Local Employer
Health Insurance Standards, Guidelines and Administration Manual

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

Employer Communications Center
1-877-533-5020

etf.wi.gov

ET-1144 (REV 5/13/2024)

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Preface

The *Local Health Insurance Employer Standards, Guidelines and Administration Manual* (ET-1144) is a reference source intended to aid your administration of and participation in the Wisconsin Public Employer Group Health Insurance Program. Its contents are based on state statute 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 and may be revised. This document will be updated regularly.

The Department of Employee Trust Funds will make every effort to communicate changes to employers via the ETF website and ETF E-mail Updates. This Employer Standards, Guidelines and Administration Manual 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 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 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, 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, 40.02 (28)

The Wisconsin Public Employers (WPE) Group Health Insurance Program is authorized by Wis. Stat. § 40.51 (7). The program is available to Wisconsin Retirement System (WRS) employers and governmental employers who are not in the WRS but who meet the definition of employer under Wis. Stat. s. 40.02 (28), per 2011 Wis. Act 133. This program 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. The BOARD may assess a Plan Stabilization Contribution to the Wisconsin Public Employers pool. This could be a per contract per month fee. The BOARD may also limit it to EMPLOYERS who have less than 50% of the participating EMPLOYEES enrolled in the IYC ACCESS PLAN coverage.

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 contain a number of provisions that affect the Group Health Insurance Programs administered by ETF. For more information, please visit ETF's website at etf.wi.gov.

101 F) Health Insurance Portability and Accountability Act (HIPAA)

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

(1) The three components of this effort are:

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

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

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

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

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

(b) Certain qualifying events such as loss of other group coverage, marriage, or the birth or adoption of a child, permit an enrollment opportunity without restriction. For more information, see the *Life Events Guide* in the health benefits 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 health benefits 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 participating WPE groups are considered MINIMUM ESSENTIAL COVERAGE.

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

102 Employer Agent Responsibilities

102 A) Designate a health insurance representative to:

(1) Receive, respond, and forward as necessary ETF E-mail Updates, which contain important news and information from ETF. Your ETF case manager will automatically subscribe you to the appropriate topics for your agency. Contact your case manager with any questions.
(2) Explain eligibility, cost, enrollment procedures and effective dates to employees.
(3) Review original required documentation to validate births, marriages, divorces, deaths, and other life events. For births, marriages, divorces and deaths, send ETF the *Employer Attestation for Documentation Received* (ET-1908) form to verify your actions to benefit coverage eligibility. Employers should *not* send digital copies of vital records per Wis. Stat. § 69.21. See Life Change Events and Documentation Requirements (ET-2846).
(4) Provide annual *Health Benefits Decision Guides,* either paper or electronic, to all new hires and current subscribers prior to the annual health benefits open enrollment period and track when each employee received one. The annual *Health Benefits Decision Guides*, available on the ETF website and updated annually (please see ET-2128, ET-2158, ET-2168, and ET-2169) provide information on what's changing, health insurance rates, uniform benefits and plan availability for the plan year.
(5) Provide information upon initial enrollment, during health benefits open enrollment, continuation-conversion provisions, and when applicable, Medicare.
(6) Secure, audit and maintain health insurance applications, audit and approve online enrollments and arrange payroll deductions.
(7) Run reports to determine eligibility for dependents turning age 26 including those who are disabled.
(8) Review, reconcile and pay monthly ETF invoices online by the 24th of each month. Refer to Chapter 15.

(9) Refer employees to the appropriate health plan contacts for claim or benefit questions. Customer service contact information is available in the health benefits 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 quarterly and provided in an employer bulletin. This list is not meant to be shared with employees, but as a tool for employers only.)

(10) EMPLOYERs newly joining or leaving the program must notify insured ANNUITANTS of the availability or loss of this coverage.

(11) EMPLOYERs newly joining or leaving the program must notify any COBRA/CONTINUANTS from the previous group plan of the change of coverage to or from this health insurance program. Notification and application should be sent to his/her last known address.

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

(13) Refer questions regarding this contract to ETF (Refer to subchapter 106).

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

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

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

103 Employer Training and Support

103 A) Training

Training for employers administering benefits under the Group Health Insurance con- tract 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 (ESS) at 1-877-533-5020 (toll-free) 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).

(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 and demographic data.

(c) Complete mass employee terminations.

(d) View and update health insurance enrollment data.

(e) Approve employee submitted changes to health insurance and demographic data.

(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 the myMembers screen.

(b) View individual health insurance eligibility and demographic data.

(c) Update health insurance enrollment data.

(d) Update demographic information.

