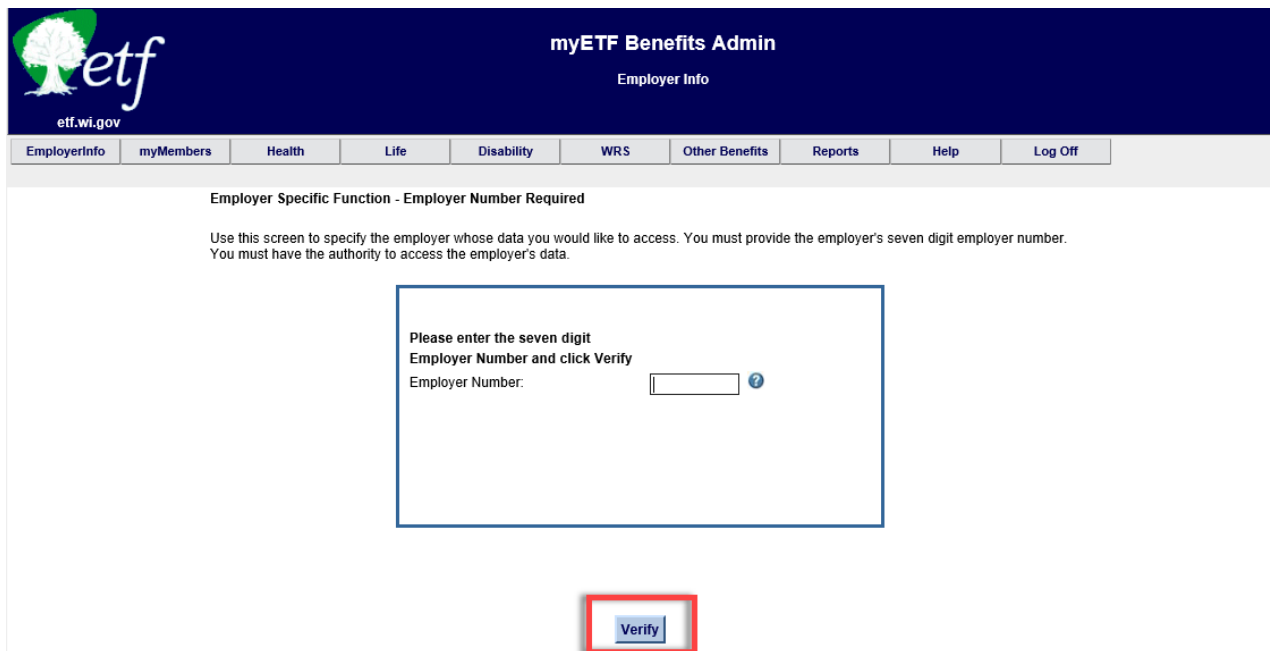


4. Enter your user ID and password.



The screenshot shows the 'myETF Benefits Admin' Administrator Log In page. At the top left is the 'etf' logo with the website 'etf.wi.gov'. The title is 'myETF Benefits Admin' and the subtitle is 'Administrator Log In'. Below the header, a message states: 'This site provides access to the online services developed by the Department of Employee Trust Funds (ETF) for administrators.' There are two main sections: 'Registered Users' and 'New Users'. The 'Registered Users' section contains a form with 'User ID:' and 'Password:' fields, each with a text input box, and a 'Login' button below. The 'New Users' section contains a message: 'If you have not yet registered for online access, click the Register Now button. You will be directed to an electronic Security Agreement (ER-8928) to complete. Fax completed form to 608-266-5801.' and a 'Register Now' button.

5. Enter your employer number and click Verify.



The screenshot shows the 'myETF Benefits Admin' Employer Info page. At the top left is the 'etf' logo with the website 'etf.wi.gov'. The title is 'myETF Benefits Admin' and the subtitle is 'Employer Info'. Below the header is a navigation menu with the following items: 'EmployerInfo', 'myMembers', 'Health', 'Life', 'Disability', 'WRS', 'Other Benefits', 'Reports', 'Help', and 'Log Off'. The main content area is titled 'Employer Specific Function - Employer Number Required'. Below the title, a message states: 'Use this screen to specify the employer whose data you would like to access. You must provide the employer's seven digit employer number. You must have the authority to access the employer's data.' There is a form with the text: 'Please enter the seven digit Employer Number and click Verify' and 'Employer Number:' followed by a text input box with a help icon. Below the form is a 'Verify' button, which is highlighted with a red rectangle.

6. You will be directed to the Employer Info screen, which displays employer contact information.



The screenshot shows the 'myETF Benefits Admin' interface. At the top left is the 'etf' logo with the URL 'etf.wi.gov'. The top right displays 'myETF Benefits Admin' and a red-bordered 'Employer Info' button. Below this is a navigation bar with buttons for 'EmployerInfo', 'myMembers', 'Health', 'Life', 'Disability', 'WRS', 'Other Benefits', and 'Reports'. The main content area shows 'Employer Number:' with a blue box containing '-000' and 'Employer Name:' with an empty blue box.

Agent Contact		Insurance Contact	
Name:	[Redacted]	Name:	[Redacted]
Telephone:	(608) 267 - 8710	Telephone:	(608) 267 - 1137
Retirement Contact		Address Information	
Name:	[Redacted]	Address:	210 MLK JR BLVD RM 406 MADISON, WI 53703- 3345
Telephone:	(608) 266 - 9090	Agent Email:	No agent email available. <a href="#">More</a>
		<a href="#">Clear</a>	

[myMembers Requests](#) [New EIN](#)



## C-2. Add Coverage

When a *Health Insurance Application/Change* ((ET-2301) available on the ETF website and updated annually) form has been received for one of the dependent reasons, all information on the form must be verified and the employer must complete the Employer Completes section. Any necessary documentation must be verified/approved. Refer to example below:

Employer Completes				
Coding instructions are in the <i>Employer Health Insurance Administration Manual</i> .				
EIN 0000-199	Employer name Central Payroll	Payroll representative email Jane.Doe@centralpayroll.wi.gov		
Group number 83900	Employee type →	Coverage type <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family	Health plan name/suffix Dean	
Business Unit (if applicable)	Employment status of applicant <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> LTE		Employee deductions <input checked="" type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax	
Hire date or date WRS-eligible employment or graduate appointment began 2/4/19	Employer received date 2/27/2019	Event date →	Prospective coverage date 5/1/2019	
Are you a WRS-participating employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Previous service check completed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Source of previous service check? <input checked="" type="checkbox"/> Online Network for Employers (ONE) <input type="checkbox"/> ETF Did employee participate in the WRS prior to being hired by you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Payroll representative signature Jane Doe		Phone number (609) 555-1234	Date signed 3/1/2019	

1. Log in to myETF Benefits. Before an employee can be enrolled in health coverage, their employer and demographic information must be entered. Select myMembers/myMembers tab as shown below.



2. Enter the employee's ETF Member ID or SSN into the appropriate box and click the Search button. If an employee was or is a dependent or subscriber on another plan without WRS enrollment, they will have a member ID.



Member Search

Member ID:  OR Social Security Number:



3. An ETF Member ID is required to create a health contract. If an employee does not yet have an ETF Member ID in myETF Benefits, you will see the following message:

**This member was not found. If you believe you have received this message in error please try again. Otherwise press the Add button to add this member to our database and assign them a member ID.**

At this point, the employer can either:

- a. Enroll the employee in the WRS via ETF Web Applications for Employers at this link [etf.wi.gov/employers/wisconsin-retirement-system](http://etf.wi.gov/employers/wisconsin-retirement-system) to create a Member ID.
  - or
  - b. Create an ETF Member ID in myETF Benefits
4. If no demographic information appears, click the Add button.

Member ID:  OR Social Security Number:



5. Some of the demographic information is displayed on the myMembers screen.
  - a. If demographic information appears, click Edit.

Edit
Print Member ID

### Member Information

<b>Member ID:</b>	1234-4321
<b>SSN:</b>	XXX-XX-X333
<b>Name:</b>	Employee Example
<b>Date of Birth:</b>	08/23/1965
<b>Date of Death:</b>	
<b>Gender:</b>	MALE
<b>Marital Status:</b>	
<b>Marital Status Date:</b>	
<b>Employer:</b>	
<b>Employment Begin Date:</b>	

When an employee is enrolled in the WRS, this information will be displayed.

If they are not enrolled in the WRS, this will be blank

6. Enter the employee's demographic information.

etf  
 etf.wi.gov

EmployerInfo	myMembers	Health	Life	Disability
--------------	-----------	--------	------	------------

### Member Information

<b>Member ID:</b>	
<b>SSN:</b>	(999999999)
<b>Name (First/Middle/Last/Suffix):</b>	<input style="width: 100px;" type="text"/> <input style="width: 100px;" type="text"/> <input style="width: 100px;" type="text"/> <input style="width: 100px;" type="text"/> <span style="float: right;">Select One ▼</span>
<b>Date of Birth:</b>	<input style="width: 100px;" type="text" value="01/21/1980"/> <span style="font-size: 0.8em;">(MM/DD/YYYY)</span>
<b>Gender:</b>	<span style="background-color: #e6f2ff; padding: 2px;">FEMALE</span> ▼
<b>Marital Status:</b>	<span style="background-color: #ffff00; padding: 2px;">MARRIED</span> ▼
<b>Marital Status Date:</b>	<input style="width: 100px;" type="text" value="08/10/2012"/> <span style="font-size: 0.8em;">(MM/DD/YYYY)</span>
<b>Employer:</b>	<span style="background-color: #ffff00; padding: 2px;">Select One</span> ▼
<b>Employment Begin Date:</b>	<input style="width: 100px;" type="text"/> <span style="font-size: 0.8em;">(MM/DD/YYYY)</span>

If Marital Status is NOT SINGLE, Marital Status Date is REQUIRED.

NOTE: Fields cannot be updated if an employee was previously enrolled (not new to myETF Benefits Online application) under another employer. New employer information will be keyed and update under Health/Member Enrolment Screen .

Mailing address and phone number are required.

**Mailing Address:**

**Country:** UNITED STATES - US

**Address Line 1:** 1234 5th ST

**Address Line 2:**

**City, State:** MADISON  
WISCONSIN - WI

**Zip Code:** 537151228 (only numbers are allowed)

**Care of:**

**Primary Phone:** 6081234567 Ext. (only numbers are allowed)

After entering the required information, click Submit.

- Review for accuracy and select the Finalist Address button if system prompted. If no finalist address exists or the entered address is correct per employee, click Entered Address and Submit again.

**Select Address:**


Entered Address      1882 E MAIN ST  
MADISON WI  
53704  
US

Finalist Address      1882 E MAIN ST  
MADISON WI  
53704-5288

**Submit**   **Clear**   **Return to myMembers**

Submit to Update Changes      Cancel Canges      Exit Edit Mode (no update)

- Click Confirm if correct or Cancel if you need to return to the previous page.

