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

**Table of Contents**

**Preface** (revised 2/25/2019)

**Chapter 1—Background Information** (revised 2/25/2019)
- 101 Applicable Policies, Statutes and Legislation
- 102 Employer Agent Responsibilities
- 103 Employer Training and Support
- 104 myETF Benefits System (MEBS)
- 105 ETF Ombudsperson Services
- 106 Employer Services Section, Insurance Unit (ESS) Contacts

**Chapter 2—Health Plan and Program Information** (revised 2/25/2019)
- 201 IYC Health Plans (HMOs, PPOs, and HDHPs)
- 202 Access Plan
- 203 State Maintenance Plan (SMP)
- 204 Three Tier Premium Structure
- 205 Contribution Rates
- 206 Opt-Out Incentive
- 207 Pharmacy Benefit Manager (PBM) – Navitus
- 208 Wellness and Disease Management Program Administrator - StayWell
- 209 Health Plan Contacts
- 210 Coordination of Benefits (COB)
- 211 Administration of Benefit Maximums
- 212 Errors
- 213 Premium Refunds due to Errors are Limited
- 214 Limited Premium and Claim Adjustments
- 215 Benefits are Non-Transferable

**Chapter 3—Eligibility** (revised 3/27/2019)
- 301 Employee, Annuitant and Continuant Eligibility
- 302 Dependent Coverage Eligibility
- 303 Employer Premium Contribution Eligibility
- 304 WRS Previous Service Check
- 305 Rehired Employee Coverage

**Chapter 4—Initial Enrollment** (revised 5/18/2019)
- 401 Initial Enrollment and Effective Dates
- 402 Declining Coverage
- 403 Enrollment Opportunities for Employees who Previously Declined or Canceled Coverage
- 404 Applying for Coverage
- 405 Primary Care Provider or Primary Care Clinic
- 405 Insurance Cards

**Chapter 5—Changing Coverage** (revised 6/4/2019)
- 501 Status Change
- 502 Changing Plans Due to a Residential Move
- 503 Changing Health Plans
- 504 Changing from Single to Family Coverage
- 505 Changing from Family to Single Coverage
- 506 Adding Dependents
507 Removing Dependents
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

Chapter 6—It's Your Choice Open Enrollment (revised 2/25/2019)
601 It’s Your Choice Open Enrollment
602 Withdrawing/Rescinding It’s Your Choice Enrollment Elections
603 When a Health Plan is not Available at It’s Your Choice
604 Late It’s Your Choice Applications

Chapter 7—Leave of Absence (LOA) (revised 2/25/2019)
701 Definition of a Leave of Absence
702 Employer Contribution Toward Health Insurance Premium While on an Unpaid Leave of Absence
703 Coverage 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

Chapter 8—Cancellation and Termination of Coverage (revised 2/25/2019)
801 Individual Termination of Coverage
802 Ending Coverage
803 Changing from Active to Annuitant Coverage
804 Voluntary Cancellation of Coverage

Chapter 9—COBRA, Continuation and Conversion (revised 2/25/2019)
901 Overview of COBRA, Continuation and Conversion
902 Persons Eligible for Continuation (Qualified Beneficiaries)
903 Employee Responsibilities
904 Qualified Beneficiary Responsibilities
905 Employer Responsibilities
906 Notice Requirement Illustration Chart
907 Continuation Coverage Information

Chapter 10—Retirement or Disability (revised 2/25/2019)
1001 Coverage – Requirements to Continue
1002 Coverage for Former State Employees Whose Coverage Lapsed
1003 Premium Payment

Chapter 11—Rehired Annuitants (revised 8/2/2019)
1101 Eligibility
1102 Coverage
1103 Disability Annuitants

Chapter 12 - Accumulated Sick Leave Conversion Credits (ASLCC) (revised 10/4/2019)
1201 Accumulated Sick Leave Conversion Credit Program
1202 Eligibility
1203 Enrollment Opportunities
1204 Unpaid Leave/Temporary Layoff
1205 Permanent Layoff
1206 Permanent Layoff Sick Leave Conversion Reference Chart
1207 Accumulated Sick Leave and Chapter 40 Terminations
1208 Certifying Credits through the Online Accumulated Sick Leave System (AcSL)
1209 Generating a Sick Leave Credit Estimate through the Online Accumulated Sick Leave System (AcSL)
1210 Escrow of Sick Leave Credits
1211 Payment
1212 Annual Statement of Account

Chapter 13 - Medicare (revised 2/25/2019)
1301 Overview of Medicare

Chapter 14 - Employee Death (revised 2/25/2019)
1401 How to Report an Employee Death
1402 Surviving Spouse and Dependents
1403 Surviving Spouse who is also an Employee Eligible for Coverage

Chapter 15 - Invoicing (revised 09/2014) (revised 2/25/2019)
1501 Viewing Your Invoice
1502 Reconciling Your Invoice
1503 Accepting and Paying Your Invoice (Wismart and Automated Clearing House (ACH))
1504 Late Interest Charge
1505 Who to Contact for Assistance

Chapter 16 – Glossary of Definitions (revised 2/25/2019)

Appendix A - Forms and Brochures (revised 2/25/2019)

Appendix B – Codes (revised 2/25/2019)
Employee Type Codes
Coverage Type Codes
Individual Relationship Codes
Health Plan Codes

Appendix C - myETF Benefits (revised 2/25/2019)
C-1 How to Log in to myETF Benefits
C-2 Add Coverage
C-3 Add Dependent
C-4 Remove Dependent
C-5 Change Health Plans
C-6 Termination of Coverage
C-7 Pending Transactions
C-8 Enrollment Inquiry
C-9 Dependent Inquiry
C-10 Address Inquiry
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 Employer Bulletins and manual 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 ETFSMBEmployerInsurance@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.
Chapter 1—Background Information

101 Applicable Policies, Statutes and Legislation

101 A) Wisconsin Statutory Authority: § 40.51

The State of Wisconsin Group Health Insurance Program is authorized by Wis. Stat. § 40.51 and is administered under the authority of the State of Wisconsin Group Insurance Board (BOARD). The program offers employees and 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.

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 It’s Your Choice Open Enrollment period. Coverage is then effective January 1 of the following year.

(b) Certain qualifying 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 Change Event Guide in the It’s Your Choice materials at etf.wi.gov or contact ETF’s Employer Communication Center at 1-877-533-5020 (toll free) or 1-608-266-3285.

A Notice of Privacy Practices is posted on ETF’s website (etf.wi.gov) and appears 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 and www.dol.gov/ ebsa/healthreform/.
102 Employer Agent Responsibilities

102 A) Designate a health insurance representative to:

(1) Sign up for e-mail updates for bulletins and announcements. We suggest that your organization also sign up for a shared, general e-mail address that may be accessed by others when the employer agent is unavailable. Sign up at http://etf.wi.gov/employer-updates.htm.

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

(3) Provide the It’s Your Choice Decision Guide (ET-2107), either paper or electronic, to all new hires and current subscribers prior to the annual It’s Your Choice Open Enrollment period and track when each employee received one.

(4) Provide information upon initial enrollment, It’s Your Choice Open Enrollment, continuation-conversion provisions and when applicable, Medicare.

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

(6) Run reports to determine eligibility for dependents turning age 26 including those who are disabled.

(7) Review, reconcile and pay monthly ETF invoices online by the 24th of each month. Refer to Chapter 15.

(8) 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.)

(9) Refer annuitant health insurance questions to ETF’s Employer Services Section, Retiree Health Insurance Unit.

(10) Refer questions regarding the contract to ETF (Refer to subchapter 106).

(11) Respond to health plan questions and audits in a timely manner.

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

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 (toll-free) or 1-608-266-3285 (local) 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 write or telephone ETF’s ombudsperson at the following:
ETF ombudspersons advocate for members and attempt to resolve complaints and problems on their behalf. If unsuccessful, the ombudsperson advises the member of subsequent avenues of appeal. Complaints should be made in writing, using the Insurance Complaint Form (ET-2405) whenever possible. Additional information regarding ETF ombudsperson services can be found under the “Members” section at etf.wi.gov.

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

### 106 Employer Services Section, 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 (ETF)

| Mailing Address       | P.O. Box 7931  
<table>
<thead>
<tr>
<th></th>
<th>Madison WI 53707-7931</th>
</tr>
</thead>
</table>
| Shipping Address      | Department of Employee Trust Funds  
|                       | 4822 Madison Yards Way  
|                       | Madison WI 53705-9100 |
| Telephone             | 1-877-533-5020 select option 2 (toll free)  
|                       | 1-608-266-3285 select option 2 (local Madison area) |
| TTY                   | 711 |
| Fax                   | 1-608-267-4549 |
| Website               | etf.wi.gov |
| E-mail                | ETFSMBEmployerInsurance@etf.wi.gov  
|                       | If you are sending demographic or sensitive documentation to ETF via e-mail, it must be sent secure. If you are unable to send secure, fax to ETF. |

**Office Hours**

7:45 a.m. to 4:30 p.m. Monday through Friday (except holidays)
106 B) Pharmacy Benefit Manager (PBM) Contact Information

<table>
<thead>
<tr>
<th>Office Address</th>
<th>Navitus Health Solutions, LLC</th>
</tr>
</thead>
</table>
| Mailing Address | Navitus Health Solutions, LLC  
P O Box 999  
Appleton, WI 54912-0999 |
| Telephone       | 1-866-333-2757 (toll free)    |
| Website         | https://www.navitus.com       |

106 C) Wellness and Disease Management Program Administrator Contact Information

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>The StayWell Company, LLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:wellwisconsin@staywell.com">wellwisconsin@staywell.com</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>1-800-821-6591 (toll free)</td>
</tr>
<tr>
<td>Website</td>
<td><a href="https://wellwisconsin.staywell.com">https://wellwisconsin.staywell.com</a></td>
</tr>
</tbody>
</table>
Chapter 2 — Health Plan and Program Requirements and Information

201 IYC Health Plans (HMOs, PPOs and HDHPs)
202 Access Plan
203 State Maintenance Plan (SMP)
204 Three Tier Premium Structure
205 Contribution Rates
206 Opt-out Incentive
207 Pharmacy Benefit Manager (PBM) – Navitus
208 Wellness and Disease Management Program Administrator - StayWell
209 Health Plan Contacts
210 Coordination of Benefits (COB)
211 Administration of Benefit Maximums
212 Errors
213 Premium Refunds due to Errors are Limited
214 Premium and Claim Adjustments
215 Benefits are Non-Transferrable

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 such as WEA)

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 IYC Medicare Plus plan offered to Medicare eligible retirees by WEA.

Uniform Benefits, as detailed in the It’s Your Choice 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. These materials are available at etf.wi.gov under the It’s Your Choice section. The latest It’s Your Choice Decision Guides (ET-2107 for actives and ET-2108 for annuitants and continuants) and the Certificates of Coverage online are the most reliable resources for details.

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

**201 B)** 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 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.

The HDHP is available to most employees and annuitants younger than age 65.

Ineligible members are:

1. Employees who are eligible for the graduate assistant/short term academic staff benefits package and are not in the WRS.
2. 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 or Tricare).

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. In order to remain in the HDHP/HSA they must file a request with the social security administration to delay Part A.*

While HDHP coverage levels are the same for IYC health plans, they differ in other ways, namely premium amount, provider network, benefit determinations and administrative requirements. Uniform Benefits and premium amounts change on an annual basis, so the latest It’s Your Choice Decision Guide online (ET-2107 for actives and ET-2108 for annuitants and continuants) are the most reliable resources for details.

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

**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 WEA Trust (WEA). 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 (higher benefit level) 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 (ET-2112) certificate of coverage for more details.

WEA 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 that meets all applicable state or federal requirements. To continue in the HDHP/HSA, an 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. In order to remain in the HDHP/HSA they must file a request with the social security administration to delay Part A., see 201 B.

203 State Maintenance Plan (SMP)

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 WEA.

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 and years of operation. To be qualified in a county, the health plan must offer 5 PCPs, a hospital if one is in the county and a chiropractor. In certain large cities, greater amounts of providers are required. 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.

Please look online at etf.wi.gov under the It’s Your Choice section or in the It’s Your Choice Decision Guide (ET-2107) 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.

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 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.

Craftworkers are not eligible as they are not eligible 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) form during It’s Your Choice 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 ETFSMBEmployerInsurance@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 Navitus MedicareRX (PDP) plan, which is underwritten by Dean Health Insurance Inc., a federally-qualified Medicare Part D prescription drug plan. In addition, these retirees will also have supplemental “Wrap” coverage that pays secondary to the Navitus MedicareRx (PDP) plan.

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

Pharmacy ID Cards

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

208 Wellness & Disease Management Program Administrator - StayWell

StayWell 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 screening, health assessment and a well-being activity are eligible to receive a $150 incentive. Some well-being activity options include: health coaching, disease management, Million Steps Challenge 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.

StayWell offers onsite health screenings and flu shot clinics for employers to host at their location. There is a minimum of 20 participants for each event. Employers may request events directly through StayWell.
209 Health Plan 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 under the It’s Your Choice section. See the Certificates of Coverage. 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.

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.

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).
301 Employee, Annuitant and Continuant Eligibility

EMPLOYEES, ANNUITANTS and CONTINUANTS shall become or be SUBSCRIBERS if they have filed with the EMPLOYER or the ET, if applicable, an application in the form prescribed by the 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 state employees: Active state and university employees participating in the Wisconsin Retirement System.
(2) Elected state officials.
(3) Members or employees of the legislature.
(4) Any blind employee 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.

301 B) Annuitants and Continuants (Former Employees/Dependents) For information related to accumulated sick leave conversion credit eligibility, see Chapter 12.

(1) Any insured employee who is retired on an immediate annuity, receives disability retirement, duty disability, 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).

(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 the It’s Your Choice Open Enrollment period in the fall (typically beginning in October) for coverage effective the following January 1, unless there is a HIPAA qualifying event (refer to subchapter 503 for qualifying events).

(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). Contact ETF for review of individual situations.
(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 G 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.

(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.

(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.

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 annually in the It’s Your Choice Decision Guide (ET-2107).

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: http://etfonline.wi.gov/etf/internet/employer/one.html.