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

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

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

105 ETF Ombudsperson Services

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

ETF offers ombudsperson services to assist members who remain dissatisfied after first having contacted the health plan and/or the Employer Services Section regarding a problem or complaint. Employers should direct employees in this situation to email, write or call ETF's ombudsperson at the following:

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

1-608-261-7947

Email ombudsperson@etf.wi.gov

ETF ombudspersons advocate for members and attempt to resolve complaints and problems on their behalf. If unsuccessful, the ombudsperson advises the member of subsequent avenues of appeal. If a member's issue cannot be resolved informally, formal written complaints should be made in writing, using the *Insurance Complaint Form* (ET-2405) if possible and should include an explanation of the issue the member is attempting to resolve. Additional information regarding ETF ombudsperson services can be found under the "Members" section at etf.wi.gov and searching Ombudsperson

Services.

106 Employer Services Section, Insurance Unit (ESS) Contacts

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 Madison WI 53707-7931
Shipping Address	Department of Employee Trust Funds 4822 Madison Yards Way Madison WI 53705-9100
Telephone	1-877-533-5020 select option 2 (toll free)
TTY	711
Fax	1-608-267-4549
Website	etf.wi.gov
Email	ETFSMBEmployerInsurance@etf.wi.gov If you are sending demographic or sensitive documentation to ETF via email, it must be sent secure. If you are unable to send secure, submit it securely through Box or fax it to ETF.
Secure Document Submission	Documents for demographic or sensitive information can be submitted securely to ETF through Box. Use this link to submit documents securely: https://etf.app.box.com/f/7a3fc2c5ca3c45c3848c44d3f6dbafab

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

106 B) Pharmacy Benefit Manager (PBM) Contact Information

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

106 C) Wellness and Disease Management Program Administrator

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

Chapter 2 — Health Plan and Program Requirements and Information

The Wisconsin Public Employers Group Health Insurance Program offers two types of plans to participating EMPLOYEES and ANNUITANTS: IYC health plans and the IYC ACCESS Plan. Effective January 1, 2015, there are four different Program Options to choose from, including a High Deductible Health Plan (HDHP) option. The EMPLOYER may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD. If dental coverage is offered through this program, it is Uniform Dental Benefits.

201 Benefit Program Option Information

201 A) Local government employers have flexibility in choosing cost-sharing plan options under the WPE Group Health Insurance Program. Employers may offer up to four program options (POs) to different classes of employees (that is, collective bargaining units). Employers may also elect whether or not to offer Uniform Dental coverage. Program options vary based upon these choices.

Four different health benefit options are available, identified by the Program Option (PO) an employer selects. The annual *Health Benefits Decision Guides*, available on the ETF website and updated annually provide information on what's changing, health insurance rates, uniform benefits and plan availability for the plan year. They are:

PO 2/12: Traditional Health Plan (ET-2128)
PO 4/14: Deductible Health Plan (ET-2158)
PO 6/16: It's Your Choice Health Plan (ET-2168)
PO 7/17: High Deductible Health Plan (ET-2169)

The EMPLOYER electing the Deductible Health Plan option coverage shall not pay the deductible on behalf of the EMPLOYEE/PARTICIPANT unless it is under Section 125 of the Internal Revenue Code.

The EMPLOYER electing the High Deductible Health Plan option coverage shall not pay the deductible on behalf of the EMPLOYEE/PARTICIPANT unless it is under Section 125 Health Savings Account (HSA) or under Section 152 and 213(d) Health Reimbursement Account (HRA) of the Internal Revenue Code. The EMPLOYER is not required to offer an HSA or HRA with the High Deductible Health Plan.

Wisconsin Public Employees
Non-Medicare Medical Benefits/Program Options (POs)