 **myETF Benefits Admin**  
Edit myMember

EmployerInfo   myMembers   Health   Life   Disability   WRS   Other Benefits   Reports   Help   Log Off

You have made the following changes. If correct, please press the Confirm button, or press the Cancel button to return back to the Edit page.

**Confirm**   **Cancel**   Confirm data entered. Changes and additions will appear in red.

Member Information      Spouse Information



## myETF Benefits Admin

Health Insurance Online Instructions

EmployerInfo myMembers Health Life Disability WRS Other Benefits Test Support Help Log Off

This screen serves as verification that the Subscriber's demographic information has been entered. Give a copy of this screen to the Subscriber. This screen also gives the Subscriber instructions on how to add coverage.

### Health Insurance Online Enrollment Instructions



Employee: DAVID M WRINKLE

Member ID: 1119-3904

Welcome to the myETF Benefits Online Health Insurance Enrollment System. Choosing a health plan is a complex and personal decision. myETF Benefits will help you select your health insurance coverage level and be your primary source of information that will help you make this important decision. Enrolling in a health insurance plan is a quick and easy process through our dedicated and secure web site, the Online Network for Members. Here you will find many different resources (such as the It's Your Choice Decision Guide) that will provide you with the tools you need to make an informed decision. The goal of myETF Benefits is to provide the most efficient and convenient method for you to research, enroll, and manage your health insurance benefits through any internet enabled computer using one of the following browsers with Java script and cookies enabled:

Internet Explorer 7

Internet Explorer 8

Fire Fox 3.0 (or higher)

#### STEP 1

##### Home Page - Online Network for Members

Go to <http://myETF.wi.gov/ONM.html> (Online Network for Members). Here you will also find links to important documents that can help you research and make informed decisions about your health care benefit coverage level. You will need your member id (shown above) and a WAMS ID (instructions below) to begin using myETF Benefits. When you are ready to enroll in the health care coverage, click on the **myETF Benefits** link to begin the login steps.

#### STEP 2

##### myIdentity Verification (WAMS ID)

Type your WAMS ID and Password. Click **Login**. If you need to set up a WAMS ID, click **Register Now**.

#### STEP 3

##### myIdentity Verification (ETF Member ID)

Type your ETF Member ID (provided by your employer) and birth date. Click **Verify** to continue.

#### STEP 4

##### myIdentity Verification (Social Security Number)

Type your Social Security Number without the dashes. This is a one-time event that only needs to be completed the first time you log in.

#### STEP 5

##### myETF Benefits - New Hire Enrollment

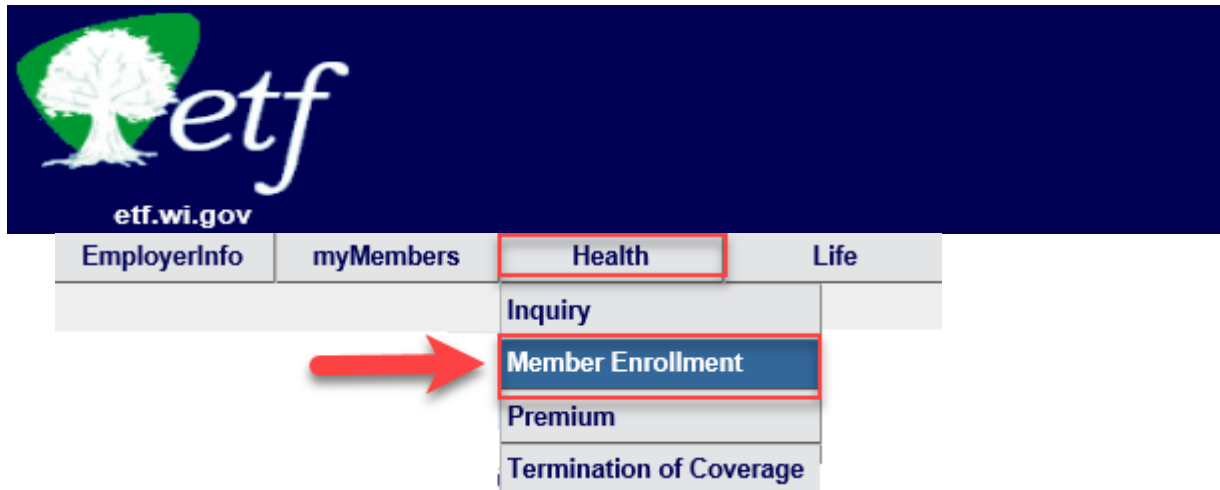
Click the **Add Coverage** button at the bottom of the page to begin making your health insurance selections.

[Return to myMembers](#)

**Note:** This is the confirmation page. This confirmation screen provides you the ETF Member ID for this employee. The confirmation screen will show a summary of changes made and will have a print button in the upper right corner and a return to myMembers button at the bottom of the page.

To print the confirmation page, click on the green Print button in the upper right corner.

9. After review of myMembers is completed an employer can enroll an employee in the health insurance benefit program. Hover over the Health tab and select Member Enrollment from the menu. You must have completed the employee's enrollment in the employer's payroll system or have the employee complete a *Group Health Insurance Application* ((ET-2301) available on the ETF website and updated annually).



10. Enter the member's ETF Member ID or SSN and click Search.

The screenshot shows the Member Search form on the ETF website. The 'Health' tab is selected. The form has two input fields: 'Member ID:' and 'Social Security Number:'. A red arrow points to the 'Search' button.



11. The employee's Member ID, SSN, and name will appear below the Member Search bar. Click Add Coverage to begin the health enrollment.

Member ID:  SSN:  Subscriber:

12. **New Enrollment:** Start at the top of the screen. Select the appropriate Add Coverage reason from the dropdown list.

etf  
etf.wi.gov

EmployerInfo myMembers Health Life Disability

Bypass Calculate Coverage Effective Date Edit

Add Coverage Reason:

- IT'S YOUR CHOICE ENROLLMENT PERIOD
- ADOPTION/PLACEMENT FOR ADOPTION
- BIRTH
- CHANGE EMPLOYEE TYPE
- DOMESTIC PARTNERSHIP
- LIMITED TERM EMPLOYMENT
- MEMBER/DEPENDENT LOSS OF OTHER COVERAGE/LOSS OF EMPLOYER CONTRIBUTION
- NATIONAL MEDICAL SUPPORT NOTICE
- NEW HIRE**
- REINSTATEMENT
- TRANSFER FROM ONE STATE AGENCY TO ANOTHER
- WISCONSIN ACT 113

Event Date:

Employer Received Date:

13. Enter the Event Date (hire date or date of life event) and the Employer Received Date. Event Date and the Employer Received Date determine the coverage effective date.

Event Date:

Employer Received Date:

- a. When the add coverage reason is NEW HIRE, the employee selects "as soon as possible" or "when my employer contributes to premium." This determines when coverage is effective.

- If the option AS SOON AS POSSIBLE is selected, an effective date is automatically generated for first of month on or after the hire date.

I WANT MY COVERAGE TO BE EFFECTIVE:  As soon as possible  When my employer contributes to premium  
 Note: If you select coverage to be effective as soon as possible you may be responsible for the entire monthly premium.

- If WHEN MY EMPLOYER CONTRIBUTES TO PREMIUM is selected, an employer can enter when coverage is effective. The employer will key the coverage begin date.

I WANT MY COVERAGE TO BE EFFECTIVE:  As soon as possible  When my employer contributes to premium  
 Note: If you select coverage to be effective as soon as possible you may be responsible for the entire monthly premium.  
 Date Eligible For Contributions:

- b. If the new hire is not the Add Coverage reason, the system automatically generates a coverage effective date based on the event date and Employer Received Date.

14. Complete the Employment Details section. If it does not default to the correct employer, make the selection from the Employer dropdown list.

Employment Details:

Employer:

Previous Employer: N/A

Employee Type:

Program Option: P14 Surcharge: S01

Employment Begin Date:

Employment Status:

Select One

FULL TIME ACTIVE EMPLOYEE

LEAVE OF ABSENCE

LIMITED TERM EMPLOYEE

PART TIME ACTIVE EMPLOYEE

15. Complete Coverage Selection section. If effective date the system provides is not what the employer expected, the employer may need to call ETF to discuss.

Coverage Selection:

Coverage Type: FAMILY

Health Plan: Non-HDHP Health Plan No Dental Plan

Effective Date: 01/01/2020

Driven by Event Date

Also driven by employer receive date.

- DEAN HP NO DENTAL - NC
- DEAN HP PREVEA360 NO DENTAL - ND
- GHC EAU CLAIRE NO DENTAL - NG
- GHC SOUTH CENTRAL WI NO DENTAL - NH
- HEALTHPARTNERS NO DENTAL - NS
- IYC LOCAL ACCESS NO DENTAL - WEA - N8
- MEDICAL ASSOCIATES HP NO DENTAL - NN
- MERCYCARE HP NO DENTAL - NO
- NETWORK HP NO DENTAL - NP
- QUARTZ-COMMUNITY NO DENTAL - OD
- QUARTZ-UW HEALTH NO DENTAL - OC
- ROBIN WITH HEALTHPARTNERS NO DENTAL - OH
- SMP LOCAL NO DENTAL - WEA - N9
- WEA TRUST EAST NO DENTAL - NT
- WEA TRUST WEST CHIPP VLY NO DENTAL - NU
- WEA TRUST WEST MAYO CLIN NO DENTAL - NW

16. Complete the Contact Information Section
- a. Select Yes to Updated Contact Information if something is changing. Select No if no contact information is changing.

Contact Information:

Update Contact Information: Select One YES

Address Line 1: 1909 PLEASANT

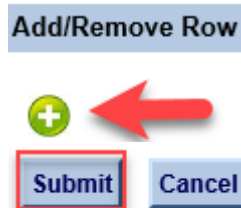
State: WISCONSIN - WI

When entering family coverage, review the employee's information and verify dependent information on the *Group Health Application/Change* ((ET-2301) available on the ETF website and updated annually) form. By default, an employee's record is first to display. Key all detailed information for each person on the plan. See instructions below.