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

(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, 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.
Chapter 4 — Initial Enrollment

401 Initial Enrollment and Effective Dates
402 Declining Coverage
403 Enrollment Opportunities for Employees who Previously Declined or Canceled Coverage
404 Applying for Coverage
405 Primary Care Provider or Primary Care Clinic
406 Insurance Cards

401 Initial Enrollment and Effective Dates

401 A) Immediately upon hire, employers must provide newly eligible employees with the current It’s Your Choice Decision Guide (ET-2107d) and the Health Insurance Application/Change Form (ET-2301). 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) 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 events creating enrollment opportunities (refer to subchapter 403), or during the annual It’s Your Choice Open Enrollment period for an effective date of January 1 of the following year.

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), the Children’s Health Insurance Program (CHIP), or Tri-Care. 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 Tri-care, 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 and plan coverage (for example BadgerCare).

3. A Health Insurance Application / Change form (ET-2301) 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 IT’S YOUR CHOICE Open Enrollment period for an effective date of January 1 of the following year or due to a qualifying 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 Event Change 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 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.

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.

*A Health Insurance Application/Change Form (ET-2301)*, 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. 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 vs. involuntary such as due to job loss)

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

(2) Marriage/Birth/Adoption/Permanent Legal Guardianship/ National Medical Support Notice/Paternity: 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—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.

(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: An employee in a WRS-covered position appointed to work fewer than 1,040
hours is eligible for less than half-time employer premium contributions and elects not to participate in health insurance coverage. The employee later receives an appointment, effective October 1, for 1,040 hours or 50% time. (Refer to note regarding number of hours in subchapter 303 B). The employee now has an additional enrollment opportunity due to this increase in hours. The employee can file an application on October 1 for coverage effective on October 1, or the employee can file the application with the employer on or before October 30, (30 days from being hired into the new appointment) for coverage effective on November 1.

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

4) 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 enrollment period for coverage effective the following January 1.

5) 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 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.

6) 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.)

404 B) Provide the employee with the It’s Your Choice Decision Guide (ET-2107) and the Health Insurance Application/Change Form (ET-2301) and/or show them where to locate those and all the It’s Your Choice materials on the ETF website at etf.wi.gov. Inform the employee of the deadline for submitting the application. Employees may also submit their application online via myETF Benefits 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 ebenebeneits 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.

(2) If employees are enrolling online via myETF Benefits, direct employees to the ETF website at 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), 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.

Subscribers can contact the health plan directly to change the physician or clinic.
Chapter 5 – Changing Coverage

501 Status Changes

502 Changing Plans Due to a Residential Move

503 Changing Health Plans

504 Changing from Single to Family Coverage

505 Changing from Family to Single Coverage

506 Adding Dependents

507 Removing Dependents

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 Status 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 Event Change Guide include:

1. Move from service area (change health plan or cancel coverage 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. Death of a dependent.
9. Spouse to spouse transfer.
10. Disability of dependent.
11. It’s Your Choice Open Enrollment period.

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 shall submit the application to ETF.
501 C) Changing the participant’s gender of record in myETF Benefits requires the participant to submit three documents to ETF. The documents provided must contain enough information, such as the participant’s name and birth date, to clearly identify the participant requesting the change. ETF is typically able to process requests within 30 days of receipt of the required documentation. ETF will send the participant notification of the effective date of the change. See below for submittal instructions.

(1) **Written request:** The participant must submit a request in writing that contains the participant’s full name (if changing, provide new and former name) and either the participant’s ETF member number or date of birth, along with a clear statement of the participant’s intent to change the recorded gender in myETF Benefits. Please include the gender the participant is requesting the records be changed to. This request may be in the form of a letter or email.

(2) **Proof of identity:** Submit a copy of one of the following documents. The document must be current (not expired) and show name and birth date or age:
   a. U.S. driver’s license
   b. State-issued non-driver identification card
   c. U.S. passport
   d. Employee identification card
   e. School identification card
   f. U.S. military identification card

(3) **Proof of gender:** Submit a copy of one of the following documents. The document must be current (not expired):
   a. U.S. driver’s license showing the new gender
   b. U.S. passport showing the new gender
   c. State-issued amended birth certificate showing the new gender*
   d. Court order directing legal recognition of change of gender
   e. Medical certification of appropriate clinical treatment for gender transition in the form of an original letter from a licensed medical provider. The medical certification letter must include all of the following:
      i. A statement that clinical treatment is being given
      ii. The date treatment began
      iii. The participant’s name and birth date
      iv. The medical provider’s name, address and phone number

* Wisconsin’s vital records law does not allow ETF to request and accept a photocopy that the participant has made of the participant’s Wisconsin-issued birth certificate. If the participant would like to use a Wisconsin-issued birth certificate as proof of gender, the participant has two options. The first option is to show the certified birth certificate to the participant’s employer. The employer can legally photocopy it, mark it “for administrative purposes” and send the copy to ETF. The second option is to send a certified copy of the participant’s amended Wisconsin-issued birth certificate to ETF directly.

(4) **Document Submittal Instructions** After gathering the above listed items, the participant may submit them as follows:
   a. **Active employees and dependents:**
      i. Submit the documents 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.
   b. **Retirees and dependents:** Submit the documents to ETF via postal mail, in person or email:
      U.S. Postal Service: WI Dept of ETF, P.O. Box 7931, Madison WI 53707-7931.
      In Person: WI Dept of ETF, 4822 Madison Yards Way, Madison, WI 53705-9100
      Email: etfsmbemployerinsurance@etf.wi.gov
502 Changing Plans Due to a Residential Move

When a SUBSCRIBER moves to another county or out of state for a minimum of three months, they have an enrollment opportunity to change health plans, even if their current plan remains available in the county to which the 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 Group Health Insurance Application/Change Form (ET-2301) to their employer (ETF for annuitants) within 30 days after the move. The new plan selected must have in-network providers in the county the SUBSCRIBER moved to as shown in the annual It’s Your Choice materials (refer to Service Areas and Provider Directory information). If the employee moved to a state that does not border Wisconsin, they will be limited to 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 application Group Health Insurance Application/Change Form by the employer.

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

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

503 Changing Health Plans

As required by federal law, an insured EMPLOYEE or CONTINUANT who is adding one or more DEPENDENTS to the policy due to marriage, birth, adoption, placement for adoption, loss of other coverage or complete loss of EMPLOYER contribution for the other coverage may change HEALTH PLANS after the event if an application is submitted within 30 days of the event. This enrollment opportunity also applies when adding a dependent due to a National Medical Support Notice or establishment of paternity. This also applies to ANNUITANTS as if federal law required it. Coverage with the new HEALTH PLAN will be effective the first day of the calendar month, which begins on or after the date the EMPLOYER receives the application selecting the new HEALTH PLAN.

504 Changing from Single to Family Coverage

504 A) An EMPLOYEE can change from single to family coverage in several situations outside of the annual It’s Your Choice Open Enrollment period. An ANNUITANT can make changes at any time since they pay their premiums post-tax.

The following are qualifying HIPAA events or are otherwise permissible:

(1) Birth.
(2) Adoption.
(3) Placement for adoption.
(4) Marriage.
(5) Receives a National Medical Support Notice or paternity acknowledgment.
(6) Transfer of custody
(7) Establishes a permanent legal guardianship.
(8) Loss of other coverage.
(9) Loss of entire employer contribution,
(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.

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 Group Health
Insurance Application/ Change Form (ET-2301) 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 It’s
Your Choice 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 It’s Your Choice Open Enrollment period unless another qualifying
event occurs in the interim.
Note: An application or online enrollment must be completed in a timely manner.

If the subscriber is single, documentation supporting the birth is required. For single mothers, this documentation is generally a birth certificate and will be required for any children born after 1/1/2019. 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 prior to 1/1/2019 upon request from ETF to the employer.

Documentation supporting the adoption, placement for adoption or the establishment of permanent legal guardianship is required as outlined in the Group Health Insurance Application/Change Form.

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) Loss of Coverage or Complete Loss of Employer Contribution: Application must be received within 30 days before or after a dependent has a loss of coverage or employer contribution. 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 Group Health Insurance Application/Change Form (ET-2301).

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:
   
   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 vs. involuntary such as due to job loss)

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 Group Health Insurance Application/Change Form.

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) 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) 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 Health Insurance Application/Change Form.

505 Changing from Family to Single Coverage

An employee can change from family to single coverage in several situations outside of the annual It’s Your Choice Open Enrollment period, provided they have experienced a family status change/event that allows the change under the plan or they have experienced a HIPAA qualifying event. An employee can change from family to single coverage if their premiums are deducted pre-tax and they experience a HIPAA qualifying event or a status change such as a divorce, their last dependent becomes ineligible for the coverage, all dependents become eligible for and enroll in other coverage, or their last eligible dependent becomes eligible for and enrolls in other coverage. 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) 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 *Health Insurance Application/Change Form*. 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 e-mail 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 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 It’s Your Choice 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 Health Insurance Application/Change Form.

506 Adding Dependents

Dependents can be added to an existing family contract outside the annual It’s Your Choice Open Enrollment period for the following reasons. Several of these events also allow the employee to change health plans under Internal Revenue Code Section 125.

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 may not be added to coverage until It’s Your Choice Open Enrollment, unless another qualifying event occurs in the interim. Refer to “Eligible Dependent Left Off Original Application” below for exceptions.

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 or Establishment of Permanent Legal Guardianship: If family coverage is already in place, the application to add the child(ren) or ward(s) must be received within 60 days after the event. 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 It’s Your Choice Open Enrollment period unless they have another qualifying 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 Group Health Insurance Application/Change Form.

If the subscriber is single, documentation supporting the birth is required. For single mothers, this documentation is generally a birth certificate and will be required for any children born after 1/1/2019. 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 prior to 1/1/2019 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.

506 C) Dependent Loss of Other Coverage or Complete Loss of Employer Contribution: If family coverage is in place, an application must be received within 30 days before or after a dependent has a loss of other coverage or 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 It’s Your Choice Open Enrollment period unless another qualifying event occurs in the interim. Refer to “Eligible Dependent Left Off Original Application” below for exceptions.

Documentation supporting the loss of coverage or employer contribution is required as outlined in the Health Insurance Application/Change Form. ETF requires documentation including the following items on letterhead from the previous insurer and/or the former employer where at least the insurer’s document is dated and issued after termination of coverage. If separate parts of the information are provided from both the employer and the former insurer on different dates, (for example, your employee who lost coverage through his spouse provides a COBRA form from his spouse’s former employer stating why coverage ended that is dated prior to the termination date, and the former insurer issues a letter after the termination date stating that coverage terminated on a preceding date), that assortment of documentation is acceptable. The documentation on letterhead must include:

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

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 Health Insurance Application/Change Form (ET-2301).

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 NSMN, 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) 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) 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 G) Eligible Dependent Left Off Original Application: If family coverage is already in place, dependents who were left off the original application can be added to coverage prospectively if the following requirements are fulfilled in compliance with 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 H) 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 It’s Your Choice Open Enrollment period. These include the following reasons:

507 A) Divorce: Upon divorce, either a Health Insurance Application/Change Form (ET-2301) 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 Health Insurance Application/Change Form.

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.

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

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

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). Coverage will terminate at the end of the month following receipt of the electronic request or paper application. If not received within 30 days, the employee will not be able to remove their dependent until the annual It’s Your Choice Open Enrollment period, even if this would result in the employee dropping to single coverage as they are their last eligible dependent.

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

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.

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 507, 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.
Chapter 6 — It’s Your Choice Open Enrollment

601 It’s Your Choice Open Enrollment Eligibility

602 Withdrawing/Rescinding It’s Your Choice Enrollment Elections

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

604 Late It’s Your Choice Applications

601 It’s Your Choice Open Enrollment Eligibility

601 A) Establishing IT’S YOUR CHOICE Open Enrollment

(1) The BOARD shall establish enrollment periods, called the IT’S YOUR CHOICE 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 ITS YOUR CHOICE enrollment period shall be held once annually in the fall of each year with coverage effective the following January 1.

(2) It’s Your Choice Open Enrollment provides an annual opportunity for uninsured employees to apply for new health insurance coverage and currently insured subscribers to change from one health plan to another, drop or add an adult dependent (age 19 or older), 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 IT’S YOUR CHOICE 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 IT’S YOUR CHOICE 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 IT’S YOUR CHOICE enrollment period for coverage effective the following January 1. Their parent must submit an application to remove them from coverage during the annual IT’S YOUR CHOICE enrollment period.

(6) A retired EMPLOYEE of the state who is receiving a retirement annuity or has received a lump sum payment under Wis. Stat. § 40.25 (1); 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) It’s Your Choice Open Enrollment Period

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

601 C) Participation in the It’s Your Choice Open Enrollment Period

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

(1) To enroll, the employee must be eligible for and 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) (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) to the employer within the designated It’s Your Choice 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.

601 D) Distribution of It’s Your Choice Decision Guide and materials

The It’s Your Choice Decision Guides (ET-2107 (actives) and ET-2108 (annuitants and continuants)) provide information on important changes, health insurance rates, uniform benefits and plan availability for the plan year. The guides are forwarded to state agencies electronically prior to the It’s Your Choice Open Enrollment period for distribution to all eligible employees, insured and uninsured (including those on leave of absence and layoff). ETF has guides mailed directly to ANNUITANTS and CONTINUANTS. There is a limited supply of paper It’s Your Choice Guides available; employers are encouraged to direct employees to the electronic version found on ETF’s website at etf.wi.gov. The It’s Your Choice 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 the It’s Your Choice box checked as the reason for submitting the application.

601 F) 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 G) 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 IT’S YOUR CHOICE 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 IT’S YOUR CHOICE 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 IT’S YOUR CHOICE 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 or has received a lump sum payment under Wis. Stat. § 40.25 (1); 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.

(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 IYC 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 It’s Your Choice Enrollment Elections

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

602 A) If the employee submitted their It’s Your Choice election on a Health Insurance Application/Change Form (ET-2301) 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 It’s Your Choice

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

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 Bulletins, e-mail updates, and the It’s Your Choice 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 It’s Your Choice 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 It’s Your Choice Applications

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

1. Employee submits application after the end of the It’s Your Choice Open Enrollment period.
2. Employer rejects and returns late application to employee with instructions on requesting review. A sample letter informing an employee of this process is found in subchapter 605.
3. Employee submits a written request (letter or e-mail) for ETF review to the employer no later than January 31 following the It’s Your Choice Open Enrollment period.
4. Employee includes in the letter or e-mail the facts or circumstances regarding the reason(s) their application is being filed late and the remedy being sought.
5. Employer develops a cover memo, letter or e-mail addressed to ETF detailing the process used to distribute It’s Your Choice materials and information to employees, the date of receipt of the employee’s It’s Your Choice application, and any pertinent facts that either supports or does not support the employee’s request.
6. Employer sends a copy of the employee’s late It’s Your Choice Group Health Insurance Application, the original employee’s letter or e-mail requesting a review, and the employer cover memo, letter or email to:
DIVISION OF INSURANCE SERVICES  
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 e-mailed using encryption to: ETFSMBEmployerInsurance@etf.wi.gov. The cover sheet or subject line should be titled “Late It’s Your Choice Application”.