For HMOs and some PPOs: Represents benefits for in-network providers		Program Option 2*/12 IYC Local Traditional Plan	Program Option 4*/14 IYC Local Deductible Plan	Program Option 6*/16 IYC Local Health Plan	Program Option 7*/17 IYC Local High Deductible Health Plan (HDHP)
Uniform Benefits	Deductible (Unless otherwise noted, it is an overall deductible)	No deductible	$500 Individual $1,000 Family Except as required by federal law. Does not apply to prescription drug copayments.	$250 Individual $500 Family Except as required by federal law. Does not apply to office visit and prescription drug copayments.	$1,600 Individual $3,200 Family Except as required by federal law. *Note:* Deductible must be met before coverage begins. For family coverage, full family deductible must be met. Deductible includes prescription drug coverage. Once met, office visit and prescription drug copayments apply up to OOPL.
	Office Visit Copayment	None	None	$15 Primary Care, $25 Specialty Care. Applies to OOPL but not deductible.	After deductible $15 Primary Care, $25 Specialty Care. Applies to OOPL.
	Coinsurance	None except 20% for durable medical equipment, adult hearing aids and adult cochlear implants.	After deductible, none except 20% for durable medical equipment, adult hearing aids and adult cochlear implants.	After deductible you pay 10% except for office visit copayments.	After deductible you pay 10% except for office visit and prescription drug copayments.
	Annual out-of-pocket limit (OOPL): includes deductible and coinsurance	None except up to $500 Individual for durable medical equipment and adult cochlear implants. Plan pays no more than $1,000 for each adult hearing aid. See etf.wi.gov.	After deductible, none except up to $500 Individual for durable medical equipment and adult cochlear implants. Plan pays no more than $1,000 for each adult hearing aid. See etf.wi.gov.	$1,250 Individual $2,500 Family	$2,500 Individual $5,000 Family

Prescription Drug Benefits	Copayment/Coinsurance (For detail including prescription drug out-of-pocket limits, visit etf.wi.gov)	
	Level 1	$5
	Level 2	20% ($50 max)
	Level 3	40% ($150 max)
	Level 4 Preferred	$50

* Program option includes dental coverage with no deductible and a $1,000 per individual annual benefit maximum with 100% coverage of filings and specified diagnostic and preventive services; and 90% coverage for non-surgical extractions and 80% coverage of certain basic services. Also includes 50% coverage up to $1,500 per child for orthodontia.

201 B) In addition to medical benefits, local employers have a choice to offer Uniform Dental or not. This is reflected in the PO code. For example, an employer who requests the Local Deductible Plan with dental would be coded P04. If the employer chose not to offer dental, the program option would be P14. Uniform Dental offers preventive, basic and some orthodontic coverage. It is not comprehensive dental coverage. For more information, see the health benefits local materials online.

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

An EMPLOYER may elect to enroll under additional program options only to collective bargaining units as approved by ETF. Individual EMPLOYEES and insured ANNUITANTS and CONTINUANTS cannot choose between POs. For example, an employer may offer PO2 for their police and firefighters and PO4 for all others. Therefore, all police and firefighters must only be offered PO2, and all others must only be offered PO4.

NOTE: Normally, local employers select one Program Option for all their employees. Rarely, a local employer might have different Program Options for different groups of employees. For example, a municipality might have different Program Options for their general employees and for their collectively bargained employees (such as protective category employees).

If a local employer has more than one Program Option, and an employee switches from one to the other due to a change in positions, the employer cancels their coverage in MEBS using the steps outlined in this manual:

1. Follow steps to cancel coverage outlined in Appendix C-6.
2. Under Step 4, when selecting options from the “Premiums are deducted” dropdown, select “Pre-tax: I (and all my dependents, if any) became eligible for and enrolled in other group coverage.

202 IYC Health Plans and HDHP (HMOs and PPOs)

IYC health plans are health maintenance organizations (HMOs) or preferred provider organizations (PPOs) that provide Uniform 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-network providers, except in the case of emergency, urgent care or when the service is not reasonably available from a plan provider.

All health plans participating in the Group Health Insurance Program offer the same level of coverage, called Uniform Benefits, with the exception of the Medicare Plus plan offered to

Medicare eligible retirees by UnitedHealthcare. Note that plans may have differing medical policies that impact coverage, for example, differences in what services are considered experimental.

Uniform Benefits, as detailed in the health benefits materials online, are designed to ease employee health plan selection and assist ETF's efforts to negotiate quality care at the lowest possible cost. Uniform Benefits permit employees to select a health plan based on cost, 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 premium amount, provider network, benefit determinations and administrative requirements. Uniform Benefits and premium amounts change on an annual basis. The annual *Health Benefits Decision Guides*, available on the ETF website and updated annually (please see ET-2128, ET-2158, ET-2168, and ET-2169) provide information on what's changing, health insurance rates, uniform benefits and plan availability for the plan year. The annual *Health Benefits Decision Guides* and the Certificates of Coverage and Schedules of Benefits (listed below) online are the most reliable resources for details.