Row	SSN	Name - First, MI, Last, Suffix		
1		CYNTHIA	K	
Insurance:		NO	Other Insurance Co:	Group No:
Medicare:		NO	Medicare:	Select
DOB		Gender	Relationship	
11/17/1955		FEMALE	SELF	
Policy No:				
HIC Number:		MBI Number:		Med A Eff Dt:

Marital Status	Marital Status Date	Tax Dep	Disabled	Physician	Add/Remove Row
DIVORCED	12/22/2009	NO	NO	NO	+
Med B Eff Dt:	Medicare Info Blank Reasons: Select				

- a. Complete the Insurance section for dependent being added:
    - Select No if there is no other health insurance coverage listed on the application for the employee.
    - Select Yes if there is other health insurance coverage listed on the application for the employee. Enter any information provided about the other insurance in the appropriate fields which open after Yes is selected.
  - b. Complete the Medicare section for the dependent being added:
    - Select No if there is no Medicare coverage for the employee.
    - Select Yes if there is Medicare coverage for the employee. Complete the required Medicare information for the dependent in the appropriate fields which open after Yes is selected.
  - c. Complete the Physician section for the dependent being added:
    - Select No if no Physician is listed on the application. Physician section can be left blank.
    - Select Yes if Physician is listed on the application and complete the fields.
17. To add additional dependents to the family contract, scroll to the right and click on the green (+) button below and click Submit when all the dependents on the application have been entered.



18. Verify the information entered is correct, check the box(es) and click Confirm.
- By Confirming this request, I apply for or am ending the insurance under the indicated health insurance and agree to the [TERMS AND CONDITIONS and NONDISCRIMINATION DISCLOSURE](#).
- To the best of my knowledge, all statements and answers are completed and true. All information is 1**
- Documentation is required to process this change. I acknowledge that it is my responsibility to provide th



19. Employer Confirmation and Verification: *Print* a copy of the confirmation screen (if desired) by clicking on the green print button in the upper right hand corner of the screen. An employer can view the contract the following day under Health/Member Enrollment.

The screenshot shows the 'myETF Benefits Admin' interface for 'Health Insurance Add Coverage'. At the top, there is a navigation menu with options: EmployerInfo, myMembers, Health, Life, Disability, WRS, Other Benefits, Test Support, Help, and Log Off. Below the menu, there are input fields for 'ETF Member ID', 'SSN: XXX-XX-X777', and 'Subscriber'. A yellow message box states: 'Your request has been submitted and will be processed overnight.' A green 'Print' button is located to the right of this message. Below the message is a 'Return to Health Enrollment Summary' button. The main content area is divided into two sections: 'Application Information' and 'Covered Individual Detail Summary'. The 'Application Information' section shows 'NEW HIRE' and a table with columns: Health Plan, Coverage Level, Begin Date, End Date, and Employer. The 'Covered Individual Detail Summary' section shows a table with columns: Name, DOB, Gender, Relationship, Marital Status, Marital Status Date, Begin Date, and End Date.

Health Plan	Coverage Level	Begin Date	End Date	Employer
[Redacted]	SINGLE			ADMINISTRATION, DEPT OF

Name	DOB	Gender	Relationship	Marital Status	Marital Status Date	Begin Date	End Date
[Redacted]		MALE	SELF	SINGLE		04/01/2015	

Employee Trust Funds 801 W Badger Rd Madison, WI 53713

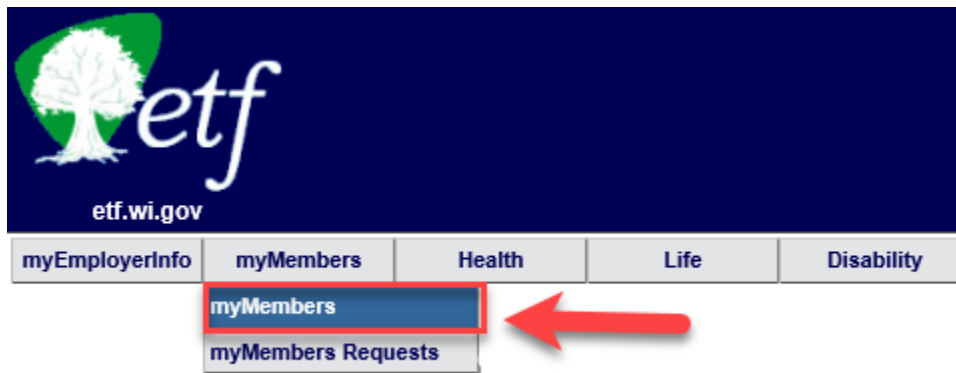
*Note:* When a second check box displays, documentation is required to be submitted to ETF to be eligible for that add reason. The pending contract will go into “Waiting for ETF Approval” status until ETF receives a copy of the required documentation. Once the documentation has been received, reviewed, and approved by ETF, the transaction will be approved and processed overnight. If ETF does not approve the documentation, the employer will be contacted with the reason why and what, if any, additional documentation is needed for processing.

### C-3. Add Dependent

When a *Health Insurance Application/Change* ((ET-2301) available on the ETF website and updated annually) form has been received for one of the Dependent reasons, all information on the form must be verified and the employer must complete the Employer Completes section. Any necessary documentation must be verified/approved. Refer to example below:

<b>Employer Completes</b> Coding instructions are in the <i>Employer Health Insurance Administration Manual</i> .			
EIN 0000-199	Employer name Central Payroll	Payroll representative email Jane.Doe@centralpayroll.wi.gov	
Group number 83900	Employee type →	Coverage type <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family	Health plan name/suffix Dean
Business Unit (if applicable)	Employment status of applicant <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> LTE		Employee deductions <input checked="" type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax
Hire date or date WRS-eligible employment or graduate appointment began 2/4/19	Employer received date 2/27/2019	Event date →	Prospective coverage date 5/1/2019
Are you a WRS-participating employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Previous service check completed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Source of previous service check? <input checked="" type="checkbox"/> Online Network for Employers (ONE) <input type="checkbox"/> ETF Did employee participate in the WRS prior to being hired by you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Payroll representative signature Jane Doe		Phone number (608) 555-1234	Date signed 3/1/2019

1. Verify the members' demographic information is correct, select myMembers under the myMembers tab.



- a. Click the Edit button on the bottom of the screen to update existing information.
- b. When an address is updated, the system will request USPS verification of the address. Always select the Finalist Address
- c. Once edits are complete, click Submit.
- d. Review the data (all changes and additions will appear in red).
- e. Click Confirm if correct, or Cancel to return to the previous screen.
- f. The Confirmation Page can be printed by clicking the green Print button.

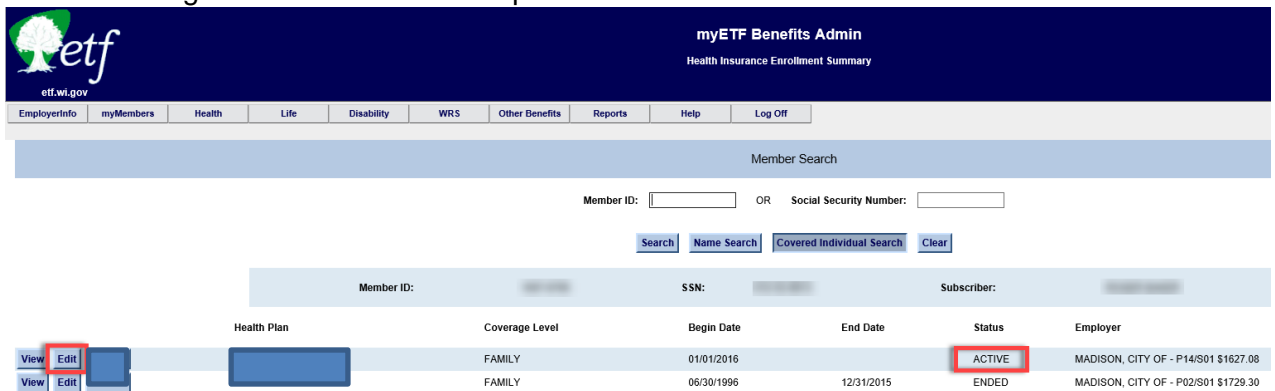
Enrollment Screen: To enroll a dependent, select Member Enrollment from the dropdown list under the Health tab.



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






3. When an employee's record returns, click Edit button on the line of the Active contract to begin the health enrollment process.



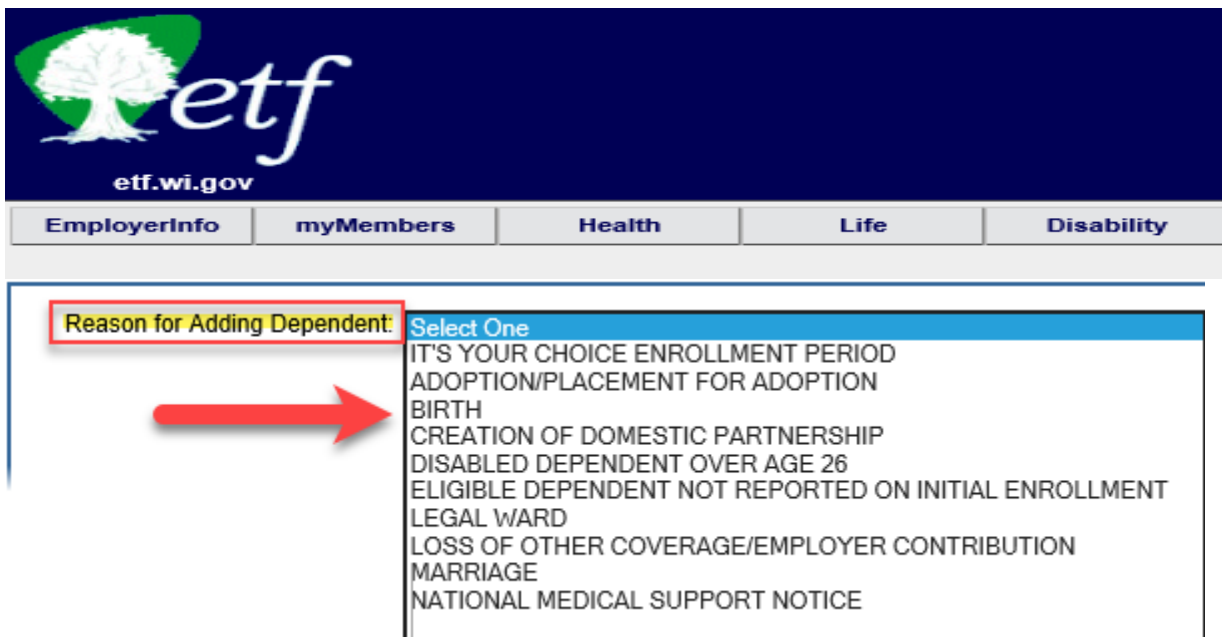


4. Check Add Dependent and click Continue and select a reason for adding the dependent. Enter the event date and employer received date.