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

605 Late It’s Your Choice Review Sample Letter

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

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

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

(2) Prepare a written request detailing the circumstances and facts surrounding the reason for your late application and the remedy you are seeking.

Submit your written request to our office at the address noted above by January 31. Do not submit your request directly to the Department of Employee Trust Funds.

(1) We will review your request for completeness and attach any pertinent documentation.

(2) We will submit your request, your health insurance application, and other documentation to the Department of Employee Trust Funds for review.

(3) The Department of Employee Trust Funds will review the materials and issue you a letter either approving or denying your request.

If you have questions, please contact (NAME) at (TELEPHONE NUMBER).
Chapter 7 — 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. The employee goes on LOA effective September 5. The employer
and employee premium will be paid for September by the employer on the 24th. The employer share continues for October, November, and December.

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

Insured employees on an unpaid leave of absence (LOA) choose whether to continue health insurance coverage during their LOA. 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.

(1) Employee returns to active performance of duty and their LOA ends within the first four months after beginning a LOA. The following applies to employees returning to active performance of duty:

(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).
(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) Employee returns to active performance of duty and the LOA ends more than four months after beginning the LOA. The following applies to employees returning to active performance of duty:

(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).

(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.

(a) The maximum length of time coverage can be continued for an employee on LOA is 36 months. After 36 months, or upon termination (whichever occurs first), coverage may be continued under continuation coverage (COBRA) regulations. (Refer to Chapter 9 for information about COBRA.)

(b) Premiums must be paid by the employee in advance, either by deduction from the last payroll check or by direct payment to the employer. Employers must receive premium payments in advance of the coverage month.

(c) 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.

(d) 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.

(e) Employers must provide It’s Your Choice information to employees on LOA prior to the beginning of the designated It’s Your Choice Open Enrollment period.

(f) 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.

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 the employee files an application to cancel coverage they are not eligible to enroll upon return to work; the coverage must lapse, not be terminated voluntarily.

704 B) 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.

704 C) Employee allowed their health insurance coverage to lapse while on LOA. The following applies upon returning to active performance of duty:

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. 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.

   a. The employee is limited to the same health plan and level of coverage they were enrolled in prior to their LOA. See the three bullet points that follow for exceptions to this requirement.

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

   c. Employee who moved while on a LOA may change health plans upon return to work.

   d. Employee who returns from a LOA that encompassed the entire previous It’s Your Choice Open Enrollment period and files an application within 30 days of returning to work, may make changes to the coverage they had prior to their LOA.

   e. Employee who did not file an application within 30 days of returning to work cannot re-enroll in coverage until the next It’s Your Choice Open Enrollment period or when a qualifying event occurs (e.g., marriage, birth, etc.), whichever occurs first. Refer to Chapter 4, subchapter 403 other enrollment opportunities.
The coverage effective date for employees returning from military leave or Family Medical Leave of Absence (FMLA) is the date the employee returns to work provided an application is filed with the employer within 30 days of returning to work. A full month’s premium is due for that month if coverage is effective before the 16th of the month. If coverage is effective on the 16th or later, the entire premium is waived for that month.

(2) Employee must indicate coverage to be effective “As Soon As Possible” or “When the Employer Contributes toward Premium” on the application.

(a) 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) 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).

(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).

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. Employee goes out on a LOA June 10.
   ii. If the employer collects pre-paid premiums, employee is eligible for employer contribution toward the health insurance premium for the coverage month of July plus August, September and October. Coverage ends/lapses October 31.
   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 June plus July, August and September. Coverage ends/lapses September 30.
   iv. Employee returns to active performance of duty on February 1.
   v. 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.
   vi. Coverage is effective February 1.
   vii. LOA ends March 3; Wis. Stat. § 40.02 (40).
   viii. Employee must pay the entire premium for the coverage month of February.
ix. Employee is eligible for the employer contribution toward the health insurance premium for the coverage month of March, the month the employee’s LOA ends.

x. 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. Employee goes out on a LOA June 10.

ii. If the employer collects pre-paid premiums, employee is eligible for employer contribution toward the health insurance premium for the coverage month of July plus August, September and October. Coverage ends/lapses October 31.

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 June plus July, August and September. Coverage ends/lapses September 30.

iv. Employee returns to active performance of duty on February 1.

v. 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.

vi. LOA ends March 3; Wis. Stat. § 40.02 (40).

vii. Employee becomes eligible for the employer contribution toward premium on March 3.

viii. Coverage is effective April 1, first of the month on or after becoming eligible for the employer contribution toward premium.

ix. Employee is only required to pay the required employee share of the monthly premium for the coverage month of April going forward.

(c) Additional information regarding employees whose health insurance coverage lapsed during an approved LOA:

i. 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.) Employees may change health plans if the change results from a move to a different county during the LOA.

ii. An employee who allows coverage to lapse and returns from a LOA that encompassed the entire previous It’s Your Choice Open Enrollment period will be allowed an It’s Your Choice enrollment opportunity provided an application is filed with the employer within 30 days of the employee’s return to active performance of duty.

iii. 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.

iv. EMPLOYEES shall also have the 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.
(d) The following are examples of situations of FMLA that may be encountered:

i. 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.

ii. 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 30 consecutive calendar days for an accumulation of hours of at least 50% of their appointed employment.

### 705 Coverage During Military Leave

#### 705 A) Wisconsin Act 162 (enacted March 17, 2004)

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, 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.

The employee or designated representative may elect within 60 days after being activated to receive benefits resulting from this legislation 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 cancel state coverage. Upon release from active duty, 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)**. The 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 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, 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) 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.

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.

2) Employee 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 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 more information on sick leave, refer to Chapter 12 - Accumulated Sick Leave Conversion Credits.)

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 as provided for under Wis. Stats. § 40.02 (56) and 40.03 (6) (g).

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 It's Your Choice Open Enrollment period, the employee must be given an It's Your Choice opportunity. It's Your Choice information should be sent to those employees who are on layoff prior to the beginning of the designated It’s Your Choice Open Enrollment
period.

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) and is limited to the same health plan and level of coverage as before the layoff. The application must be received within 30 days of the employee’s return to work. Coverage is effective the first of the month following the employer’s receipt of the completed Group Health Insurance Application. After 30 days, enrollment is limited to the It’s Your Choice Open Enrollment period or if there is another qualifying event that occurs.

2) The employee may change level of coverage only if a special enrollment opportunity (e.g., marriage, birth, etc.) occurs during the layoff. (Refer to Chapter 4, subchapter 403 for information about special enrollment opportunities.)

3) Employees moving to a different health plan service area during a layoff may change health plans.

4) An employee who returns from a layoff that encompassed the entire previous It’s Your Choice Open Enrollment period will be allowed an open enrollment opportunity provided an application is filed with the employer within 30 days of the employee’s return to work.

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. Within 30 days of the date of discharge the EMPLOYEE must submit to the EMPLOYER the initial PREMIUM payment to keep the coverage in force. Additional payments may be made until a determination has been reached, but shall be submitted to the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS were previously paid.

707 B) If the final decision is adverse to the EMPLOYEE, the date of termination of employment shall, for purposes of health care coverage, be the end of the month in which the decision becomes final by expiration without appeal of the time within which an appeal might have been perfected, or by final affirmation on appeal.

707 C) The PREMIUMS referred to in this section shall be the gross amount paid to the HEALTH PLAN for the particular coverage, including the pharmacy and administrative fees. The EMPLOYEE shall be required to pay any amounts normally considered the EMPLOYER portion, the EMPLOYER shall refund to the EMPLOYEE any amounts paid in excess of the normal EMPLOYEE contribution if their discharge is overturned.

707 D) 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
(4) The employee must pay both the employee and employer share of premium due each month until the appeal is resolved.

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

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

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

If the discharge is for reasons other than gross misconduct, the employee is eligible to continue health insurance for the balance of 18 months from the original termination date (the balance of the continuation period). If the discharge is for gross misconduct, the employee is eligible for conversion coverage and should contact the health plan for information on benefits, rates and policy provisions. (Refer to Chapter 9 for information about continuation and conversion.) 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 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 five months 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.
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

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. 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.

(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 Tri-Care 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.

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 STANDARD 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 STANDARD 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 or rescind coverage, except to the extent attributable to a failure to pay timely premiums towards coverage. 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 212.

801 G) Upon determination that a SUBSCRIBER is ineligible for the HIGH DEDUCTIBLE HEALTH PLAN (HDHP), coverage shall revert to the regular Uniform Benefit with the same HEALTH PLAN retroactive to either January 1 of the plan year in which the eligibility error was discovered, or the HDHP effective date if after January 1 of the current plan year. PREMIUMS and claims shall be retroactively adjusted.

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

<table>
<thead>
<tr>
<th>Reason</th>
<th>Coverage End Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancel Coverage</td>
<td>Refer to subchapter 804</td>
<td>Employee is voluntarily ending coverage. Refer to subchapter 804 regarding Internal Revenue Code (IRC) Section 125 pre-tax and post-tax requirements. If employee does not pay required premiums while out on a leave of absence (LOA), this is a cancellation, voluntarily ending coverage.</td>
</tr>
<tr>
<td>Termination of Employment</td>
<td>End of the calendar month in which the employee terminates employment.</td>
<td>Employee’s coverage is an involuntary loss of coverage. If employee is terminating employment because they are retiring, going on an unpaid LOA or on permanent layoff, but is not starting an immediate annuity, refer to Chapter 12 regarding reporting sick leave.</td>
</tr>
<tr>
<td>Termination of Employment prior to effective date of coverage</td>
<td>The application is void and any premiums paid or deducted will be refunded.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Cancel Spouse-To-Spouse Employment
Refer to subchapter 804

<table>
<thead>
<tr>
<th>Reason</th>
<th>Coverage End Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Approval (Non-ICI)</td>
<td>Coverage is continued as an annuitant without lapse upon approval of a disability benefit.</td>
<td>This is an employer entry in myETF Benefits. No application to end coverage is required from employee. ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs. Refer to subchapter 803. Also, refer to Chapter 12 for reporting sick leave.</td>
</tr>
<tr>
<td>Retirement</td>
<td>Coverage is continued as an annuitant without lapse upon retirement if an employee retires with an immediate annuity.</td>
<td>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. ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs. Refer to subchapter 803. Also, refer to Chapter 12 for reporting sick leave.</td>
</tr>
<tr>
<td>Death of Subscriber with Single Coverage</td>
<td>End of the calendar month in which the death occurred.</td>
<td>Refund any premiums paid in advance for coverage beyond the end of the month in which death occurred.</td>
</tr>
<tr>
<td>Death of Subscriber with Family Coverage</td>
<td>Coverage under the employee’s contract continues through the last day of the month for which the premium was deducted.</td>
<td>Do not refund any premiums unless authorized by ETF. Refer to Chapter 12 for reporting sick leave. Refund may be due if coverage was paid for the next month. Coverage automatically continues for survivors.</td>
</tr>
</tbody>
</table>
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 Chapter 12). 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 Cancelation of Coverage

When an employee wishes to cancel coverage for any of the reasons listed in subchapter 801, they cannot complete their request mid-year without an eligible family status change that is allowed under the plan language (contract) or a HIPAA qualifying 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.

<table>
<thead>
<tr>
<th>Event</th>
<th>Eligibility Requirements</th>
<th>Coverage End Dates</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move from Service Area</td>
<td>Health Insurance Application (ET-2301) or electronic enrollment request must be submitted within 30 days of the move from the service area date.</td>
<td>End of the month following receipt of the application/electronic enrollment request or the event date, whichever is later.</td>
<td>The coverage end date for a cancelation request is always the end of a month. Retroactive cancelations are not allowed.</td>
</tr>
<tr>
<td>Pre-Tax Employee Terminating Employment</td>
<td>Health Insurance Application or electronic enrollment request must be no later than the month employment terminates. The event date is the date employee terminates</td>
<td>End of the month following receipt of the application/electronic enrollment request or the event date, whichever is later.</td>
<td>The coverage end date for a cancelation request is always the end of a month. Retroactive cancelations are not allowed.</td>
</tr>
<tr>
<td>Event</td>
<td>Eligibility Requirements</td>
<td>Coverage End Dates</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pre-Tax Employee Going on an Unpaid LOA</td>
<td>Health Insurance Application or electronic enrollment request must be later than the month employee goes on a LOA. The event date is the date employee begins a LOA.</td>
<td>End of the month following receipt of the application/electronic enrollment event date, whichever is later.</td>
<td>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 cancelation request is always the end of a month. Retroactive cancelations are not allowed.</td>
</tr>
<tr>
<td>Pre-Tax Family Status Change</td>
<td>An allowed family status change under the plan language (contract) or a HIPAA qualifying event must occur. Group Health Insurance Application/ Change Form or</td>
<td>End of the month following receipt of an application/ request or the event date, whichever is later.</td>
<td>Refer to Chapter 5 for status changes allowed under the plan language (contract) and HIPAA qualifying events. Documentation may be required.</td>
</tr>
</tbody>
</table>
myETF electronic enrollment request must be submitted within 30 days of the IRC Section 125 status change, the event.

If an allowed family status change has not occurred, an employee can submit an application in October, November or December requesting coverage to be canceled effective December 31. Coverage end date for a cancelation request is always the end of a month. Retroactive cancellations are not allowed.

<table>
<thead>
<tr>
<th>Event</th>
<th>Eligibility Requirements</th>
<th>Coverage End Dates</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums Deducted Post Tax</td>
<td><em>Health Insurance Application</em> or myETF Electronic enrollment be submitted.</td>
<td>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.</td>
<td>An application can be submitted requesting a future cancelation date other than the end of the month following receipt of the application. Coverage can be canceled mid-year. Coverage end date for a cancelation request is always the end of a month. Retroactive cancellations are not allowed.</td>
</tr>
</tbody>
</table>
Chapter 9 – COBRA, Continuation and Conversion

901 Overview of COBRA, Continuation and Conversion

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

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 event,” employees and their covered dependents become “qualified beneficiaries” and must be offered continuation coverage (refer to subchapter 905 for employer responsibilities).