Form # ET-	**Title of Certificate of Coverage or Schedule of Benefits (Program Option)**
2180	Uniform Benefits Certificate of Coverage [For Access Plans too]
2108sb	Local Traditional Plan and Health Plan Medicare Schedule of Benefits (P02/12/P06/16/P07/17/P08)
2131sb	Local Traditional Access Plan Schedule of Benefits (PO2, PO12)
2158sb	Local Deductible Plan Schedule of Benefits (PO4, PO14)
2162sb	Local Deductible Access Plan Schedule of Benefits (PO4/14)
2107sb	IYC Health Plan Schedule of Benefits (PO6/16/PO8)
2112sb	Access Plan Local Health Plan and LAHP Schedule of Benefits (PO6/16/08)
2107sbhd	High Deductible Health Plan (HDHP) Schedule of Benefits (PO7/17)
2170sb	Access High Deductible Health Plan (HDHP) Schedule of Benefits (PO7, PO17)
4113	Medicare Plus (Certificate of Coverage and Schedule of Benefits)
2100cc	Medicare Advantage without deductible (Evidence of Coverage)
2100ccd	Medicare Advantage with Deductible PO4/14 (Evidence of Coverage)

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

Employers may choose to offer Uniform Dental Benefits. If they do, you will be enrolled in Program Option 2 (Traditional), 4 (Deductible), 6 (IYC Health Plan) or 7 (HDHP). See section 201 B) or more information on program options.

203 IYC Local ACCESS Plan and IYC ACCESS HDHP

The IYC Local ACCESS Plan (formerly the Standard Plan) is a statewide/nationwide Preferred Provider Organization (PPO) that is currently administered by Dean Health Plan. Participants enrolled in the IYC ACCESS Plan can see a provider of their choice without the network restrictions associated with an HMO. In exchange for this freedom to select the provider of their choice, the participants have different benefit levels depending on whether the provider selected is in-network (Uniform Benefits) or out-of-network (lesser benefit level). PPOs have different copayment and deductible schedules for out-of-network providers, except in the case of emergency or urgent care. Participants can review the *IYC ACCESS Plan* Certificate of Coverage online for more details:

PO 2/12: Traditional Access Plan (ET-2131sb)

PO 4/14: Deductible Access Plan (ET-2162sb)

PO 6/16: Access Plan for Local Health Plan (ET-2112sb)

PO 7/17: Access High Deductible Health Plan (ET-2170sb)

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

Premium rates for the IYC Access Plan may vary based upon the geographic location of the municipality. The difference is to be determined annually by the BOARD's actuary.

204 State Maintenance Plan (SMP) and Health Plan Qualification

The State Maintenance Plan (SMP) offers the same Uniform Benefits package as the IYC health plans, but is available only in those counties that do not have a qualified Tier 1 IYC Health Plan as noted in the current health benefits materials. In those counties, the 88% or 105% formula is based on SMP rates. SMP is administered by Dean Health Plan.

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

205 Contribution Rates

205 A) Under Wis. Stat. § 40.51 (7) and Wisconsin Administrative Code ETF 40.10, participating employers have the choice of three structures available for establishing employer contribution toward premium. The 88% calculation method (see section 205B), the three-tiered premium structure (see section 205D) and the 105% formula method (see section 205C) that is only available to those groups identified in the law following passage of 2011 Wisconsin Act 10. See also section 403.

You may view a half hour webinar on contribution rates at etf.wi.gov under training in the employer's section.

Contributions can vary by employee groups. A group can be defined by:

1) start dates,
2) full-time equivalency,
3) coverage type (single or family),
4) collective bargaining agreements,
5) geographic location or
6) other breakdown approved by ETF.

The employer must apply the same adjusted contribution rate equally to all employees within the same group, regardless of the plan they select.

The rate tables ETF provides on-line indicate the maximum employer share following the restrictions below. If a health plan's premium is equal to or less than the employer's share, the employer pays the entire premium. The employer may adjust the employer contribution downward to require employees who select low-cost plans to pay some amount. If a health plan's premium is substantially higher than the employer contribution rate, the employee contribution will be the difference between the total premium rate and the employer contribution rate.

Locals may offer employees a health insurance opt-out incentive. See 208 and 503A 6 for more information.

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

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. In order 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 (see 204D below).

205 B) 88% formula method:

The 88% rate tables ETF provides on-line indicate the maximum employer share following the restrictions below. The 88% calculation method aligns with the 105% calculation as required by the statutes.

> (1) The EMPLOYER contribution toward PREMIUM for any EMPLOYEE shall be at least 50% but not more than 88% of the gross PREMIUM of the average cost Tier 1 qualified IYC health plan approved by the BOARD which is in the service area of the EMPLOYER.

(See 207 for more information on service area.)

(2) The minimum contribution for an EMPLOYEE who is appointed to work less than 1,040 hours per year shall be no less than 25% of the lowest cost qualified IYC health plan that is in the service area of the EMPLOYER and approved by the BOARD.