I would like to:  ADD DEPENDENT   
 CHANGE HEALTH PLAN   
 REMOVE DEPENDENT 




5. Select the appropriate Reason for Adding Dependent from the dropdown list.


The screenshot shows the top navigation bar of the etf.wi.gov website with the logo and the URL. Below the navigation bar are tabs for "EmployerInfo", "myMembers", "Health", "Life", and "Disability". The "Reason for Adding Dependent" dropdown menu is open, showing a list of reasons. A red arrow points to the "BIRTH" option. The list of reasons includes: "IT'S YOUR CHOICE ENROLLMENT PERIOD", "ADOPTION/PLACEMENT FOR ADOPTION", "BIRTH", "CREATION OF DOMESTIC PARTNERSHIP", "DISABLED DEPENDENT OVER AGE 26", "ELIGIBLE DEPENDENT NOT REPORTED ON INITIAL ENROLLMENT", "LEGAL WARD", "LOSS OF OTHER COVERAGE/EMPLOYER CONTRIBUTION", "MARRIAGE", and "NATIONAL MEDICAL SUPPORT NOTICE".

Reason for Adding Dependent: **Select One**

- IT'S YOUR CHOICE ENROLLMENT PERIOD
- ADOPTION/PLACEMENT FOR ADOPTION
- BIRTH
- CREATION OF DOMESTIC PARTNERSHIP
- DISABLED DEPENDENT OVER AGE 26
- ELIGIBLE DEPENDENT NOT REPORTED ON INITIAL ENROLLMENT
- LEGAL WARD
- LOSS OF OTHER COVERAGE/EMPLOYER CONTRIBUTION
- MARRIAGE
- NATIONAL MEDICAL SUPPORT NOTICE

6. Complete the Event Date (date of qualifying life event) and Employer Received Date. The Effective date will auto-populate based on the Event and Received dates entered.

Event Date:  

Employer Received Date:  

**Drive Effective date**

**Date MUST BE within 30 days of EVENT DATE or system error if outside 30 days.**

7. Complete the Identification section.

SSN:

First Name:


Middle Initial:


Last Name:

Suffix:

Member ID:

Gender:


Date of Birth:  

Date of Death:  

Marital Status:

Marital Status Date:

- DIVORCED
- DOMESTIC PARTNER
- MARRIED
- SINGLE
- WIDOWED

Marital Status Date:  

**If not SINGLE, Marital Status Date is required**

Tax Dependent:

Disabled:

Begin Date:

End Date:

ETF's Insurance:

Relationship:

Standard Plan Wait Indicator:

8. Complete the Other Health Insurance section.
- a. Select No from the dropdown menu if there is no other health insurance coverage listed on the application for the dependent.
  - b. Select Yes from the dropdown menu if there *is* other health insurance coverage listed on the application for the dependent. Enter any information provided about the other insurance in the appropriate fields.

Other Health Insurance: Choose ▼

9. Complete the Medicare section.
- Select No from the dropdown menu if there is no Medicare coverage for the dependent.
  - Select Yes from the dropdown menu if there is Medicare coverage for the dependent. Complete the required Medicare information for the dependent in the appropriate fields.

Medicare: Choose ▼

11. Complete the Physician section for the dependent being added. The Physician section can be left blank if physician information is not available.

**Physician:**

National Provider ID:  OR Physician Last/Clinic Name:

Physician First Name:

12. Click Submit.

Submit Cancel

13. Verify data entered and click Confirm

By Confirming this request, I apply for or am ending the insurance under the indicated health insurance and agree to the [TERMS AND CONDITIONS and NONDISCRIMINATION DISCLOSURE](#).

**To the best of my knowledge, all statements and answers are completed and true. All information is t**

Documentation is required to process this change. I acknowledge that it is my responsibility to provide th

Confirm Cancel

*Note:* When a second check box displays, documentation is required to be submitted to ETF to be eligible for that add reason. The contract will go into "Waiting for ETF Approval" status until ETF receives a copy of the required documentation. Once the documentation has been received, reviewed and approved by ETF, then the transaction will be approved and processed overnight. If ETF does not approve the documentation, the employer will be contacted with the reason why and what, if any, additional documentation is needed for processing.

14. **Employer Confirmation and Verification:** *Print* a copy of the confirmation screen (if desired) by clicking on the green print button in the upper right hand corner of the screen. An employer can view the contract the following day under Health/Member Enrollment.

The screenshot shows the 'myETF Benefits Admin' interface. At the top, there is a navigation menu with options like 'myMembers', 'Health', 'Life', 'Disability', 'WRS', 'Other Benefits', 'Reports', 'Maintenance', 'Help', and 'Log Off'. Below the menu, a message states: "Your request has been submitted and will be processed overnight." The main content area displays the following information:

- ETF Member ID: [Redacted]
- Employer: CENTRAL PAYROLL EMPLOYEE TRUST FUNDS - P01/S01 5894 46
- SSN: [Redacted]
- Health Plan: GHC SOUTH CENTRAL VI
- Subscriber: [Redacted]
- Coverage Level: SINGLE

Below this information are three buttons: "Return to Enrollment Summary", "Return to Report Enrollment Change", and "Add Additional Eligible Dependent". A green "Print" button is located in the upper right corner of the form area. The form itself contains the following sections:

- Reason for Adding Dependent:** ADOPTION/PLACEMENT FOR ADOPTION. Event Date: 02/15/2020. Employer Received Date: 02/20/2020. Effective Date: 02/15/2020. Bypass Calculate Coverage Effective Date Edit?
- Identification:**
  - SSN: [Redacted]
  - Gender: MALE
  - First Name: BRENDAN
  - Date of Birth: [Redacted]
  - Middle Initial: S
  - Date of Death: [Redacted]
  - Last Name: [Redacted]
  - Marital Status: SINGLE
  - Suffix: [Redacted]
  - Marital Status Date: [Redacted]
  - Member ID: [Redacted]
- Tax Dependent:** YES, Disabled: NO, Begin Date: 02/15/2020, End Date: [Redacted]
- ETF's Insurance:** PRIMARY, Relationship: CHILD, Standard Plan Wait Indicator: NO
- Other Health Insurance:** NO
- Medicare:** NO
- Medicare Eligibility Reason:** [Redacted]
- Medicare A Effective Date:** [Redacted]
- Medicare B Effective Date:** [Redacted]
- Medicare Info Blank Reasons:** [Redacted]
- Physician:** National Provider ID: [Redacted] OR Physician Last/Clinic Name: [Redacted] Physician First Name: [Redacted]

Return to Enrollment Summary      Return to Report Enrollment Change      Add Additional Eligible Dependent

If no other action to perform, click to return to the contract summary

Click to perform another action

Click to Add another dependent

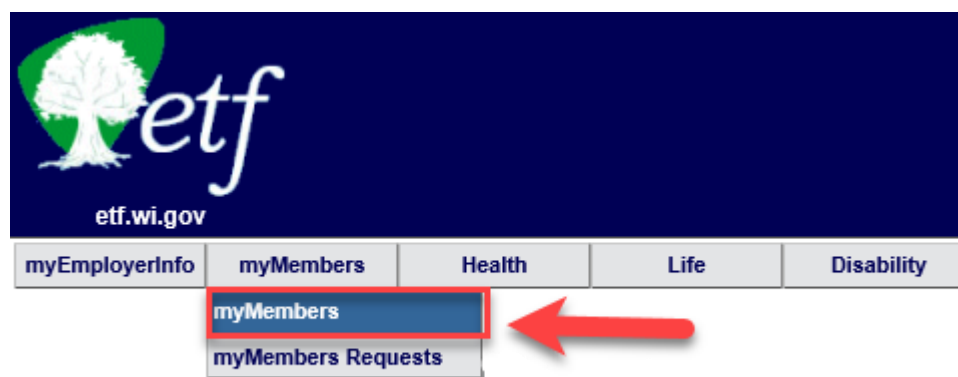
15. Click Return to Enrollment Summary to return to the active contract.
- To perform an additional change, click Return to Report Enrollment Change button. Example of multiple changes: Add Dependent and Change Health plan or Remove Dependent and Change Health Plan must be keyed in myETF Benefits on the same day.
    - Add or Remove Dependent first and then Change Health Plan. If an employee is electing to Add or Remove and Change Health Plan because of a Life Event, BOTH changes MUST be performed on the same day for the system to correctly process the changes under one life event reason (Birth, Marriage, Divorce, etc). If these steps are performed on two separate days, the change in health plan will not process.

## C-4 Remove Dependent

When a *Health Insurance Application/Change* ((ET-2301) available on the ETF website and updated annually) form has been received for one of the Dependent reasons, all information on the form must be verified and the employer must complete the Employer Completes section. Any necessary documentation must be verified/approved. Refer to example below:

Employer Completes Coding instructions are in the <i>Employer Health Insurance Administration Manual</i> .					
EIN 0000-199	Employer name Central Payroll		Payroll representative email Jane.Doe@centralpayroll.wi.gov		
Group number 83900	Employee type →	Coverage type <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family	Health plan name/suffix Dean		
Business Unit (if applicable)	Employment status of applicant <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> LTE		Employee deductions <input checked="" type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax		
Hire date or date WRS-eligible employment or graduate appointment began 2/4/19	Employer received date 2/27/2019		Event date →	Prospective coverage date 5/1/2019	
Are you a WRS-participating employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Previous service check completed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Source of previous service check? <input checked="" type="checkbox"/> Online Network for Employers (ONE) <input type="checkbox"/> ETF Did employee participate in the WRS prior to being hired by you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Payroll representative signature Jane Doe		Phone number (608) 555-1234	Date signed 3/1/2019		

1. Verify the demographic information is correct, choose the myMembers tab and select myMembers.

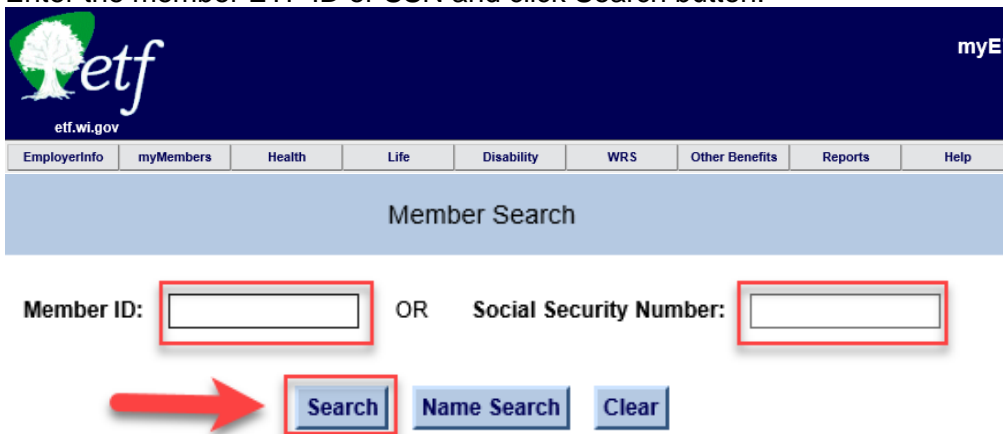


- a. Click the Edit button on the bottom of the screen to update existing information.
- b. When an address is updated, the system will request USPS verification of the address. Always select the Finalist address.
- c. Once edits are complete, click Submit.
- d. Review the data (all changes and additions will appear in red).
- e. Click Confirm if correct or Cancel to return to the previous screen.
- f. The Confirmation Page can be printed by clicking the green print button.