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 events:

1) Death of spouse (employee). (Refer to Chapter 14 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 events:

1) Death of parent/stepparent (employee; refer to Chapter 14 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.

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 event in which an 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.

Children born or adopted while the parent is continuing group coverage may also be covered for the remainder of the parent's period of continuation. A participant who has single coverage must elect family
coverage within 60 days of the birth or adoption in order for the child to be covered. The HEALTH PLAN will automatically treat the child as a qualified dependent, as required by COBRA and provide any required notice of COBRA rights. See section 1402 C), however COBRA coverage ends for all qualified beneficiaries when the maximum COBRA duration has been met.

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) 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.

COBRA coverage ends when the subscriber or dependents enroll in Medicare Parts A and B. If Part B becomes effective after the continuation begins, the continuation period ends at the end of the month prior to when Medicare Parts A and B become effective for the Medicare eligible subscriber or dependent.

905 Employer Responsibilities

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

1) Continuation - Conversion Notice (ET-2311), with the employer sections completed.

2) Group Health Insurance Application (ET-2301). This form is needed to enroll in continuation or conversion. The employee does not need to complete the application if continuing the coverage already in effect. The employee must still complete and return the Continuation - Conversion Notice.

Note: A continuation notice must be provided within the five-day period even when it is determined the qualified beneficiary is not entitled to continuation coverage, for example, notice of the qualifying event was not provided to the employer within the required time period. (Refer to subchapter 906 for information on providing notice.)
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 or will move to a different county for more than three months, they are eligible to change to another health plan without restrictions, provided the application is received within 30 days after the move. The application must be returned to the employer if the change would be effective before the termination of coverage paid through the employer; otherwise, the application must be returned to ETF.

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:

<table>
<thead>
<tr>
<th>Event</th>
<th>Occurs</th>
<th>Coverage Continues Until</th>
<th>Employee or Beneficiary Must Notify Employer By</th>
<th>Employer Must Provide Continuation Notice By</th>
<th>To Elect Continuation, Application Must Be Submitted To ETF By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child (or stepchild, DP’s dependent) turns 26 and is not disabled.</td>
<td>3/15</td>
<td>3/31</td>
<td>N/A*</td>
<td>5 days after receipt of notice</td>
<td>The later of 60 days after coverage terminates or 60 days after employer issues <a href="#">ET-2311</a>.</td>
</tr>
<tr>
<td>Dependent of Minor Eligibility Ends as Dependent turns 18</td>
<td>03/15</td>
<td>03/31</td>
<td>N/A*</td>
<td>5 days after receipt of notice</td>
<td>The later of 60 days after coverage terminates or 60 days after employer issues <a href="#">ET-2311</a>.</td>
</tr>
</tbody>
</table>

* Employer must check for aging out dependents monthly. See Appendix.
### 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

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
<th>Date 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Status Terminates for &gt;26-Year-Old Dependent</td>
<td>03/15</td>
<td>03/31</td>
<td>05/30</td>
<td>5 days after receipt of disability Status change letter</td>
</tr>
<tr>
<td>Divorce Decree is Entered</td>
<td>03/15</td>
<td>End of the month in which continuation notice is given</td>
<td>05/30</td>
<td>If continuation notice is given late, check with ETF.</td>
</tr>
<tr>
<td>Employee Terminates Employment</td>
<td>03/15</td>
<td>03/31</td>
<td>N/A</td>
<td>5 days after receipt of notice</td>
</tr>
</tbody>
</table>
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 It’s Your Choice Open Enrollment period or following a residential move out of the county.

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

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

Continuants may elect to convert to individual coverage (conversion at non-group rates) upon reaching the maximum continuation coverage period. Continuants are responsible for knowing when group continuation coverage ends and must contact their health plan directly to make application for conversion coverage set forth in Wis. Stat. §632.897 and/or Marketplace plan as provided by the health plan.
Chapter 10 — Retirement or Disability

1001 Coverage – Requirements to Continue
1002 Coverage for Former State Employees Whose Coverage Lapsed
1003 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 Chapter 12 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.

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.

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 be 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, ETF will notify the employer of the disability retirement or duty disability benefit. The employer will then need to terminate the employee from active coverage. (Refer to Chapter 8.) ETF also will send the employee a letter and a Group Health Insurance Application (ET-2301) 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 Continuation– Conversion Notice (ET-2311) to ETF within 90 days of the termination of employment if the terminated EMPLOYEE is not eligible for an immediate annuity. (Refer to Chapter 9.)

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 Chapter 12) 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 Continuation-Conversion Notice 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.
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 Premium Payment

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

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

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

3) Direct Pay - When the annuity is not sufficient to cover the entire premium or the member only receives duty disability or Long-Term Disability Insurance (LTDI) benefits, the health plan will directly bill the subscriber, and the subscriber will pay premiums directly to the health plan.

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

ETF may authorize PREMIUM payments to be made directly to the HEALTH PLAN where circumstances require such without member notification. Failure to make required PREMIUM payments by the due dates established by the HEALTH PLAN and approved by ETF shall cause the health care coverage to be canceled.
Chapter 11 — Rehired Annuitants

1101 Eligibility

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

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

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

Any retiree health insurance the 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) electing coverage must be received by the employer within 30 days following the WRS participation begin date. When the employee retires again, refer to Chapter 12 for instructions on continuation of health insurance coverage, as the former annuitant is now considered an active employee.

A rehired annuitant electing to return, or statutorily required to return, to active WRS participation, but not electing to enroll in health insurance through the active employer ceases to be eligible for annuitant health coverage.

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) 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.
Chapter 12 — Accumulated Sick Leave Conversion Credits (ASLCC)

1201 Accumulated Sick Leave Conversion Credit Program
1202 Eligibility
1203 Enrollment Opportunities
1204 Unpaid Leave/Temporary Layoff
1205 Permanent Layoff
1206 Permanent Layoff Sick Leave Conversion Reference Chart
1207 Accumulated Sick Leave and Chapter 40 Terminations
1208 Certifying Credits through the Online Accumulated Sick Leave System (AcSL)
1209 Generating a Sick Leave Credit Estimate through the Online Accumulated Sick Leave System (AcSL)
1210 Escrow of Sick Leave Credits
1211 Payment
1212 Annual Statement of Account

1201 Accumulated Sick Leave Conversion Credit Program

1201 A) In accordance with Wis. Stats. §§ 40.95 & 40.05(4)(b) & (bc), eligible employees can convert accumulated sick leave hours to a dollar-based credit to pay premiums for coverage under the State Group Health Insurance Program (if an applicable compensation plan or collective bargaining agreement provides for sick leave conversion).

Accumulated sick leave is converted to credits only for the payment of state group health insurance premiums. The sick leave credits are computed as Hours x Highest Basic Pay Rate = Sick Leave Credits. The “highest basic pay rate” for purposes of calculating accumulated sick leave conversion is the highest hourly rate at which the employee accrued sick leave that is eligible for conversion under s. 13.121(4), s. 36.30, s. 230.35(2), s. 238.04(8), or s. 757.02(5). In essence, for a pay rate to be used in the calculation, an employee must have earned sick leave eligible for conversion at that pay rate. Pay for service such as limited term employment, or project employment that does not provide sick leave, cannot be used as an employee’s highest basic pay rate.
1202 Eligibility

The following individuals are eligible to use sick leave credits to pay for post-termination health insurance coverage:

1202 A) A terminated, vested employee (per Wis. Stat. § 40.05 (4) (b)) enrolled in the State Group Health Insurance Program at time of termination who:

1) Retires with an immediate monthly annuity or retirement lump sum benefit that has an effective date within 30 days of termination; or
2) Terminates employment at age 55 or older (50 for protective category employees) and has 20 years of creditable WRS service; or
3) Qualifies for disability retirement benefits under Wis. Stat. §40.63, duty disability benefits under Wis. Stat. §40.65, or Long-Term Disability Insurance (LTDI) benefits under Wis. Admin. Ch. ETF 50.

1202 B) An eligible surviving spouse and/or dependents (per Wis. Stat. § 40.05 (4) (be)). Eligibility for a survivor to use these sick leave credits may be dependent upon whether the employee was covered by a state group health insurance family policy on the date of death. Refer to the Sick Leave Conversion Credit Program (ET-4132) brochure for more information.

An eligible survivor who was covered under the employee’s state group health insurance family policy on the date of the employee’s death will automatically continue coverage. ETF will process the continuation.

1202 C) A vested employee (per Wis. Stat. § 40.02 (25) (b) (6e) and (6g) who, at the time of termination, was a(n):

1) State constitutional officer.
2) Member or officer of the Legislature.
3) State agency head or administrative official appointed by the governor with senate confirmation.
4) Head of certain legislative service agencies.
5) Employee with 20 years of WRS creditable service, who terminated before their minimum retirement age and did not elect a WRS separation benefit.

Note: For these employees, accumulated sick leave credits may be preserved upon termination of employment. Vesting requirements and eligibility to use sick leave credits will be reviewed by ETF when the employee applies for a WRS retirement benefit.

1202 D) Employee on unpaid leave (Refer to subchapter 1204.)

1202 E) An employee on permanent layoff (Refer to subchapter 1205.)

In all situations above, at the time of termination the employer must certify the employee’s accumulated sick leave through the online Accumulated Sick Leave system (AcSL). Refer to subchapter 1207.

1203 Enrollment Opportunities
PARTICIPANTS who have escrowed their sick leave or have their sick leave preserved as provided for in statute may reenroll with any HEALTH PLAN without underwriting restrictions as follows:

1203 A) Coverage for those who have escrowed under Wis. Stat. § 40.05 (4) (b) and (bc) may enroll during the IT'S YOUR CHOICE enrollment period and be effective the first day of the month selected by the PARTICIPANT of the following year.

1203 B) For the PARTICIPANTS defined in Wis. Stat. § 40.02 (25) (b) (6e) and (6g) whose sick leave has been preserved under Wis. Stat. § 40.05 (4) (bc), coverage will begin on the first of the month following ETF's receipt of the health insurance application, unless otherwise specified on the application.

1203 C) PARTICIPANTS losing eligibility for other coverage or the EMPLOYER'S contribution towards the other coverage ceases, may elect coverage under any HEALTH PLAN by filing an application with ETF within 30 days of the loss of eligibility, or notice of loss of eligibility, and by providing evidence satisfactory to ETF of the loss of eligibility. A PARTICIPANT enrolled for single coverage, though eligible for family coverage, may change to family coverage if any eligible DEPENDENTS are covered under the other plan and 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. Coverage shall be effective on the date of termination of the prior plan or the date of the event. A full month's PREMIUM is due for that month if coverage is effective before the 16th of the month. Otherwise the entire PREMIUM for that month is waived.
1204 Unpaid Leave / Temporary Layoff

1204 A) Unpaid Leave of Absence:

<table>
<thead>
<tr>
<th>Length of Coverage Availability</th>
<th>Payment of Premiums</th>
<th>Employee-Required Contributions</th>
<th>Employer-Required Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>An additional 3 months of employer contribution toward premium. Thereafter, employee may continue for up to 36 months under COBRA continuation provisions, by paying the full premium after the employer contribution ends.</td>
<td>Paid in advance by deduction from last payroll check or by personal check prior to the start of the coverage period for which premiums are due.</td>
<td>After the 3 additional months of employer contribution toward premium upon leave or temporary layoff, employees still on leave can continue coverage by paying the entire share of premium to their employer in advance.</td>
<td>First 3 months (in addition to any prepaid months at time of termination) after employee is on leave.</td>
</tr>
</tbody>
</table>

If the employee does not pay, the coverage should be terminated retroactively to the date of non-payment. Coverage may be reinstated if payment is received.
### 1204 B) Temporary Layoff:

<table>
<thead>
<tr>
<th>Length of Coverage Availability</th>
<th>Payment of Premiums</th>
<th>Employee-Required Contributions</th>
<th>Employer-Required Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>An additional 3 months of employer contribution toward premium. Thereafter, employee may continue for up to 36 months under COBRA continuation provisions, by paying the full premium after the employer contribution ends. Can remain on coverage up to 5 years if using sick leave credits. COBRA coverage after the employer contribution ends, sick leave credits are exhausted or employee is still using credits after 5 years have elapsed.</td>
<td>Paid in advance by deduction from last payroll check or by personal check then prior to the start of the coverage period for which premiums are due. If the employee does not pay, the coverage should be terminated retroactively to the date of non-payment. Coverage may be reinstated if payment is received.</td>
<td>After the 3 additional months of employer contribution toward premium upon temporary layoff, employees still on leave can continue coverage by paying the entire share of premium to their employer in advance. During temporary layoff, only, accumulated unused sick leave may be converted by the employer to a dollar amount to pay premiums. Premiums are deducted until: ~ the sick leave credits are exhausted, or ~ the 1st of the month following the employee’s acceptance of other employment offering a comparable health insurance plan or policy, or ~ five years have elapsed from the date of layoff, whichever occurs first.</td>
<td>First 3 months (in addition to any prepaid months at time of termination) after employee is laid off.</td>
</tr>
</tbody>
</table>

### 1205 Permanent Layoff

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. In addition, all employees terminated due to permanent layoff are entitled to an additional three months of state contribution toward the health insurance premium. This is in addition to the premiums that have already been remitted in advance through normal payroll deduction.

### 1205 A) Conversion of Accumulated Sick Leave [Wis. Stat. § 40.05 (4) (b)] - This provision applies to a state employee terminated due to permanent layoff (or a state employee otherwise terminated, e.g., for retirement purposes) who:

1) Begins an immediate monthly annuity; or
2) Receives a lump sum annuity; or
3) Has 20 years of creditable service and is eligible to retire on an immediate annuity but delays application.

These state employees are eligible to convert accumulated sick leave under the provisions of the Accumulated Sick Leave Conversion Credit Program (ASLCC) and Supplemental Health Insurance Conversion Credit Program (SHICC) as follows:

1) Accumulated unused sick leave is converted at the employee’s highest basic rate of pay while employed by the state. Accumulated and supplemental sick leave is certified by the employer through the online Accumulated Sick Leave system (AcSL). Upon receipt of the employer’s certification of the converted sick leave, ETF will establish a sick leave account to be used for payment of health insurance premiums.

2) Sick leave may be used to fund the employee’s premium contribution effective the first of the month following the date the layoff begins, if there is an employee contribution due, for the three additional months of employer paid premium as provided in Wis. Stat. § 40.05 (4)(a)

3) After the three additional months of state contribution toward premiums, the employer will certify the remaining unused sick leave balance to ETF, and the full amount of the premium will then be deducted by ETF from the sick leave credits until the credits are exhausted.

4) Under Wis. Stat. § 40.05 (4) (b), the employee may elect to delay using converted sick leave credits if the employee is covered under a comparable health insurance plan. Comparable health insurance means a plan or policy that provides hospital and medical benefits substantially equivalent to those of the Access Plan established under Wis. Stat. § 40.52 (1).

1205 B) Conversion of Accumulated Sick Leave [Wis. Stat. § 40.05 (4) (bc)].

This provision applies to a state employee terminated due to permanent layoff (or a state employee otherwise terminated, e.g., for retirement purposes) who:

1) Has attained 20 years of creditable service,
   a) Remains a participant (does not take a separation benefit from the WRS), and
2) Is not eligible for an immediate annuity due to not being minimum retirement age, i.e., age 55 (age 50 for protective occupations).
   b) Once eligible to apply for a monthly retirement annuity or lump sum retirement annuity, these state employees are eligible to convert accumulated sick leave under the provisions of the ASLCC program and, if eligible, the SHICC program, effective the date on which ETF receives the employee’s retirement application as follows:
     i) Accumulated unused sick leave is converted at the employee’s highest basic rate of pay while employed by the state. Accumulated and Supplemental sick leave is certified by the employer through the online Accumulated Sick Leave system (AcSL). Upon receipt of the employer’s certification of the converted sick leave, ETF will establish a sick leave account to be
used for payment of health insurance premiums.

3) At the request of the employee, the employer must convert accumulated sick leave to fund the employee's premium contribution, if any, effective the first of the month following the date the layoff begins under the provisions of Wis. Stat. § 40.05 (4) (a)

3. After the three additional months of state contribution toward premiums, the employer will certify the remaining unused sick leave balance to ETF through the online Accumulated Sick Leave system (AcSL), unless the employee requests the employer continue converting accumulated sick leave under Wis. Stat. § 40.05 (4) (bm) [refer to C below].

c) An employee covered under a comparable health plan with sick leave preserved under Wis. Stat. § 40.05 (4) (bc), may elect, at the time they are eligible for an annuity and submit a retirement application, to delay using the converted sick leave credits per Wis. Stat. § 40.05 (4) (b). Comparable health insurance means a plan or policy that provides hospital and medical benefits that are substantially equivalent to the AccessPlan established under Wis. Stat. § 40.52 (1).

1205 C) Conversion of Accumulated Sick Leave Wis. Stat. § 40.05 (4) (bm).

Note: Accumulated and supplemental sick leave are not certified by the employer through the on-line Accumulated Sick Leave system (AcSL) for employees only eligible for sick leave conversion under Wis. Stat. § 40.05 (4) (bm), i.e., termination due to layoff. The use of sick leave conversion under Wis. Stat. § 40.05 (4) (bm), during layoff is the record keeping and funding responsibility of the employing agency. The employee premium is to be remitted to ETF in the same manner as other active employees participating in the Group Health Insurance Program.

This provision applies to a state employee terminated due to permanent layoff, including those who are:

   a) not eligible for an immediate annuity; or
   b) eligible to begin an immediate annuity with fewer than 20 years of creditable service, but defer application.

These employees may request that the employer convert their accumulated sick leave for the purpose of paying health insurance premiums, as detailed below.

It is the employer's responsibility to notify employees subject to permanent layoff of the following provisions:

1) Upon request, between the date on which the employee receives notice of layoff and the actual layoff date, accumulated unused sick leave may be converted by the employing agency at the employee's highest basic rate of pay while employed by the state, for payment of health insurance premiums.

2) Sick leave may be used to fund the employee's premium contribution effective the first of the month following the date the layoff begins. After the three additional months of state contribution toward the premiums, the employee is responsible for the full employee and employer premium, although sick leave credits may be converted by the employer to pay the entire cost.

3) An employee using sick leave credits under this provision that returns
to state employment and is eligible for reinstatement will have any unused sick leave hours reinstated.

4) The full amount of the required premium shall be deducted from the credits until the first of the following occurs:

a) The credits are exhausted;

b) The employee accepts other employment with a comparable health insurance policy or plan (even if the employee declines the coverage). This coverage ends the first of the month following the date of other employment; or

c) Five years’ elapse from the layoff date.

Health insurance continuation coverage (in compliance with COBRA) using the Continuation - Conversion Notice (ET-2311) must be offered when the available sick leave premium contribution ends. (Refer to Chapter 9.)
# 1206 Permanent Layoff Sick Leave Conversion Reference Chart

<table>
<thead>
<tr>
<th>Employee status at time of permanent layoff.</th>
<th>Statutory Reference</th>
<th>State Health Contribution</th>
<th>ASLCC Program</th>
<th>SHICC Program</th>
<th>Administrative Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Begins immediate annuity or annuity lump sum. [§40.25 (1)]</td>
<td>§40.05(4)(a)3, §40.05(4)(b)</td>
<td>Up to one month prepaid plus additional 3 months. (For example STAR agencies should provide current month plus 3 months. For agencies that pre-pay, they should provide a current month, pre-paid month plus 3 months.)</td>
<td>Sick leave converted upon layoff. Employee can choose to use sick leave to pay the employee premium contribution during the three additional months of employer paid premium, effective the 1st of the month following the date the layoff begins. Remaining sick leave will be certified to ETF and used once the employer's obligation under §40.05(4)(a)3 has been met unless Escrowed according to § 40.05 (4)(b).</td>
<td>Available after ASLCC is exhausted if the employee has 15 or more full years of adjusted continuous state service. Other DPM regulations apply.</td>
<td>• Employing agency pays premiums for 3 months after layoff (not including prepaid months) as though an active employee. • Employing agency certifies the employee’s remaining accumulated sick leave through the on-line Accumulated Sick Leave system (AcSL). (Instructions located in subchapter 1207.) • ETF deducts full amount of premium until sick leave credits are exhausted.</td>
</tr>
<tr>
<td>2. Eligible for an immediate annuity with less than 20 years of WRS creditable service, but defers application.</td>
<td>§40.05(4)(a)3, §40.05(4)(bm)</td>
<td>Up to 1 month prepaid plus additional 3 months. • If requested, employing agency converts sick leave for health insurance until: • Credits are exhausted; • 1st of month following employee’s acceptance of other employment with a comparable health insurance plan or policy; or • 5 years have elapsed; whichever occurs first.</td>
<td>Any remaining sick leave after §40.05(4)(bm) use for the employee premium contribution for the first three months, effective the first of the month following the date the layoff begins, is lost unless employee reinstates into state service within five years.</td>
<td>Available after ASLCC is exhausted if the employee has 15 years or more of adjusted continuous state service. Other DPM regulations apply. Any remaining credits after the five-year limit under §40.05 (4)(bm) are lost.</td>
<td>• Employing agency pays premiums for three months after layoff as though employee is an active employee. • Employing agency converts sick leave and submits health insurance premiums to ETF as though an active employee. • Employing agency responsible for administration, funding and monitoring sick leave balance.</td>
</tr>
</tbody>
</table>

This chart provides information regarding sick leave conversion at the time of an employee’s permanent layoff (based upon employee status at the time of termination).
<table>
<thead>
<tr>
<th>Employee status at time of permanent layoff.</th>
<th>Statutory Reference</th>
<th>State Health Contribution</th>
<th>ASLCC Program</th>
<th>SHICC Program</th>
<th>Administrative Responsibility</th>
</tr>
</thead>
</table>
| 3. Eligible for an immediate annuity with 20 or more years of WRS creditable service, but defers application. | §40.05(4)(a)3 §40.05(4)(b) | Up to one month prepaid plus additional three months. (For example STAR agencies should provide current month plus 3 months. For agencies that pre-pay, they should provide a current month, pre-paid month plus 3 months.) | Sick leave converted upon layoff. Employee can choose to use sick leave to pay the employee premium contribution during the three additional months of employer paid premium, effective the first of the month following the date the layoff begins. Remaining sick leave will be certified to ETF and used once the employer’s obligation under §40.05 (4) (a) 3 has been met unless escrowed according to §40.05 (4) (b). | Available after ASLCC is exhausted if the employee has 15 years of adjusted continuous state service. Other DPM regulations apply. | • Employing agency pays premiums for three months after layoff (not including prepaid months) as though an active employee.  
• Employing agency certifies the employee’s remaining accumulated sick leave through the online Accumulated Sick Leave system (AcSL). (Instructions located in subchapter 1207.)  
• ETF deducts full amount of premium until sick leave credits are exhausted. |
| 4. Not eligible for immediate annuity with fewer than 20 years of creditable service. | §40.05(4)(a)3 §40.05(4)(bm) | Up to one month prepaid plus additional three months. If requested, employing agency converts sick leave for health insurance until:  
• Credits are exhausted;  
• First of month following employee’s acceptance of other employment with a comparable health insurance plan or policy; or  
• Five years have elapsed, whichever occurs first. | Any remaining sick leave after §40.05 (4) (bm) use is lost unless employee reinstates into state service within five years. | Available after ASLCC is exhausted if the employee has 15 years of adjusted continuous state service. Other DPM regulations apply.  
Any remaining credits after §40.05(4) (bm) use are lost. | • Employing agency pays premiums for 3 months after layoff (not including prepaid months) as though an active employee.  
• Employing agency converts sick leave and submits health insurance premiums to ETF as though an active employee.  
• Employing agency responsible for administration, funding and monitoring sick leave balance. |
<table>
<thead>
<tr>
<th>Employee status at time of permanent layoff.</th>
<th>Statutory Reference</th>
<th>State Health Contribution</th>
<th>ASLCC Program</th>
<th>SHICC Program</th>
<th>Administrative Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Ineligible for an immediate annuity with 20 or more years of WRS creditable service.</td>
<td>§40.05(4)(a)3 §40.05(4) (bm) §40.05(4) (bc)</td>
<td>• Up to one month prepaid plus additional three months. • If requested, employing agency converts sick leave for health insurance until: * credits are exhausted; * first of month following employee’s acceptance of other employment with a comparable health insurance plan or policy; or * five years have elapsed; whichever occurs first.</td>
<td>Sick leave converted upon layoff. Employee can choose to use sick leave to pay the employee premium contribution during the three additional months of employer paid premium, effective the 1st of the month following the date the layoff begins. After the three additional months of employer contribution: 1. Employing agency certifies any remaining sick leave through the online Accumulated Sick Leave system (AcSL) to be preserved by ETF until the employee applies for a retirement benefit; or 2. Employee requests to continue using converted sick leave to pay for premiums through the employer until credits are exhausted, the 1st of the month following employee’s acceptance of other employment with a comparable health insurance plan or policy; or five years have elapsed; whichever occurs first. Employing agency then certifies any remaining sick leave through the online Accumulated Sick Leave system (AcSL) to be preserved by ETF until the employee applies for a retirement benefit.</td>
<td>Available after ASLCC is exhausted if the employee has 15 years of adjusted continuous state service. Other DPM regulations apply.</td>
<td>• Employing agency pays premiums for 3 months after layoff (not including prepaid months). Employee can choose to use converted sick leave to pay any employee share of premiums. • Employer reports employee to ETF as though an active employee. Then: • Employing agency certifies any remaining sick leave through the online Accumulated Sick Leave system (AcSL) to be preserved by ETF for conversion upon receipt of retirement application. (Instructions located in sub-Chapter 1207.) • Employing agency responsible for administration, funding and monitoring sick leave balance during any period when the employee is using these credits to pay the premiums while still covered as an active employee.</td>
</tr>
</tbody>
</table>
1207 Accumulated Sick Leave and Chapter 40 Terminations

Effective April 1, 2006, an employee does not have to sever the employee/employer relationship to receive § 40.63 Disability Retirement. Employers may now elect to keep an employee on a leave of absence for purposes of maintaining fringe benefits not administered under Chapter 40, i.e., benefits provided by the employer but not administered by ETF. Employees terminated for Chapter 40 purposes but remaining on leave of absence for non-Chapter 40 benefit purposes are considered Chapter 40 terminations.

Sick leave balances with which the employee intends to pay for health insurance premiums are considered earnings not-paid. State employees must sever the employee/employer relationship if they wish to convert sick leave balances to pay for health insurance premiums.

If an 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 spouse does not have access to the deceased state employee’s accumulated sick leave.

1208 Certifying Credits through the Online Accumulated Sick Leave System (AcSL)

An employer must certify accumulated and supplemental sick leave credits through the AcSL system within 30 days after an employee’s termination. Certify credits for each employee terminating from state service who:

1) Is age 55 or older (age 50 if protective occupation);
2) Is approved for disability retirement benefits under Wis. Stat. §40.63 or duty disability benefits under Wis. Stat. §40.65;
3) Died;
4) Is a public official (qualifies for delayed sick leave usage under 1991 Wisconsin Act 39 [Public Official]); or
5) Is terminating after 20 years of service but is not eligible for an immediate annuity (qualifies for delayed sick leave usage under 2003 Wisconsin Act 33).

1208 A) Access

Employers can access AcSL through the myETF Benefits for Administrators menu.

1) Log in to myETF Benefits with your User ID and Password.
2) Under the ‘Health’ tab, choose the option “Accumulated Sick Leave”.

1208 B) Menu

1) The AcSL menu will appear on the left-hand side of your screen. Initially, the menu only
provides you with two options: AcSL Dashboard and Employer Web Page.

Note: If you are an employer with access to submit on behalf of multiple Employer IDs, you
must select the appropriate Employer ID from the drop-down box.

2) As you begin the process of entering a sick leave certification, additional menu options appear. Select
any of the available menu options at any time to navigate to that screen.
1208 C) Member Search

1) Search for the member with the Social Security number (minimum last four), ETF Member ID or Last Name/First Name.

2) Click ‘Search for Member’ to initiate the search.

3) Verify the employee and click on ‘View Member Information’.

4) You can sort the results by utilizing the sort function next to the field name.

1208 D) Sick Leave Certification Entry

1) Click ‘Start New Certification’.
2) Fill in the termination date and choose the reason for termination from the drop-down menu.
   
a. The termination date must be formatted as mm/dd/yyyy. The termination date can neither be blank nor in the future or you will receive an error message.
   
b. The termination reason cannot be blank.

3) Click “Next”.

   **Note:** If the termination reason is “Retirement” or “Death” the member **must** have active health insurance coverage under the State Group Health Insurance Program in order for the sick leave credits to be certified.

   a. You will receive the following error message if the employee is not currently covered under the State Group Health Insurance Program.