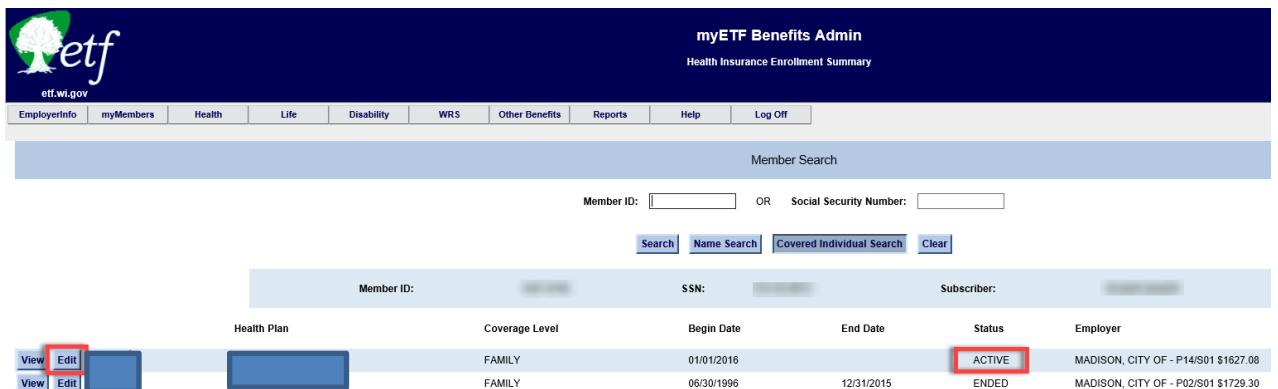
To remove a dependent from an existing contract, hover over the Health tab and select Member Enrollment from the dropdown menu.



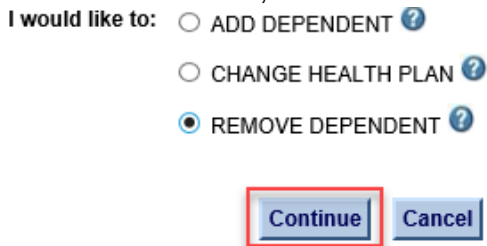
2. Enter the member ETF ID or SSN and click Search button.



3. When the employee's record returns, click Edit button on the line of the Active contract.



On the next screen, select Remove Dependent and continue.



4. Select a Reason to remove the dependent and check the box next to the dependent to be removed and click Submit.



**Reason for Removing Dependent:** Select One  
 CHANGE FAMILY TO SINGLE COVERAGE  
 DEATH OF DEPENDENT  
 DIVORCE  
 ELIGIBLE FOR OTHER GROUP INSURANCE

5. Complete the Event Date (date of qualifying life event) and Employer Received Date (date application was received by employer).

Event Date: 01/13/2019 MM/DD/YYYY

Employer Received Date: 01/23/2020 MM/DD/YYYY

6. When Divorce is selected, an additional box will display for the Date of COBRA Notice. Enter the “Date Notice Provided” from the *Continuation – Conversion Notice* (ET-2311). This date determines the termination of coverage date for the former spouse and step-children.

Reason for Removing Dependent: DIVORCE Event Date:  MM/DD/YYYY

Employer Received Date:  MM/DD/YYYY Date of COBRA Notice:

- a. When removing the spouse and step-children but maintaining Family coverage and the notification date is not within the same month as the divorce (event), the coverage will end at the end of the month of the COBRA (ET-2311) notification date or the date of divorce, whichever is later.

Example: The divorce occurred on 1/21/2020, the ET-2301 was received by employer on 2/3/2020 and the ET-2311 notification date (the date the ET-2311 was sent to former spouse and stepchildren) is 2/5/2020, the health insurance coverage will term on 2/29/2020.

- b. When changing coverage level from family to single due to divorce, the reason selected in myETF Benefits will be Change from Family to Single Coverage/not Divorce). Coverage will end at the end of the month in which the divorce (event) occurred or the COBRA notification date, whichever is later.

Example: Divorce occurs 1/21/2020, ET-2301 received by employer on 1/27/2020, and the ET-2311 notification date (the date the ET-2311 was sent to



former spouse and step-children) is 1/27/2020, the health contract will terminate on 1/31/2020. The spouse and step-children cannot be removed until the divorce is finalized. They are sent COBRA information and applications when they are removed from the plan.

7. Check the box next to the dependent to be removed and click submit
  - a. When the reason is Divorce, the system will automatically check the box next to the spouse and stepchildren
  - b. When the reason is Change from Family to Single Coverage, the system will automatically check the boxes next to all dependents other than the subscriber.

Select	Member ID	Name	Birthdate	Gender	Relationship
<input type="checkbox"/>	██████	████████████████████	██/██/██	MALE	SELF
<input type="checkbox"/>	██████	████████████████████	██/██/██	FEMALE	SPOUSE
<input type="checkbox"/>	██████	████████████████████	██/██/██	FEMALE	STEPCHILD
<input type="checkbox"/>	██████	████████████████████	██/██/██	MALE	CHILD

8. Verify the information is correct, check the boxes, and click Confirm.

By Confirming this request, I apply for or am ending the insurance under the indicated health insurance and agree to the [TERMS AND CONDITIONS and NONDISCRIMINATION DISCLOSURE](#).

**To the best of my knowledge, all statements and answers are completed and true. All information is**

Documentation is required to process this change. I acknowledge that it is my responsibility to provide th

*Note:* When a second check box displays, documentation is required to be submitted to ETF. The contract will go into “Waiting for ETF Approval” status until ETF receives a copy of the required documentation. Once the documentation has been received, reviewed and approved by ETF, then the transaction will be approved and processed overnight. If ETF does not approve the documentation, the employer will be contacted with the reason why and what, if any, additional documentation is needed for processing.

You must then either have the documentation in hand, expect to receive it soon, or request it from the employee at that time.

9. Confirmation and Verification: Verify the information entered is correct. The transaction will process overnight (or once ETF approves) and will transmit to the health plan via the nightly file. An employer can view the contract the following day. *Print* a copy of the confirmation screen (if desired) by clicking on the green print button in the upper right hand corner of the screen.

Members Health Life Disability WRS Other Benefits Reports Maintenance Test Support Help Log Off

ETF Member ID: 1000-1024 SSN: XXX-XX-X245 Subscriber: [REDACTED]  
 Employer: [REDACTED] Health Plan: [REDACTED] Coverage Level: FAMILY

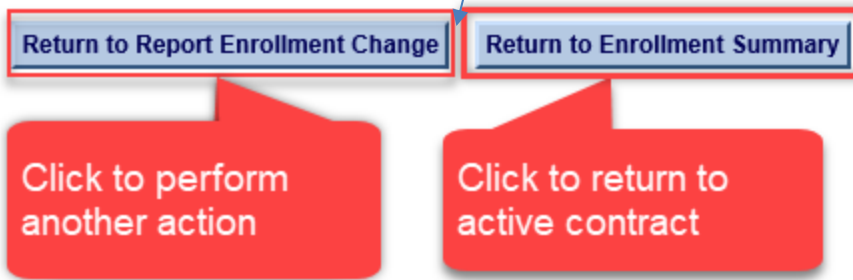
The Reason for Removing Dependent will terminate all eligible dependents and requires a change in coverage level. By confirming this change, member's coverage level will be updated to single coverage. Please remember to update any other benefit information that may be effected by this change outside of health benefits.

[Return to Report Enrollment Change](#) [Return to Enrollment Summary](#)

Your request has been submitted and will be processed overnight. [Print](#)

Reason for Removing Dependent: ELIGIBLE FOR OTHER GROUP INSURANCE

Select	Member ID	Name	Birthdate	Gender	Relationship	Tax Dependent	Disabled	Medicare A	Medicare B	Begin Date	Old End Date	New End Date
<input type="checkbox"/>	[REDACTED]	[REDACTED]	[REDACTED]	MALE	SELF	YES	NO	NO	NO	01/01/2018		
<input checked="" type="checkbox"/>	[REDACTED]	[REDACTED]	[REDACTED]	FEMALE	LEGAL WARD	YES	NO	NO	NO	01/01/2018		02/29/2020



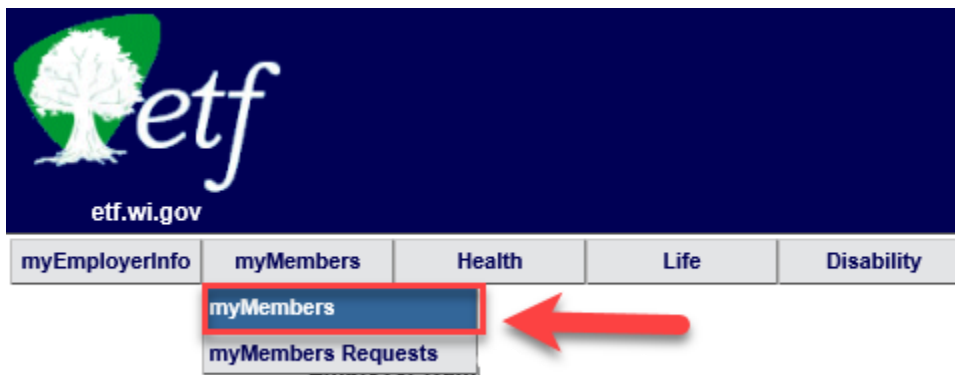
10. Click Return to Enrollment Summary to return to the active contract.
- To perform an additional change, click Return to Report Enrollment Change button. Example of multiple changes: Add dependent and change health plan or remove dependent and change health plan must be keyed in myETF Benefits on the same day.
    - Add or Remove Dependent first and then Change Health Plan. If an employee is electing to Add or Remove and Change Health Plan because of a life event, *both* changes *must* be performed on the same day for the system to correctly process the changes under one life event reason (birth, marriage, divorce, etc). If these steps are performed on two separate days, the second change will not process.