   ![Error Message]

   b. If you believe this message is in error, please contact ETF for assistance.

   c. If a **preserved** sick leave account is on file, you will receive the following message:

   ![Preserved Sick Leave Account]

   i. What is a “preserved” sick leave account?
• If an employee terminates employment with at least 20 years of creditable
  WRS service, they qualify to have their sick leave preserved.
• If an employee is either a state constitutional officer, a member or an officer of the
  legislature, or the head of a state department or agency who was appointed by the
  governor with senate confirmation, they qualify to have their sick leave preserved after
  termination.

4) You **must choose one** of the following:

   a. “This sick leave certification should override and replace the previous sick leave
e   certification.”
      i. “**Override and replace**” should be used for situations where the employee returns to state
         employment within a valid reinstatement period and had their remaining sick leave balance
         from the previous period of employment added to the starting leave balance for the current
         period of state employment.

   b. “The sick leave hours on this certification should be combined with those reported on the
      previous sick leave certification.”
      i. “**Combined**” should be used for situations where an employee returned to state employment
         outside of a valid reinstatement period and wasn’t eligible to receive their remaining sick
         leave balance from the previous period of state employment.

5) Then click ‘Next’ to proceed.

**1208 E) Entering Sick Leave Hours for Submission**

1) Click ‘Enter Sick Leave Hours to Submit’ at the bottom of the screen.

2) Enter all the necessary employee information.
   
   a. **For UW Employers Only** – Employers certifying sick leave on behalf of UW
      employees are required to answer the following question:

   ![Sick Leave Hours Certification](image)

*For more specific details on academic staff and the required information that may be
needed for these certifications, please contact UW System Administration Office of Human
Resources and Workplace Diversity.*

See next page.
<table>
<thead>
<tr>
<th>Field Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unused Sick Leave Hours</td>
<td>Required field.</td>
</tr>
<tr>
<td>Other Creditable Leave Hours</td>
<td>Optional field. Must reflect the number of hours of sabbatical or unused vacation that eligible employees elect to convert.</td>
</tr>
<tr>
<td>Highest Basic Hourly Pay Rate as State Employee</td>
<td>Required field.</td>
</tr>
<tr>
<td>Seniority Date</td>
<td>Required field. Date must be formatted as MM/DD/YYYY.</td>
</tr>
<tr>
<td>Bargaining Unit</td>
<td>Optional field.</td>
</tr>
<tr>
<td>Years of Service in General/Executive Category within the First 24 Years</td>
<td>The combined total of the value entered in this field and the “Years of Service in Protective Category” field must equal the lesser of 24 years or the value in “Full Years of Service”.</td>
</tr>
<tr>
<td>Years of Service in Protective Category within the First 24 Years</td>
<td>The combined total of the value(s) entered in this field and the “Years of Service in General/Executive Category” field must equal the lesser of 24 years or the value in “Full Years of Service”.</td>
</tr>
<tr>
<td>“Full Years of Service/Seniority”</td>
<td>Automatically calculates based on the term date and seniority date that were entered.</td>
</tr>
<tr>
<td>SHICC Eligible Hours</td>
<td>Enter the total sick leave hours eligible for SHICC.</td>
</tr>
<tr>
<td>SHICC, 500 Hour Restoration</td>
<td>This field will accept only values of “0” or “500”.</td>
</tr>
</tbody>
</table>
3) The certification contains a field for ‘Employer Notes’ to be used for your reference, to share info with ETF, etc. These notes will stay with the certification in AcSL but will not appear on the printed certification.

   Indicate the following in the Employer Notes area:
   a. If this employee was not eligible for SHICC (i.e. Craftworker).
   b. If this retiree’s spouse is a State employee and will be picking up active health coverage due to loss of coverage.
   c. If the employee is subject to an academic year exception.

4) If you need to save the certification for completion later, click ‘Save Draft’.

5) If you have finished the certification, click ‘Submit to ETF’.

   **Note:** If you have restricted access, you will not see the ‘Submit to ETF’ button. You must click on ‘Submit for Review’ to send the certification to your central payroll office for review. Your central payroll office will then submit the certification to ETF.

1208 F) Employees on Layoff and Sick Leave Certification

For employees who are on layoff and are eligible to use their sick leave credits through their employer to pay for health insurance premiums:

1) The employing agency is responsible for administration, funding and monitoring sick leave balances. Therefore, the employing agency must manually track how much sick leave is used to pay premiums.

2) You can generate the dollar amount of sick leave available for the employee by using the ‘Generate Estimate’ function in AcSL. Estimates are only available to view immediately after it is generated and cannot be saved in AcSL. You may save it as a PDF to your own computer.
3) You can key it as an actual certification and save it as a draft (refer to instructions provided previously in this section on how to save a certification as a draft). 

**Note:** Do not submit this to ETF. The employing agency is responsible for administration of these balances.

4) If eligible, the employing agency certifies any remaining sick leave through AcSL to be preserved by ETF for conversion upon receipt of retirement application.

5) The employing agency will follow the same instructions provided previously in this section on how to submit a sick leave certification. There are, however, two special things to note when submitting a sick leave certification for layoff situations:

   - Enter the full amount of Accumulated Sick Leave and SHICC the employee had *at the time of layoff.*
   - In the “Employer Notes” field, please indicate “LAYOFF”, as well as how many of the sick leave credits have been used through the employer to pay for premiums.

6) ETF will adjust the sick leave balance based on the information you provide.

---

**1208 G) ETF Review and Acceptance/Rejection of Certification**

1) Once you submit the certification, ETF will review it and then either **approve** the certification and set up a sick leave account or **reject** the certification and return it to you, the employer.

   a. While in *Draft* status, you can change the certification values as often as needed before submitting to ETF.

   b. Once you ‘Submit to ETF’ the values are *frozen.* If you determine that something needs to change, you will need to amend the certification.

   c. In some situations, ETF may reject the sick leave certification and return it to the employer (e.g., missing information or incorrect amounts).
      - If the employee is not vested or employee did not take an immediate annuity, etc., ETF will close the sick leave certification due to ineligibility.

**1208 H) Printing a Certification**

1) Once a certification has been submitted, print a copy. Choose “View Certification” from the Member Info Overview page and select the “View Printable Certification” button. A PDF of the certification that you can print for your records.
1208 J) Amended Certification vs. New Certification

1) **Creating a New Certification:** If there are additional sick leave hours to report (i.e. an employee who retired and had his/her hours reported to ETF returns to work as a rehired annuitant, becomes a participating WRS employee, and then retires again. The sick leave earned during that 2nd period of employment should be reported on a NEW certification.)

**Note:** Only hours earned as a participating employee in the WRS are eligible for conversion upon re-retirement. Hours earned as a non-participating employee are not convertible on re-retirement because no employer contributions have been paid on sick leave earned in non-participating status.
2) **Amending**: If you determine that **any** value (term date, term reason, ASLCC hours or pay rate, SHICC seniority date, etc.) originally keyed was incorrect and needs to be changed.

### 1208 K) Amending a Certification

A certification can be amended (corrected) after it has been submitted to ETF.

1) To amend a certification, click, “View/Amend Certification”, located to the right of the submitted sick leave certification (This button will **not** appear until a certification has been submitted to ETF.)

2) Any field on a certification can be amended. At the top of the screen, you will see a statement regarding the status of the certification. Choose “Amend Certification” to make changes.

3) Indicate “Yes” if you want to amend the certification.

   a) You can amend a certification as many times as needed. The print version of an amended certification will also display “This is an AMENDED certification” at the top of the page and in the status tracking at the bottom of the right-hand side of the form.

Example follows:
a. Any field the employer has entered on the certification can be amended.

4) If you need to save the amended certification for completion later, click ‘Save Draft’.

5) Once you have finished amending the certification, click ‘Submit to ETF’.

Note: If you have restricted access, you will not see the ‘Submit to ETF’ button. You must click on ‘Submit for Review’ to send the certification to your central payroll office for approval.
1) There are multiple tabs on the AcSL Dashboard page. The first is labeled ‘Member Search’, where you search for your employees.

The other tabs serve as a work queue to help employers track their certifications. At any time, an employer can view certifications in any of the following statuses:

1208 M) “Draft”:

1) “Draft”. Certifications the employer started but not finished.
2) Also includes certifications keyed by employers with Restricted Access that have been “submitted for review” for their central payroll office.
   a) An employer representative with Full Access needs to open these certifications, review them, and then choose ‘Submit to ETF’.

1208 N) “Submitted”:

1) “Submitted”. Certifications the employer submitted to ETF but have not been reviewed and accepted.

1208 O) “Awaiting Retirement or Disability Application”:

1) ETF is waiting for additional information from the employee before we can approve the certification – in some cases, the employee does not apply for an immediate annuity, in which case the certificate will be rejected and returned to the employer. Sick leave credits should then be added back onto the employer’s records (in the event the employee returns to work).

1208 P) “Returned”:

1) Certifications rejected by ETF and returned to the employer. Certifications may be returned due to missing information or because it has been determined the employee is not eligible to use these credits for post-retirement health insurance. ETF will send e-mail...
notifications when certifications are moved to this queue. Once in this queue, employers can either: 1) update or correct the certification before resubmitting it to ETF or 2) delete the certification if the employee is not eligible to use these credits to pay for post-retirement health insurance; the credits should be added back onto the employer’s records (in the event the employee returns to work).

Once a certification is approved by ETF, it will disappear from the work queues. ETF will then establish a sick leave account for the member, and the employer’s role in the process is complete.

Contact ETF if you have questions or need assistance keying a certification.

1209 Generating a Sick Leave Credit Estimate through the Online Accumulated Sick Leave System (AcSL)

Employers can generate a sick leave credit estimate for their employees in AcSL. The estimate will provide a sick leave certification total based on what the employer enters the estimated hourly wage and sick leave hours. You can either print a hard copy of the PDF to give to your employee, or you can save a copy of the PDF to your desktop to e-mail the document to the employee.

1) After searching for and selecting a member in the “Member Search” tab, click the ‘Generate Estimate’ button on the Member Information Overview screen.

2) Enter in the projected future termination date, and reason for termination.
3) Click ‘Next’. AcSL will display current health insurance information.
4) Click on the ‘Enter Estimated Sick Leave Hours’ button.
1) **For UW Employers only** – Employers generating estimates on behalf of UW employees are required to answer the following question:

```
Was the employee an academic year faculty, academic staff or limited appointee at the time of termination or retirement?  ○ YES  ○ NO
```

2) Enter the employee’s ASLCC and SHICC information.
   
   a. Refer to subchapter 1207 for instructions on the sick leave certification’s input fields.

3) Click the ‘Print Copy for Member’ button. A PDF of the sick leave credit estimate will be generated.
   
   Example follows:
Note: Sick leave estimates cannot be saved in the AcSL system. You can save a copy of the PDF to your computer.

Example follows:
1210 Escrow of Sick Leave Credits

Eligible state employees or their surviving dependents insured under the State Group Health Insurance Program at the time of termination may elect to escrow (bank) their accumulated sick leave credits. The employee can elect to escrow the sick leave for an indefinite period if continuously covered by comparable non-state health insurance coverage. Comparable non-state health insurance coverage means a plan with hospital and medical benefits substantially equivalent to the state’s Access Plan (not the Access HDHP). Comparable coverage may be an HDHP with an employer contribution to a Health Savings Account or Health Reimbursement Account that brings the value of the plan to the level of the Access Plan.

If the employee is a dependent on a spouse’s state group health insurance contract, the sick leave credits will automatically be placed “on hold” until the spouse retires and depletes their sick leave credits. Both spouses must meet the sick leave eligibility requirements.

To escrow, the employee must complete a Sick Leave Credit Escrow Application (ET-4305). The decision to escrow can be done no more than one time per year, either at the time of termination of employment or at a later date when the employee enrolls in a comparable non-state health insurance plan. The sick leave account will be escrowed on the first of the month following receipt of the signed and completed form.

More detailed information is available in the Sick Leave Conversion Credit Program Brochure (ET-4132). For questions on escrowing sick leave credits or to obtain forms, you can direct employees to go online to etf.wi.gov or call ETF toll-free at 1-877-533-5020 or 608-266-3285.
1211 Payment

Payment for the use of Sick Leave Conversion Credits is secured from the Sick Leave Conversion Credit fund to which each participating employer contributes through the Wisconsin Retirement System monthly contribution report.

1212 Annual Statement of Account

Annually, ETF mails annuitants, survivors and dependents an annual statement giving the account status, beginning balance and the current balance of their accumulated sick leave account.
Chapter 13 - Medicare

1301 Overview of Medicare

1301 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.

1301 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) 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.

1301 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 - 1 and Medicare Family - 2 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.

   a) 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.

1301 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.

1301 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.

1301 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.

1301 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.

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

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

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

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

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

ET-1118 Chapter 13 (REV 2/25/2019)
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 person. Send a copy of the documents to that person. Follow up with the HEALTH PLAN if the matter is not resolved in a timely manner.

3) Contact your legal counsel for assistance.

4) Prepare a letter to the requestor. 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
Chapter 14 — Employee Death

1401 How to Report an Employee Death
1402 Surviving Spouse and Dependents
1403 Surviving Spouse who is also an Employee Eligible for Coverage

1401 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 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.

1402 Surviving Spouse and Dependents

1402 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. 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.

1402 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.

1402 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 Chapter 12.)

### 1403 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 1402. Premiums will be paid through accumulated sick leave conversion credits, WRS annuity, or directly by the surviving spouse/ to the health plan.
Chapter 15 — Invoicing

1501 Viewing Your Invoice
1502 Reconciling Your Invoice
1503 Accepting and Paying Your Invoice (Wismart and Automated Clearing House (ACH))
1504 Late Interest Charge
1505 Who to Contact for Assistance

1501 Viewing Your Invoice

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

Each month, ETF invoices employers for coverage for the current month based on all active health insurance contracts in 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).

<table>
<thead>
<tr>
<th>Coverage Month</th>
<th>ETF Generates Employer Invoices</th>
<th>Premiums due from Employers to ETF</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Active</td>
<td>January 2017</td>
<td>January 1, 2017</td>
</tr>
<tr>
<td>State Annuities</td>
<td>January 2017</td>
<td>December 1-10, 2016</td>
</tr>
</tbody>
</table>

1501 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 e-mail 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 e-mail is below:
The e-mail address used is the one provided on the Online Network for Employers Security Agreement (ET-8928) when requesting access to the myETF Benefits system. The invoice charges premiums for the current calendar month on all health insurance contracts that are active in that month.