## C-5 Change Health Plans

When a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) has been received for one of the Dependent reasons, all information on the form must be verified and the employer must complete the Employer Completes section, and any necessary documentation has been verified/approved. Refer to example below:

Employer Completes Coding instructions are in the <i>Employer Health Insurance Administration Manual</i> .				
EIN 0000-199	Employer name Central Payroll		Payroll representative email Jane.Doe@centralpayroll.wi.gov	
Group number 83900	Employee type →	Coverage type <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family	Health plan name/suffix Dean	
Business Unit (if applicable)	Employment status of applicant <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> LTE		Employee deductions <input checked="" type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax	
Hire date or date WRS-eligible employment or graduate appointment began 2/4/19	Employer received date 2/27/2019	Event date →	Prospective coverage date 5/1/2019	
Are you a WRS-participating employer? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Previous service check completed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Source of previous service check? <input checked="" type="checkbox"/> Online Network for Employers (ONE) <input type="checkbox"/> ETF Did employee participate in the WRS prior to being hired by you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Payroll representative signature Jane Doe		Phone number (608) 555-1234	Date signed 3/1/2019	

1. Verify the demographic information is correct; hover over the myMembers tab and select myMembers.

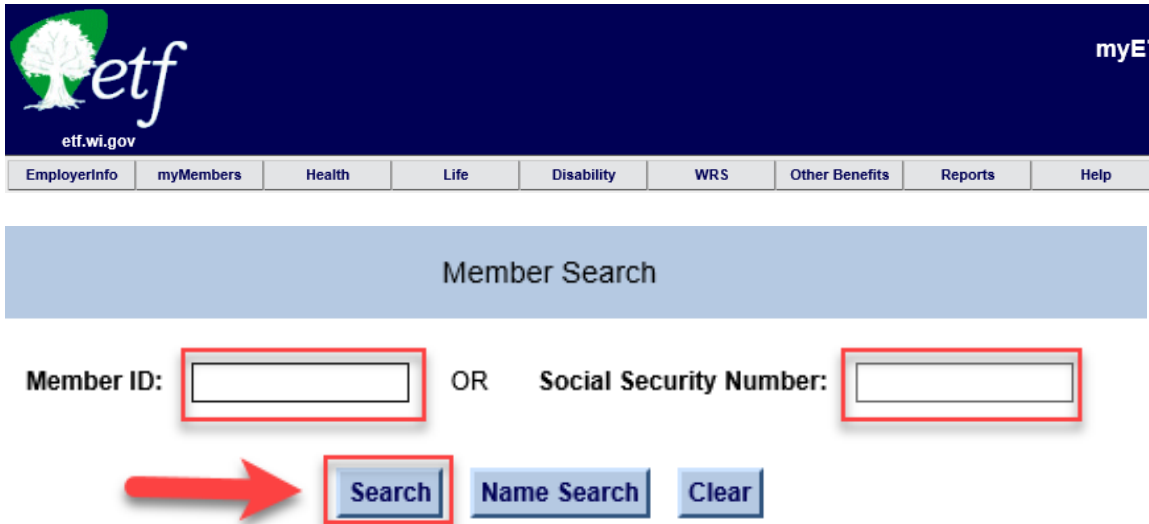


- a. Click the Edit button on the bottom of the screen to update existing information.
- b. When an address is updated, the system will request USPS verification of the address. Always select the Finalized address.
- c. Once edits are complete, click Submit.
- d. Review the data (all changes and additions will appear in red).
- e. Click Confirm if correct or Cancel to return to the previous screen.
- f. The Confirmation Page can be printed by clicking the green print button.

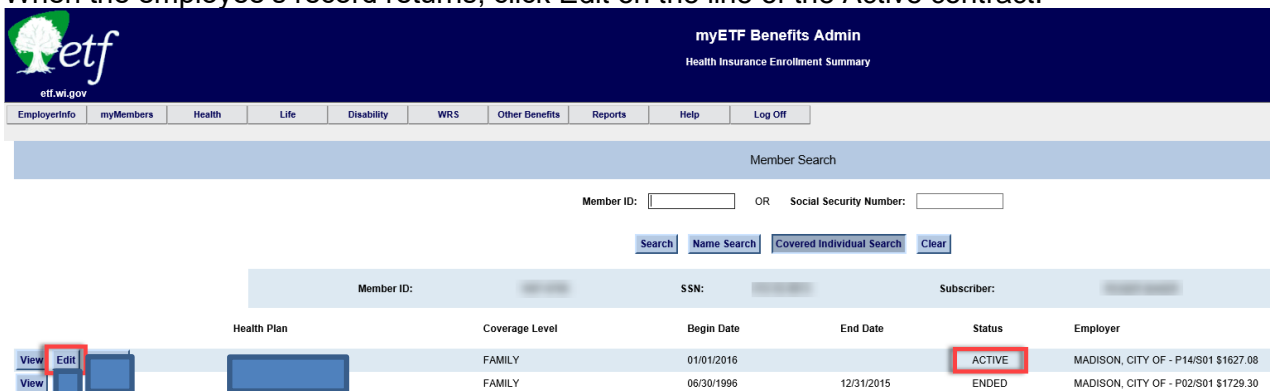
- In myETF Benefits, hover over the myMembers tab and select myMembers from the dropdown menu.



- Enter the ETF Member ID or SSN and click the Search button.



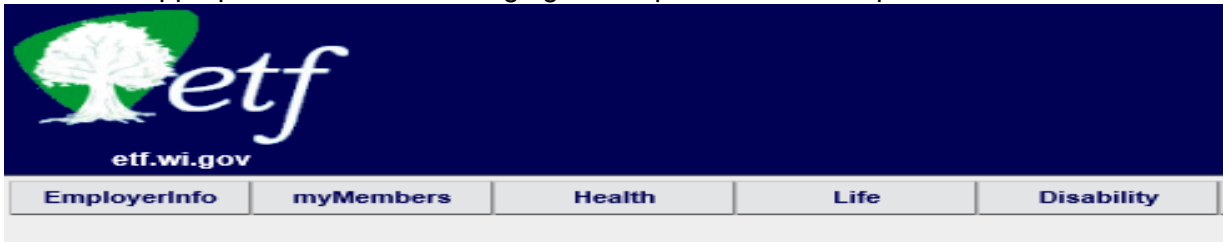
- When the employee's record returns, click Edit on the line of the Active contract.



5. Check Change Health Plan.

- I would like to:
- ADD DEPENDENT ?
  - CHANGE HEALTH PLAN ?
  - REMOVE DEPENDENT ?

Select the appropriate reason for changing health plan from the dropdown menu.



Reason for Changing Health Plan: **Select One**

- IT'S YOUR CHOICE ENROLLMENT PERIOD
- DUE TO ADOPTION/PLACEMENT FOR ADOPTION
- DUE TO BIRTH
- DUE TO CREATION OF DOMESTIC PARTNERSHIP
- DUE TO MARRIAGE
- LOSS OF MEDICARE ELIGIBILITY
- MEDICARE ELIGIBLE
- MOVE FROM SERVICE AREA
- SUBSCRIBER LOSS OF OTHER COVERAGE/EMPR CONTRIBUTION

6. Complete the Event Date (date of qualifying life event) and Employer Received Date (date application was received by employer).

Event Date:  MM/DD/YYYY

Employer Received Date:   MM/DD/YYYY

7. If the reason is move from service area, select the New Residential County from the dropdown menu. (There is an Out of State/NA option.)

- Select a health plan from the dropdown list. *Note:* The End Date of the old health plan and the Begin Date for the new health plan automatically generate based on the Event Date and Employer Receive Date provided above.

**Health Plan**

Current: WEA TRUST EAST

New: Non-HDHP Health Plan Dental Plan Select One

- DEAN HP
- DEAN HP PREVEA360
- GHC EAU CLAIRE
- GHC SOUTH CENTRAL WI
- HEALTHPARTNERS
- IYC ACCESS HP - WEA
- MEDICAL ASSOCIATES HP
- MERCYCARE HP
- NETWORK HP
- QUARTZ COMMUNITY
- QUARTZ UW HEALTH
- ROBIN WITH HEALTHPARTNERS
- SMP - WEA
- WEA TRUST EAST
- WEA TRUST WEST CHIPP VLY
- WEA TRUST WEST MAYO CLIN

Coverage Level	Begin Date	End Date
FAMILY	01/01/2016	01/31/2020
FAMILY	02/01/2020	

End Date is driven by Event Date and the Employer Received Date

New Health Plan Effective Date is driven by Event Date & Employer Received Date

- Verify the member and dependent information on the bottom of the screen is correct. Make updates, if needed.
- Click Submit.

Submit
Cancel

- Verify the correct health plan is keyed and click Confirm.

By Confirming this request, I apply for or am ending the insurance under the indicated health insurance and agree to the [TERMS AND CONDITIONS and NONDISCRIMINATION DISCLOSURE](#).

**To the best of my knowledge, all statements and answers are completed and true. All information is**

Documentation is required to process this change. I acknowledge that it is my responsibility to provide th

Confirm
Cancel

*Note:* When a second check box displays, documentation is required to be submitted to ETF. The pending contract will go into “Waiting for ETF Approval” status until ETF receives a copy of the required documentation. Once the

documentation has been received, reviewed, and approved by ETF, the transaction will be approved and processed overnight. If ETF does not approve the documentation, the employer will be contacted with the reason why and what, if any, additional documentation is needed for processing.

You must then either have the documentation in hand, expect to receive it soon, or request it from the employee at that time and submit it to ETF for review and approval.

- Confirmation and Verification:** Verify the information entered is correct. *Print* a copy of the confirmation screen (if desired) by clicking on the green print button in the upper right hand corner of the screen.

ETF Member ID: 1000-1119      SSN: XXX-XX-X561      Subscriber: [REDACTED]  
 Employer: [REDACTED]      Health Plan: [REDACTED]      Coverage Level: FAMILY

Your request has been submitted and will be processed overnight. [Print](#)

Note: During It's Your Choice, you may also change member's coverage level by returning to the Report Change to Health Enrollment. To change to family coverage please select Add Dependent and It's Your Choice. To change from family to single coverage please select Remove Dependent.

[Return to Report Enrollment Change](#)   [Return to Enrollment Summary](#)

Reason for Changing Health Plan: MOVE FROM SERVICE AREA

Health Plan	Coverage Level	Begin Date	End Date	Employer
Current:	FAMILY	01/01/2018	02/29/2020	[REDACTED]
New:	FAMILY	03/01/2020		[REDACTED]

Covered Individual Detail Summary

Name	DOB	Gender	Relationship	Begin Date	End Date
[REDACTED]	08/25/1964	MALE	SELF	03/01/2020	
[REDACTED]	02/18/1996	MALE	CHILD	03/01/2020	

[Return to Report Enrollment Change](#)   [Return to Enrollment Summary](#)

Click to perform another action      Click to return to active contract

- Click Return to Enrollment Summary to return to the active contract.
  - To perform an additional change, click Return to Report Enrollment Change button. Example of multiple changes: Add Dependent and Change Health plan or Remove Dependent and Change Health Plan must be keyed in myETF Benefits on the same day.
    - Add or Remove Dependent first and then Change Health Plan. If an employee is electing to Add or Remove and Change Health Plan because of a Life Event, BOTH changes MUST be performed on the same day for the system to correctly process the changes under one life event reason (Birth, Marriage, Divorce, etc). If these steps are performed on two separate days, the second request will not process.



## C-6 Termination of Coverage

Termination of health insurance coverage can occur for multiple reasons. Some reasons require a *Health Insurance Application/Change* (ET-2301) available on the ETF website and updated annually) form, such as Cancel Coverage due to eligibility for other group insurance. The remaining reasons, Death of Subscriber, Disability Approval (Non-ICI), Retirement, and Termination of Employment, do not require an application. In order to process the termination of a member's health insurance, you will need to follow the procedure listed below.

- Under Health, select Termination of Coverage from the dropdown menu.

The screenshot shows a navigation menu with three main tabs: 'myEmployerInfo', 'myMembers', and 'Health'. Under the 'Health' tab, there is a dropdown menu with four options: 'Inquiry', 'Member Enrollment', 'Premium', and 'Termination of Coverage'. A red arrow points to the 'Termination of Coverage' option, which is also highlighted with a red box.

- Enter the member's ETF Member ID or SSN. Tab over to the End Date field to enter the health contract termination date. Edit the Event Date and Received Date, if necessary. Leave the Begin date field blank. The Begin date will autofill once Reason is selected.

The screenshot shows a form with a table for entering termination details. The table has columns for Row, Member, SSN, Member ID, Contract Status, Begin Date, Event Date, Received Date, End Date, and Reason. A red box highlights the 'Begin Date' field with the text 'Will auto-fill once Reason is selected'. Three numbered red callouts are present: '1 Enter Member ID' pointing to the Member field, '2 Enter End Date' pointing to the End Date field, and '3 Edit, if needed' pointing to the Event Date field. The form also includes fields for Employer Number (0991000) and Employer Name, and a 'Submit' button.

- Select the Reason for terminating the contract.

The screenshot shows the 'Reason' dropdown menu open, displaying a list of options: 'CANCEL COVERAGE', 'CANCEL DUE TO SPOUSE-TO-SPOUSE TRANSFER', 'DEATH OF SUBSCRIBER', 'DISABILITY APPROVAL (NON-ICI)', 'INVOLUNTARY TERMINATION', 'RETIREMENT', and 'TERMINATION OF EMPLOYMENT'. The form also shows fields for Event Date (4/2022), Received Date (01/04/2022), and End Date (01/31/2022), along with a 'Submit' button.

Reports Help Log Off

Employer Name: MADISON, CITY OF [New EIN](#)

Dependents with a *Continuation-Conversion Notice* (ET-2311) within 5 days of the q voluntarily canceling coverage and the employe  
 :ancel outside of the *It's Your Choice* period.

Begin Date	Event Date	Received Date	End Date	Reason	Coverage Level	Add/Remove Row
01/01/2018	02/18/2020	02/18/2020	02/29/2020	Select One <b>CANCEL COVERAGE</b> CANCEL DUE TO SPOUSE-TO-SPOUSE TRANSFER DEATH OF SUBSCRIBER DISABILITY APPROVAL (NON-ICI) INVOLUNTARY TERMINATION LOSS OF MEDICARE ELIGIBILITY (FORCED) LOSS OF MEDICARE PART B COVERAGE NON-PAYMENT OF DIRECT-PAY SUBSCRIBER PREMIUM TERMINATION OF EMPLOYMENT	FAMILY	

educted: Select One

- When the reasons of Cancel Coverage is selected, a Premiums are deducted dropdown menu will appear. Select the appropriate option.

Contract Status	Begin Date	Event Date	Received Date	End Date	Reason	Coverage Level	Add/Remove Row
ACTIVE	01/01/2018	02/18/2020	02/18/2020	02/29/2020	CANCEL COVERAGE	FAMILY	

Premiums are deducted: Select One

- Post-tax: Coverage may be cancelled at any time.
- Pre-tax: I am terminating employment.
- Pre-tax: I am going on an unpaid leave of absence.
- Pre-tax: I am going to less than half-time employment.
- Pre-tax: My employee premium contribution has increased significantly.
- Pre-tax: I (and all my dependents, if any) became eligible for and enrolled in other group coverage.
- Pre-tax: Annual Its Your Choice open enrollment period.

When the other Reasons are selected, the Premiums are Deducted menu does not generate

- Click Submit.

- Verify the information and the termination date are correct. Click Confirm.


Suscriber Type	SSN	Member ID	Member	Health Plan	Coverage Level
Actual					FAMILY

Begin Date	Event Date	Received Date	End Date	Reason
01/01/2016	01/28/2020	01/28/2020	01/31/2020	TERMINATION OF EMPLOYMENT

- To view the termination date on the contract, go to Health, Member Enrollment and search with the Member ID. Employers will see a message in red stating that the

cancel request in **Approved Not Applied** status.

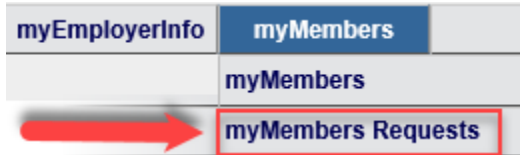
EmployerInfo	myMembers	Health	Life
		Inquiry	
		<b>Member Enrollment</b>	
		Premium	
		Termination of Coverage	



## C-7 Pending Transactions

myMembers Requests is the home of several processing queues where all transactions and changes made on myETF Benefits will go while pending approval or if already approved, waiting for the overnight batch process. There are total of nine queues.

1. To access myMembers Requests, go to myMembers and click on myMembers Requests from the dropdown menu.



2. Enter your eight-digit employer number (ex: 0991-000) and click Verify.

Please enter the seven digit  
Employer Number and click Verify

Employer Number:



3. The Members Requests screen displays with default Request Status **PENDING**. Click the down arrow to view all Request Status.

Employer Number: 0991000

Employer Name:

Request  
Status:

APPROVED  
APPROVED - NOT APPLIED  
APPROVED - PROCESSING ERROR  
CANCELLED  
DENIED  
**PENDING**  
PENDING SICK LEAVE/CONVERSION  
REJECTED BY VALIDATION FILTER  
SPLIT CONTRACT INCOMPLETE  
WAITING ETF APPROVAL DISABLED  
WAITING FOR ETF APPROVAL

Request Status Defined:

**Approved:** Approved transactions that are processed and complete.

**Approved – Not Applied:** Transactions entered same day but do not require ETF approval or ETF has approved and they are pending the nightly batch processing run

**Approved – Processing Error:** Transactions that failed the batch processing and may need to be reentered.

**Canceled:** Transactions that either the employer or ETF canceled prior to the nightly batch run.

**Denied:** Transactions that failed to meet eligibility requirements or the documentation supplied was insufficient or incorrect.

**Pending:** If a member (employee) requested a log-in and password and went in and keyed their own changes, then the transaction would go into the “Pending” queue. The Pending queue is the only queue in which the employer can approve a transaction.

**Waiting for ETF Approval – Disabled:** Transactions with a member adding an adult dependent older than age 26 who is disabled. The transaction will stay in this queue until the disability verification process has been completed and ETF has received a copy of the health plan disability approval letter from the health plan for the dependent.

**Waiting for ETF Approval:** Transactions that require additional documentation prior to approval. If you had to check two boxes on the confirmation screen, it means that the transaction will wait until ETF receives and reviews the submitted documentation and thus approves the transaction.

Transactions that are in *Pending, Approved-Not Applied, Waiting for ETF Approval – Disabled* and *Waiting for ETF Approval* can be edited, if necessary. When Edit is selected, you are returned to the entry screen and you will follow the same submission procedures as before.

Note: Editing a contract does not always work!

Sometimes editing a waiting contract instead of canceling and starting over causes more issues with contract Begin and Effective dates.

- Select Request Status – (e.g. WAITING FOR ETF APPROVAL) from the dropdown menu and click Search.

The screenshot shows a search form with the following elements:

- Request Status:** A dropdown menu with 'WAITING FOR ETF APPROVAL' selected.
- Search and Clear buttons:** Located at the bottom of the form.
- Filter fields:** Includes 'Request Status' (set to PENDING), 'Benefit Program' (set to ALL), 'Request' (set to ALL), 'Request Date', 'Reason for Request' (set to ALL), 'Employer Contact', 'Request From Date', 'Request To Date', 'Max Rows' (set to 50), 'Employer Action Date', and 'Member ID'.
- Annotations:** A red box highlights the 'Request Status' dropdown. A red arrow points from the dropdown to the 'Search' button. A red text box says: 'The most common search is the default, however, you can narrow the search by entering any or all of the information below.' A blue arrow points from the 'Search' button to the 'Search' button in the larger screenshot below.

- The transactions that fit the search criteria will generate. Click Select button to view the transaction you want to view or approve

The screenshot shows a table with the following columns: Member ID, Member, Request Date, Benefit Program, and Request Description. A red text box above the table says: 'May change the number of lines to display on the screen'. A callout box points to the 'Show 10 entries' dropdown with the text: 'Can change the number of requests shown on each page'. A 'Select' button is highlighted in a red box on the first row of the table.

Member ID	Member	Request Date	Benefit Program	Request Description
[Redacted]	[Redacted]	01/28/2020	HEALTH	ADD DEPENDENT
[Redacted]	[Redacted]	01/28/2020	HEALTH	CHANGE COVERAGE LEVEL

- To Cancel a selected transaction (due to a keying error, incorrect date, etc) in the Waiting for ETF Approval or Approved Not Applied queue, click Cancel Activity. Enter comments, check the cancel request box, and click Confirm.

The screenshot shows a form with the following elements:

- Buttons:** 'Cancel Activity', 'Edit', and 'Return to myMembersRequests'.
- Comments:** A text area containing 'Keying error'.

I would like to cancel this request

The screenshot shows two buttons: 'Confirm' and 'Return to Request Detail'. The 'Confirm' button is highlighted with a red box.

- Return to Health – Member Enrollment to rekey the contract.

7. To Approve a selected transaction in the Pending queue:
  - a. Review and verify the information entered is correct:
    - i. Click the Approved button and it will automatically take you back out to the queue.
    - ii. Click Return to myMembers Requests if you are not ready to approve.
    - iii. All approved transactions will go to the Approved-Not Applied queue to be processed in the nightly batch run.
    - iv. You can go in the following day to verify the transaction processed correctly by reviewing the employees information on the myMembers screen and contract on the myMembers screen in myETF Benefits.
  
8. To Edit a selected transaction in the Pending queue:
  - Click the Edit button to update any information
  - Click the Cancel button to cancel the transaction, in which case it will need to be re-entered by the employee.
  - Enter a reason for the cancellation in the Comments box. Check the box next to "I would like to cancel this request."
  - Click the Confirm button.
  
9. To Deny a selected transaction in the Pending queue (a review discovered member was not eligible to make the requested change).
  - Click the Deny button
  - Enter a reason for the denial in the Comments box
  - Check the box next to "I would like to deny this request."
  - Click the Confirm button.