1501 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 e-mail to the person authorized to accept the invoice to remind them that the employer invoice has not been accepted. An example of such an e-mail is below.

The latest date an employer must accept the invoice is the 24th of each month. If the employer invoice is not accepted by 5:45 p.m. on the 24th of each month, any unaccepted employer invoice will automatically be accepted by the myETF Benefits system. See Section 1503 for more information on accepting and paying the monthly invoice and due dates.
1501 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 e-mail contact information by clicking on the employer e-mail address update link. If the user is not updating their e-mail contact information, click the ‘Continue’ button to move to the Health Insurance Invoice Summary screen.

3) The Health Insurance Invoice Summary screen provides the user with the ability to search for the invoice by coverage month and year. Users can review the current coverage month’s invoice or previous invoices. This screen also provides employers with the invoice amount, invoice number, invoice date, 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 1502. 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 1503 for more information and instructions on accepting and paying your invoice.
1502 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”.

1502 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.

![Invoice Detail Screen]

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.
1502 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.

1502 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.
1503 Accepting and Paying Your Invoice

Wismart
Automated Clearing House (ACH)

1503 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 e-mail 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 e-mail letting them know that the system has accepted the invoice and they need to submit a payment.

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

1503 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).

1503 C) Automated Clearing House (ACH):

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

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

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

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

This will have 3 sections.

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

2) **Payment Information** – This is where users will select their payment terms
   
   a) Frequency – Select One Time.
   
   b) Payment Date – Select either Pay Now or Pay on a future date.
      
   i) Selecting Pay on a future date allows the user to select the date the funds will be withdrawn. It can be any date in the future, but
preferably on or before the due date.

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

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

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

   Once all 3 sections are complete, click ‘Continue’.

   The Review Payment screen will appear. Verify that it’s correct. If okay, user can click ‘Continue’.
If successful, a printable Confirmation Page appears that will include a confirmation number. The user will also receive an e-mail with the confirmation number and payment details.

Upon successful completion, the payment will post to the employer's invoice at 11:00 a.m. on the payment date selected.
There is no direct link to the U.S. Bank E-Payment Service so if an employer exits before scheduling a payment they will need to log back into myETF Benefits. Instead of the ‘Accept’ button, the employer will see a ‘Pay’ button. Click ‘Pay’ and then ‘Confirm’ on the next screen. The ‘Pay’ button is displayed until a payment has been posted to the invoice.

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

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

2) Check e-mails – Employers would have received an e-mail with the payment details and a confirmation number.

3) Call ETF using the phone number listed on the invoice – Staff will be able to look up any scheduled payments.

4) Continue to the US Bank E-Payment Service and Log In if they are a registered user.
   a) Click on the ‘My Account’ tab.
      i) Go to Scheduled Payments – This will list any pending payments. It will remain here as pending until the payment date.
         1) If there is a pending payment, no further action is needed and the user can logout.
         2) If there is no pending payment, the user should select the ‘Make a Payment’ tab and complete the process to submit a payment.

1504 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:

\[
\text{Interest Charge} = \text{Invoice Premium Due} \times \text{Number of days late} \times 0.04\%
\]

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.

![My Account Interface]

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.

![Payment Methods Interface]

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.
1505 Who to Contact for Assistance

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

Laura Vang: 1-608 261-0064 or laura.vang@etf.wi.gov.

Rolanda Franklin: 1-608-266-0781 or rolanda.franklin@etf.wi.gov.
Chapter 16 — Glossary of Definitions

“ACCESS PLAN” means the fee-for-service health care plan 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 those items and services as listed in Uniform Benefits.

"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 and shown on the records of the HEALTH PLAN in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

"EMPLOYEE" means 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 who is the legal signatory to the State of Wisconsin Group Health Insurance Program Agreement

"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” means the enrollment period referred to in ETF materials that is available at least annually to 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.

"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.
"PARTICIPANT" means the SUBSCRIBER or any of the 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.
## Appendix A — Forms and Brochures

<table>
<thead>
<tr>
<th>Document name</th>
<th>Form number</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits (Health Insurance contract)</td>
<td>ET-1136</td>
<td>Contact ETF for a copy.</td>
</tr>
<tr>
<td>Health Insurance Application/Change for Retirees &amp; COBRA Continuants</td>
<td>ET-2331</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B — Codes

1. **Employee Type Codes**
2. **Coverage Type Codes**
3. **Individual Relationship Codes**
4. **Health Plan Codes**

### 1) Employee Type Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Employee Coverage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>State-elected</td>
<td>Legislators, state constitutional officers, circuit, supreme court, or appeals judges, chief clerk or Sergeant-at-Arms of the Senate or Assembly</td>
</tr>
<tr>
<td>02</td>
<td>Regular State</td>
<td>State Employee</td>
</tr>
<tr>
<td>03</td>
<td>UW Classified</td>
<td>UW other than faculty.</td>
</tr>
<tr>
<td>04</td>
<td>UW Unclassified</td>
<td>UW Faculty</td>
</tr>
<tr>
<td>05</td>
<td>Beyond Vision (aka WISCRAFT)</td>
<td>For use by Beyond Vision (aka WISCRAFT) only - for blind employees.</td>
</tr>
<tr>
<td>07</td>
<td>State Annuitant</td>
<td>Retired employee who is eligible for health insurance.</td>
</tr>
<tr>
<td>08</td>
<td>State Surviving Spouse/Dependent</td>
<td>Used for survivors of currently insured subscriber who dies while carrying family health insurance coverage.</td>
</tr>
<tr>
<td>10</td>
<td>State Continuant</td>
<td>ETF Use Only - Continuant</td>
</tr>
<tr>
<td>11</td>
<td>State Participant – 1991 WI Act 152</td>
<td>Terminated State Employee with at least 20 years of creditable service.</td>
</tr>
<tr>
<td>12</td>
<td>Graduate Assistant</td>
<td>Graduate Assistants, employees in training, short-term academic staff, fellows, and scholars.</td>
</tr>
<tr>
<td>13</td>
<td>Continuant- Graduate Assistant</td>
<td>ETF Use Only - Graduate Assistant Continuant.</td>
</tr>
<tr>
<td>14</td>
<td>Local Annuitant</td>
<td>Retired local employee who is eligible for health insurance through ETF.</td>
</tr>
<tr>
<td>17</td>
<td>LTE</td>
<td>Limited term employees.</td>
</tr>
</tbody>
</table>
### 2) Coverage Type Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Coverage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Single</td>
<td>Coverage is for the subscriber (employee) only.</td>
</tr>
<tr>
<td>02</td>
<td>Family</td>
<td>Coverage is for the subscriber (employee) and eligible dependent(s).</td>
</tr>
<tr>
<td>03</td>
<td>Graduate Assistants - Single</td>
<td>Coverage is for the subscriber Graduate Assistant (employee) only.</td>
</tr>
<tr>
<td>04</td>
<td>Graduate Assistants - Family</td>
<td>Coverage is for the subscriber Graduate Assistant (employee) and eligible dependent(s).</td>
</tr>
<tr>
<td>05</td>
<td>Medicare - Single</td>
<td>Single coverage for annuitant or continuant subscriber with Medicare.</td>
</tr>
<tr>
<td>06</td>
<td>Medicare - Family 1</td>
<td>Family coverage for annuitant or continuant subscriber; one or more persons with Medicare.</td>
</tr>
<tr>
<td>07</td>
<td>Medicare - Family 2</td>
<td>Family coverage for annuitant or continuant subscriber, subscriber and all dependents with Medicare.</td>
</tr>
</tbody>
</table>

### 3) Individual Relationship Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Spouse</td>
</tr>
<tr>
<td>03</td>
<td>Parent of Minor Dependent</td>
</tr>
<tr>
<td>15</td>
<td>Legal Ward</td>
</tr>
<tr>
<td>17</td>
<td>Stepson or Stepdaughter</td>
</tr>
<tr>
<td>18</td>
<td>Self</td>
</tr>
<tr>
<td>19</td>
<td>Child</td>
</tr>
<tr>
<td>24</td>
<td>Dependent of a Minor Dependent</td>
</tr>
</tbody>
</table>
4) Health Plan Codes

2019 CARRIER CODES FOR HEALTH INSURANCE

<table>
<thead>
<tr>
<th>HMO Dental (Y)</th>
<th>HMO Dental (N) (LAHP)</th>
<th>HDHP Dental (Y)</th>
<th>HDHP Dental (N)</th>
<th>HEALTH CARRIER NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>OE</td>
<td>JE</td>
<td>XE</td>
<td>IYC ACCESS HP - WEA</td>
</tr>
<tr>
<td>06</td>
<td>OF</td>
<td>JF</td>
<td>XF</td>
<td>SMP - WEA</td>
</tr>
<tr>
<td>15</td>
<td>NC</td>
<td>HC</td>
<td>WC</td>
<td>DEAN HEALTH PLAN</td>
</tr>
<tr>
<td>17</td>
<td>ND</td>
<td>HD</td>
<td>WD</td>
<td>DEAN PREVEA360</td>
</tr>
<tr>
<td>18</td>
<td>OG</td>
<td>JG</td>
<td>XG</td>
<td>UHC MEDICARE ADVANTAGE</td>
</tr>
<tr>
<td>30</td>
<td>NG</td>
<td>HG</td>
<td>WG</td>
<td>GHC EAU CLAIRE</td>
</tr>
<tr>
<td>35</td>
<td>NH</td>
<td>HH</td>
<td>WH</td>
<td>GHC-SCW</td>
</tr>
<tr>
<td>63</td>
<td>NN</td>
<td>HN</td>
<td>WN</td>
<td>MEDICAL ASSOCIATES HEALTH PLAN</td>
</tr>
<tr>
<td>64</td>
<td>NO</td>
<td>HO</td>
<td>WO</td>
<td>MERCY CARE HEALTH PLAN</td>
</tr>
<tr>
<td>70</td>
<td>NP</td>
<td>HP</td>
<td>WP</td>
<td>NETWORK HEALTH</td>
</tr>
<tr>
<td>71</td>
<td>NQ</td>
<td>HQ</td>
<td>WQ</td>
<td>SECURITY HEALTH PLAN CENTRAL</td>
</tr>
<tr>
<td>77</td>
<td>OB</td>
<td>JB</td>
<td>XB</td>
<td>SECURITY HEALTH PLAN VALLEY</td>
</tr>
<tr>
<td>85</td>
<td>NS</td>
<td>HS</td>
<td>WS</td>
<td>HEALTHPARTNERS</td>
</tr>
<tr>
<td>86</td>
<td>NT</td>
<td>HT</td>
<td>WT</td>
<td>WEA TRUST PPO EAST</td>
</tr>
<tr>
<td>87</td>
<td>NU</td>
<td>HU</td>
<td>WU</td>
<td>WEA TRUST PPO NORTHWEST CHIPPEWA VALLEY</td>
</tr>
<tr>
<td>90</td>
<td>NW</td>
<td>HW</td>
<td>XW</td>
<td>WEA TRUST NORTHWEST MAYO</td>
</tr>
<tr>
<td>96</td>
<td>OC</td>
<td>JC</td>
<td>XC</td>
<td>QUARTZ-UW HEALTH</td>
</tr>
<tr>
<td>97</td>
<td>OD</td>
<td>JD</td>
<td>XD</td>
<td>QUARTZ-COMMUNITY</td>
</tr>
<tr>
<td>98</td>
<td>OH</td>
<td>JH</td>
<td>XH</td>
<td>ROBIN WITH HEALTHPARTNERS</td>
</tr>
</tbody>
</table>
Appendix C — myETF Benefits

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

C-1.  How to Log into myETF Benefits

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

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

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

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

Employer Resources

Welcome to the employer ETF resources page.

Find employer-specific information about ETF’s insurance programs, the WRS and how to participate. Keep up to date with employer news, bulletins, employer manuals and training opportunities.
4) Enter your User ID and Password.
5) Enter your employer number and click the ‘Verify’ button.

6) You will be directed to the myEmployerInfo screen. From here, you can update your information as well as select functions from the drop-down menus.
C-2. Add Coverage

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

<table>
<thead>
<tr>
<th>EIN</th>
<th>Employer name</th>
<th>Payroll representative email</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000-199</td>
<td>Central Payroll</td>
<td>Jane. <a href="mailto:Doe@centralpayroll.wisc.gov">Doe@centralpayroll.wisc.gov</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group number</th>
<th>Employee type</th>
<th>Coverage type</th>
<th>Health plan name/suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>83900</td>
<td></td>
<td></td>
<td>Dean</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Business Unit (if applicable)</th>
<th>Employment status of applicant</th>
<th>Employee deductions</th>
<th>Hire date or date WRS-eligible employment or graduate appointment began</th>
<th>Employer received date</th>
<th>Event date</th>
<th>Prospective coverage date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Full time □ Part time □ LTE</td>
<td>□ Pre-tax  □ Post-tax</td>
<td>2/4/19</td>
<td>2/27/2019</td>
<td></td>
<td>5/1/2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you a WRS-participating employer?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous service check completed?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Source of previous service check?</td>
<td>Online Network for Employers (ONE)</td>
<td>ETF</td>
</tr>
<tr>
<td>Did employee participate in the WRS prior to being hired by you?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payroll representative signature</th>
<th>Phone number</th>
<th>Date signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe</td>
<td>(608) 555-1234</td>
<td>3/1/2019</td>
</tr>
</tbody>
</table>
1) In myETF Benefits, highlight the myMembers tab and select myMembers from the drop down list.

2) Enter the employee’s ETF Member ID or SSN into the appropriate box and click the ‘Search’ button or click ‘Enter’ (if it is a brand-new employee with no prior WRS service, there will not be an ETF Member ID).
a) If the employee’s basic demographic information pops up, scroll to the bottom of the page and click the ‘Edit’ button.

b) If the employee cannot be found, click the ‘Add’ button near the top of the screen.

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

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

If the address returns to the validation screen, you may be missing the apartment number or unit number designation. Either contact the member to verify the address or if you know it is correct, then select the ‘Radio’ button in front of the address as keyed and click the ‘Submit’ button.
5) Once you are on the review page, review the data (any changes/additions will appear in red).
   a) If all corrections/additions are correct, click the ‘Confirm’ button.
   b) If additional changes are needed, click the ‘Cancel’ button and return to the previous screen and follow the procedures under Number 3.

Note: This is the confirmation page when adding a new member into myETF Benefits. The confirmation screen will look different if you are only updating information; that confirmation screen will show a summary of changes made and will have a print button in the upper right corner as well as a Return to myMembers button at the bottom of the page.

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

6) At the top of the screen, highlight the Health Tab and select Member Enrollment from the drop-down.
7) Click the ‘Add Coverage’ button at the bottom of the screen.

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

![](image)

17) Verify all the information on the review page.
   a) If all the information is correct, check the ‘Terms and Conditions’ box and click the ‘Confirm’ button.
b) If the information is not correct, click the ‘Cancel’ button and return to the previous screen to make changes.

18) Print a copy of the confirmation screen (if desired) by clicking on the green print button in the upper right hand corner of the screen.

After the nightly batch runs, you can go in on the following day and view the contract you entered.
C-3.  Add Dependent
A Health Insurance Application/Change Form (ET-2301) has been received for one of the Add Dependent reasons, all information has been verified, the employer section completed, and any necessary documentation has been verified/approved.

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

2) Enter the employee’s ETF Member ID or SSN into the appropriate box and click the ‘Search’ button or click Enter.
3) Verify that all demographic data is current.

a) If any updates/changes need to be made, then click the ‘Edit’ button at the bottom of the screen.

b) Make any updates/changes to the appropriate editable fields.

c) If it was an address update, an address validation program will run and ask you to verify and select the correct address from the bottom of the screen.

d) Select the ‘Finalist’ address which includes the ZIP+4, and click the ‘Submit’ button again.

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

4) Once you are on the review page, review the data (any changes/additions will appear in red).

a) If all corrections/additions are correct, click the ‘Confirm’ button.

b) If additional changes are needed, click the ‘Cancel’ button and return to the previous screen and follow the procedures under Number 3.

c) If you wish to print the confirmation page, click on the green ‘Print’ button in the upper right corner.
5) At the top of the screen, highlight the Health tab and select Member Enrollment from the drop-down.

6) Click the ‘Edit’ button on the line for the Active contract.

7) Select the “Radio” button next to **Add Dependent** and click the ‘Continue’ button.
8) Select the “Reason for Adding Dependent” from the drop-down menu. (For Example – Loss of Other Coverage).

9) Enter the Event Date (date of the qualifying event).
10) Enter the Employer Received Date (date application received by the employer).

   **Note:** The Effective Date will auto-populate based on the Event and Received dates entered.

11) Complete the “Identification Section” for the dependent being added.
12) Complete the “Other Health Insurance.”
   a) Select **No** from the drop down if there is **no** other health insurance coverage listed on the application for the member.
   b) Select **Yes** from the drop down if there is **other** health insurance coverage listed on the application for the member.

13) Complete the “Medicare” section for the dependent being added.
   a) Select **No** from the drop-down if there is **no** Medicare coverage for the member.
   b) Select **Yes** from the drop down if there is **Medicare** coverage for the member.

14) Complete the “Physician” Section for the dependent being added.
15) Verify data entered and click the ‘Submit’ button.
16) Check the box next to the Terms and Conditions statement.
   a) If there is a second check box, stating that documentation is required and you have the documentation or are expecting the documentation, check the box.

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

17) Review the data and if correct, click the ‘Confirm’ button.
<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Employees</td>
<td>[List]</td>
</tr>
<tr>
<td>Covered Group</td>
<td>[List]</td>
</tr>
<tr>
<td>Coverage</td>
<td>[List]</td>
</tr>
<tr>
<td>Policy Number</td>
<td>[Number]</td>
</tr>
<tr>
<td>Policy Coverage</td>
<td>[List]</td>
</tr>
<tr>
<td>Policy Type</td>
<td>[List]</td>
</tr>
<tr>
<td>Effective Date</td>
<td>[Date]</td>
</tr>
<tr>
<td>Termination Date</td>
<td>[Date]</td>
</tr>
<tr>
<td>Plan Type</td>
<td>[List]</td>
</tr>
</tbody>
</table>

Report for: [Name]

[Table with columns for different fields such as Policy Number, Policy Coverage, etc.]
18) Review the summary screen and print the confirmation (if desired).

19) Additional Changes on same application (if applicable).
   a) If you have additional dependents to add for the same reason / same effective
date, click the ‘Add Additional Dependent’ button and follow the steps for adding a
dependent.

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

21) After the nightly batch runs (once transaction has been approved), you can go in on
the following day and view the contract changes you entered.
C-4. Remove Dependent

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

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

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

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

10) Select the ‘Radio’ button next to **Add Dependent** and click the ‘Continue’ button.

11) Select the “Reason for Removing Dependent” from the drop-down menu. (For
12) Enter the Event Date (date of the qualifying event).
13) Enter the Employer Received Date (date application received by employer).
14) Check the box/boxes next to the dependent(s) being removed.
   a) For **Divorce** the system will automatically check the box next to the spouse and for any step-children.
   b) For **Change From Family to Single Coverage**, the system will automatically check the boxes next to all dependents other than the subscriber.
15) Click the ‘Submit’ button at the bottom of the screen.

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

b) If removing spouse/step-children only, and family coverage will remain in place and the notification date is not within the same month as the divorce (event) occurred, the coverage will end the end of the month of the notification date or the application received date, whichever is later. (e.g., Divorce occurs 01/21/2014, ET-2301 received by employer 02/03/2014 and ET-2311 notification date (date sent to former spouse/dependents) is 02/05/2014 – coverage cannot term until 02/28/2014).

If switching from Family to Single Coverage due to the divorce (reason selected in myETF Benefits will be Change From Family to Single Coverage not Divorce), then coverage will end the end of the month in which the divorce (event) occurred or the application received date, whichever is later. (e.g., Divorce occurs 01/21/2014, ET-2301 received by employer 01/27/2014 and ET-2311 notification date (date sent to former spouse/dependents) is 01/27/2014 – coverage ends 01/31/2014).

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

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

18) Review the summary screen and print the confirmation (if desired).
19) If you have completed all necessary transactions from the application, click on the “Return to Enrollment Summary” button.

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

C-5. Change Health Plans

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

1) In myETF Benefits, highlight the myMembers tab and select myMembers from the drop down list.
2) Enter the employee’s ETF Member ID or SSN into the appropriate box and click the ‘Search’ button or click ‘Enter’.
3) Verify that all demographic data are current.

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

10) Select the ‘Radio’ button next to **Change Health Plan**.
11) Select the “Reason for Changing Health Plan” from the drop-down menu. (For Example – Move From Service Area).

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

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

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

22) After the nightly batch runs, you can go in on the following day and view the contract changes you entered.
C-6. Termination of Coverage

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

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

![myETF Benefits Admin](image)

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

![myETF Benefits Admin](image)
2) Highlight the Health tab and select Termination of Coverage.

3) Enter the SSN or ETF Member ID.
4) Leave the Begin Date field blank.
5) Enter the Event Date.
6) Enter the Received Date (date the employer received app or term notice).
7) Enter the End Date (last day of health insurance coverage).
8) Select the Reason from the drop-down menu.
   a) If you select the reason Cancel Coverage, you will receive a secondary drop-down menu asking you to select whether or not the employee share of the premium is deducted “Post- Tax” or “Pre-Tax.” If the premiums are deducted “Pre-Tax” then you select the appropriate qualifier.
b) If you select the reason Retirement, a secondary box will pop up requesting you to enter the employee’s sick leave hours and pay rate.

9) Hit tab or wait a few seconds, member information should populate, including the begin date of the current Active contract.
10) Click the ‘Submit’ button at the bottom of the screen.

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

a) If you wish to review/verify the term processed highlight the Health tab and select Member Enrollment.
12) Enter the ETF Member ID or SSN and click the ‘Search’ button or hit ‘Enter.’ The term date should appear in red.

C-7. Pending Transactions

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

i. **Approved**: These are all the approved transactions that have been processed completely.

ii. **Approved – Not Applied**: These are the transactions that have been entered that day that do not require ETF approval, or that ETF has approved, but are awaiting the nightly batch processing run.

iii. **Approved – Processing Error**: The transactions that end up here, are here because some part of the data entry failed in the batch and may need to be re-entered.

iv. **Canceled**: These are transactions that either the employer or ETF canceled prior to the nightly batch run. There could be several reasons why they were canceled.

v. **Denied**: These are transactions that failed to meet eligibility requirements or the documentation supplied was insufficient/incorrect.

vi. **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.

vii. **Pending Sick Leave/Conversion**: When coverage is terminated by the employer using the reason “Retirement,” the employer is required to enter an estimated sick leave amount and an hourly pay rate. If the member is older than age 65 or if the sick leave total will not pay for three months of premiums as an annuitant, the transaction will be routed to this queue for ETF to address.

1) **Waiting for ETF Approval – Disabled**: This queue is where a transaction will go when a member is trying to add 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 for that dependent.
2) **Waiting for ETF Approval:** This is the queue for all the other 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 go here until ETF receives and approves the relevant 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. They take you back to the entry screen and you follow the same submission procedures as before.

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

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

2) Select a “status” from the drop-down menu. Define your search. The most common search is the default set up, however you can narrow the search by the following means:
   a) Reason (the reason for the application).
   b) Employer contact.
   c) Benefit Program.
   d) Request Type (Add Coverage, Add Dependent, Remove Dependent, etc.).
   e) Max Rows (max number of rows to show).
   f) Request Date.
   g) EmployerAction Date (date entered).
   h) Member ID.
   i) Range – Request From Date and Request ToDate.

3) Click the ‘Search’ button. If there are more than 10 lines, you may need to select the number of lines to show from the drop down on the left, just above the displayed range of data.

4) Click the ‘Select’ button next to the transaction you want to view/approve.
5) Review/verify that the information entered is correct. If the transaction is in the pending queue, and all information is correct:
    a) Click the ‘Approved’ button and it will automatically take you back out to the queue.
    b) Click on “Return to myMember Requests”, if you are not ready to approve.

6) If the transaction is in the Pending queue, and all the information is not correct:
    a) Click the ‘Edit’ button to update any information.
    b) Click the ‘Cancel’ button to cancel the transaction, in which it will need to be re-entered by the member (employee).
    c) Enter a reason for the cancellation.
    d) Check the box next to “I would like to cancel this request.”
    e) Click the ‘Confirm’ button.
7) If the transaction is in the Pending queue, and after the review of information the member is not eligible to make the requested change.
   a) Click the ‘Deny’ button.
   b) Enter a reason for the denial.
   c) Check the box next to “I would like to deny this request.”
   d) Click the ‘Confirm’ button.

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

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

C-8. Enrollment Inquiry

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

1) In myETF Benefits, highlight the ‘Health’ tab.
2) Highlight Inquiry.

3) Highlight Enrollment Reports.
4) Select Enrollment Inquiry.

5) Select the Coverage Month.

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

8) Select the Coverage Type option of your choice (default is ALL).
9) Click the ‘Display’ button to display the results of your query.

a) You can select the number of entries to show at one time.
b) You can search for specific information (example: Employee Type, MID#, SSN, Last Name etc.)
c) You can skip to a certain page, next page, or last page.
d) You can sort by a specific column (small red arrows).
10) Click the ‘Save As’ button to export the results to a Microsoft Excel spreadsheet.

11) You will be given the option to Open or Save the Excel spreadsheet or Cancel the export.

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

You can then choose to save the query or exit from Excel. It will not change your query in myETF Benefits.
C-9. Dependent Inquiry

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

2) Highlight ‘Inquiry’.
3) Highlight ‘Enrollment Reports’.

4) Select ‘Dependent Inquiry’.
5) Select the Coverage Month.

6) Select the Coverage Year.
7) Select the Health Plan option of your choice (default is All).

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

10) Select the Tax Dependent Status of your choice (default is **All**).
11) Click the ‘Display’ button to display the results of your query.

a) You can select the number of entries to show at one time.
b) You can Search for specific information (example: Health Plan, Coverage Type, Employee Type, Subscriber SSN, Dependent SSN, Dependent MID#, etc.)
c) You can skip to a certain page, next page, or last page.
d) You can sort by a specific column (small red arrows).
12) Click the ‘Save As’ button to export the results to a Microsoft Excel spreadsheet.

a) You will be given the option to Open or Save the Excel spreadsheet or Cancel the export.
13) Upon choosing to Open the spreadsheet, it will export the query to Excel and show it in the following format.

<table>
<thead>
<tr>
<th>Health</th>
<th>Coverage</th>
<th>Employee Type</th>
<th>Sub ISN</th>
<th>Exp</th>
<th>Dep</th>
<th>Sub Name</th>
<th>Dept Name</th>
<th>Dept DOB</th>
<th>Dept Gender</th>
<th>Dept Marital Status</th>
<th>Cov Exp Date</th>
<th>Cov Exp Rate</th>
<th>Disabled</th>
<th>Tax Dept</th>
</tr>
</thead>
<tbody>
<tr>
<td>X X X</td>
<td>X X X</td>
<td>X X X</td>
<td>XXXXXXXXXX</td>
<td>LAST FIRST</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
</tr>
<tr>
<td>X X X</td>
<td>X X X</td>
<td>X X X</td>
<td>XXXXXXXXXX</td>
<td>LAST FIRST</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
</tr>
<tr>
<td>X X X</td>
<td>X X X</td>
<td>X X X</td>
<td>XXXXXXXXXX</td>
<td>LAST FIRST</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
</tr>
<tr>
<td>X X X</td>
<td>X X X</td>
<td>X X X</td>
<td>XXXXXXXXXX</td>
<td>LAST FIRST</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
</tr>
<tr>
<td>X X X</td>
<td>X X X</td>
<td>X X X</td>
<td>XXXXXXXXXX</td>
<td>LAST FIRST</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
</tr>
<tr>
<td>X X X</td>
<td>X X X</td>
<td>X X X</td>
<td>XXXXXXXXXX</td>
<td>LAST FIRST</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
<td>X X X X</td>
</tr>
</tbody>
</table>

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

C-10. Address Inquiry
The Address Inquiry 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.

1) In myETF Benefits, highlight the ‘Health’ tab.
2) Highlight ‘Inquiry’.

3) Highlight ‘Enrollment Reports’.

4) Select ‘Address Inquiry’.

5) Select the number of days for the drop-down.
6) Click the ‘Display’ button to display the results of your query.

a) You can select the number of entries to show at one time.
b) You can Search for specific information (example: Subscriber SSN, Subscriber MID#, Name, etc.)
c) You can skip to a certain page, next page, or last page.
d) You can sort by a specific column (small red arrows).
7) Click the ‘Save As’ button to export the results to a Microsoft Excel spreadsheet.

8) Directions.