## C-8. Enrollment Inquiry

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

1. To view an enrollment summary, hover to Health/Inquiry/Enrollment Reports and select Enrollment Inquiry.



2. Enter your eight-digit employer number (ex: 0991-000) and click Verify.

Please enter the seven digit  
Employer Number and click Verify

Employer Number:



3. Click the dropdown arrow to below to narrow to your search by month, year, health plan, relationship, coverage type, and click Display.

Employer Number: 0991-000

Employer Group:

Coverage Month:  Year:

Health Plan:

Relationship:

Coverage Type:

Tax Dependent:

4. The results of the query can be organized and sorted:
- Option to select the number of entries to show on the screen at one time

Show   entries

- May search for specific information (employee type, Member ID, SSN, last name, etc)
- Can skip to a page, next page, or last page

- May sort by a specific column (small arrows)

Search:

Last Name	First Name	Birthdate	Gender	Coverage Effective	Coverage Expiration	Health Plan	Coverage Type
	KIMBERLY		F	2018-01-01		OC	02
	KAITO		M	2018-01-01		OC	02
	BRIAN		M	2018-01-01		OC	02
	DAVID		M	2018-01-01		OC	02
	DONALD		M	2020-01-01		OC	01

5. The results of the query can be exported to a Microsoft Excel spreadsheet
- Select Save As to export the results to Excel

- Choose to open, save, or cancel the Excel spreadsheet

Do you want to open or save HealthInsuranceListing\_20200218.xls from web.etf.wi.gov?

- Select Open – the query will display in the following format

Employee	Member I	SSN	Last Name	First Name	Birth Date	Gender	Coverage	Coverage	Health Pl	Coverage	Type	Code
12345 - Employer Name February 2020 Health Plan = ALL, Coverage Type = ALL												
3	06					F	2018-01-01		OC	02		
4	06					M	2018-01-01		OC	02		
5	06					M	2018-01-01		OC	02		
6	06					M	2018-01-01		OC	02		
7	06					M	2020-01-01		OC	01		
8	06					M	2019-01-01		NC	02		
9	06					F	2018-01-01		OC	02		
10	06					M	2018-01-01		OC	02		

- Choose to save the query or exit from Excel. It will not change your query in myETF Benefits.

### C-9. Dependent Inquiry

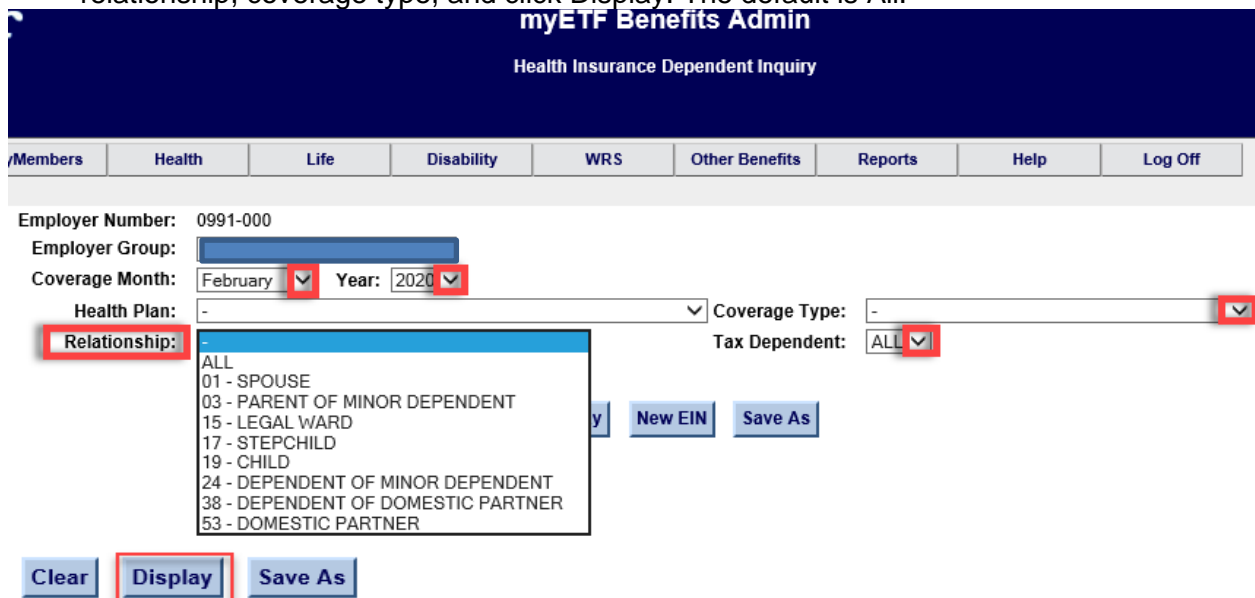
The Dependent Inquiry is a function of myETF Benefits where an employer can go to view a summary of all their employees (subscribers) and their dependents that are, or have been enrolled in the State Group Health Insurance Program and entered in myETF Benefits. This is a monthly report based on available invoices. This query can either be very broad or broken down by a specific health plan, coverage type, relationship- ship, and/or tax dependency status. This query can be used to locate disabled dependents, employees turning 65, and dependents who will be removed from a contract when they turn 26.

To use this inquiry function, you will follow the procedures listed below.

1. To view Dependent summary, hover to Health/Inquiry/Enrollment Reports and select Dependent Inquiry.



2. Click the dropdown arrows to narrow to your search by month, year, health plan, relationship, coverage type, and click Display. The default is All.



3. The results of the query can be organized and sorted:
  - a. Option to select the number of entries to show on the screen at one time



- b. May search for specific information (employee type, Member ID, SSN, last name, etc)
  - c. Can skip to a page, next page, or last page



- d. May sort by a specific column (small arrows)

4. The results of the query can be exported to a Microsoft Excel spreadsheet
  - a. Select Save As to export the results to Excel



- b. Choose to open, save, or cancel the Excel spreadsheet



- c. Select Open and the query will open in Excel

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

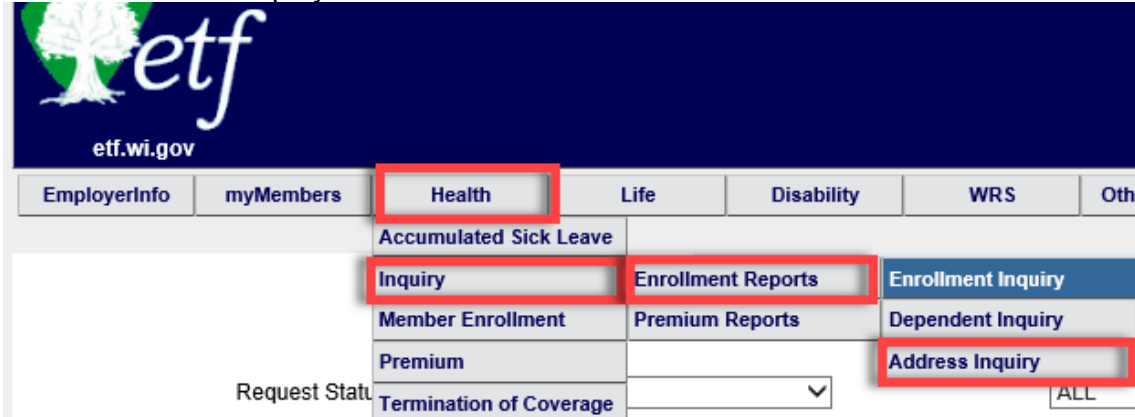
Health	Coverage	Employee Type	Sub SSN	Sub Name	Dep SSN	Dep	Dep Name	Dep DOB	Dep Gender	Dep Marital Status	Cov Eff Date	Cov Exp Date	Rel Code	Disabled?	Tax Depe
3	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD	'01	N	Y	
4	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX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

- d. Choose to save the query or exit from Excel. It will not change your query in myETF Benefits.

### C-10. Address Inquiry

The Address Inquiry is a function of myETF Benefits where an employer can go to view a summary of all subscriber addresses that have been updated. This query can look back 30, 60, or 90 days or can be run to look at all address changes that have been made.

- To access Address Inquiry, hover to Health/Inquiry/Enrollment Reports and click on Address Inquiry as shown below.



- Click the Display button to view all or select the number of days from the dropdown and click Display.

Employer Number: 0991-000

Employer Group:

Number of Days :



- To search by individual member, enter the member ID in the Search bar below. To sort by name, click the down/up arrow.

Show 10 entries Search:

n	Member ID	SSN	First, Middle, Last Name	Empr No	Empr Grp No	Address Line 1	Line 2	City	State	Zip Code	Country	Effective Date
1			A	0991000	70991				WI	537192353	US	2019-09-03
2				0991000	70991				WI	535349165	US	2018-08-02
3				0991000	70991				WI	535989131	US	2018-03-02
4			3	0991000	70991				WI	539251590	US	2018-01-02
5	1			0991000	70991				WI	539011644	US	2019-07-02

4. The results of the query can be organized and sorted:
  - a. Option to select the number of entries to show on the screen at one time



- b. May search for specific information (employee type, Member ID, SSN, last name, etc)
  - c. Can skip to a page, next page, or last page

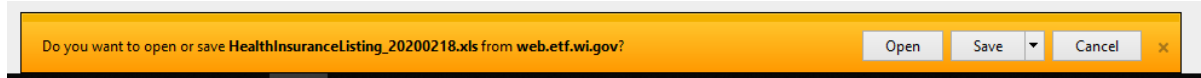


- d. May sort by a specific column (small arrows)

5. The results of the query can be exported to a Microsoft Excel spreadsheet
  - a. Select Save As to export the results to Excel



- b. Choose to open, save, or cancel the Excel spreadsheet



- c. Select Open and the query will open in Excel

**Employer Number = 0991000**

**Employer Group N [REDACTED] CITY OF**

**Days = 30**

Member ID	SSN	Last Name	Middle In	First Name	Employer	Employer Address	L Address	L City	State	Zip Code	Address	Effective Date
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	0991000	70991	[REDACTED]	MADISON	WI	53704512	US	2020-02-06
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	0991000	70991	[REDACTED]	VERONA	WI	53593844	US	2020-02-06
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	0991000	70991	[REDACTED]	MADISON	WI	53713102	US	2020-02-06
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	0991000	70991	[REDACTED]	EDGERTC	WI	53534131	US	2016-06-02
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	0991000	70991	[REDACTED]	MADISON	WI	53705473	US	2020-02-06
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	0991000	70991	[REDACTED]	COLUMBL	WI	53925972	US	2020-02-06
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	0991000	70991	[REDACTED]	MADISON	WI	53718301	US	2020-02-06
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	0991000	70991	[REDACTED]	SAINT DAVID	WI	53116234	US	2020-02-06

- d. Choose to save the query or exit from Excel. It will not change your query in myETF Benefits.