(3) If the amount of EMPLOYER contribution changes, a new enrollment offering may be made to its EMPLOYEES, as determined by ETF.

205 C) 105% formula method:

The 105% formula applies to those listed below (or a three tier structure that aligns with the 105% formula may be used):

(1) Represented employees who are subject to a collective bargaining agreement that was in place before June 28, 2011.

(2) Non-represented managerial law enforcement or managerial fire-fighting employees initially hired by a local employer before July 1, 2011. These employees are paid at the same percentage as represented law enforcement or fire-fighting personnel hired before July 1, 2011.

(3) Represented law enforcement or fire-fighting employees initially hired before July 1, 2011 and who on or after July 1, 2011 became a non-represented law enforcement or fire-fighting managerial employee. These employees are paid at the same percentage as represented law enforcement or fire-fighting personnel hired before July 1, 2011.

The EMPLOYER contribution toward PREMIUM for any EMPLOYEE shall be:

(1) At least 50% but not more than 105% of the gross PREMIUM of the low cost qualified IYC health plan approved by the BOARD which is in the service area of the EMPLOYER. (See 207 for more information on service area.)

(2) The minimum contribution for an EMPLOYEE who is appointed to work less than 1,040 hours per year shall be 25% of the lowest cost qualified IYC health plan that is in the service area of the EMPLOYER and approved by the BOARD.

(3) If the amount of EMPLOYER contribution changes, a new offering may be made to its EMPLOYEES, as determined by ETF.

205 D) Three Tier Premium Contribution Structure Available

1) The 3 Tier Premium Structure is also available for employers to use in establishing the maximum employee contribution toward premium. 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 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.

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

2) EMPLOYERS who determine the EMPLOYEE PREMIUM contribution based on the tiered structure established for state EMPLOYEES must do so in accordance with Wis. Adm. Code § ETF 40.10. The criteria for a local employer to implement tiering is as follows:

(a) The employee portion of the monthly premium will increase for plans in higher tiers by at least $20 for single coverage and $50 for family coverage for each successively higher tier.

(b) The employee's single or family premium contribution must be the same for all plans in a given tier.

(c) A number of provisions affect the amount an employer may contribute toward the employee cost of health insurance. 2011 Wisconsin Act 10 requires that participating local employers not pay more than 88% of the average premium cost of the qualified tier one health plans. If a collective bargaining agreement remains in effect, the terms of that agreement regarding group health insurance apply. In addition, Administrative Code ETF 40.10 prohibits the employer from paying more than 105% of the least costly qualified health plan within the employer's county.

(d) The employer must pay at least 50% of the premium for employees who work 1,040 hours or more per year and can pay no less than 25% of the premium for employees who work fewer than 1,040hours per year.

206 Employer Paid Annuitants

ANNUITANTS for whom the EMPLOYER contributes toward the PREMIUM shall be treated as EMPLOYEES for the purpose of PREMIUM and coverage reporting.

207 Service Area

The county of the employer is considered the service area for local employers.

In rare circumstances, an employer may find that the lowest cost tier 1 qualified plan identified for their county in the 88% employer contribution tables does not represent the health plan chosen by most of their employees. This is usually caused by the employer's location in a county when compared to the provider service area offered by the health plan. In this case and at the request of a participating employer, ETF will review the service area used to determine the least / average cost qualified plan used for determining the employer's maximum premium contribution. (See section 205 for more information.) If ETF reviews the service area, the least / average cost plan will either be based on the zip code locations that include at least 80% of the covered employees of the participating employer, or, when an employer has offices in multiple counties, the least / average cost plan is determined by the

county office to which the employee reports to work. Once ETF has made such an assessment, that service area will determine the least / average cost plan until it is demonstrated that there has been a significant change in employee residency and the area no longer meets the 80% criteria.

208 Opt-Out Incentive

Local government employers have flexibility to offer a health insurance opt-out incentive similar to the State's policy. They may offer payments to employees in lieu of enrolling for health insurance coverage in the program.

209 Pharmacy Benefit Manager (PBM) - Navitus

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

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

Retirees may choose to be enrolled in another Medicare Part D plan, but it is neither recommended nor required. Retirees who choose to enroll in another Medicare Part D plan will be disenrolled from ETF's Medicare Pharmacy Part D plan. However, they will still maintain the supplemental "Wrap" coverage, which will be secondary to the other Medicare Part D plan. There is no partial premium refund for enrolling in another Medicare Part D plan.

Pharmacy ID Cards

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

210 Wellness & Disease Management Program Administrator - WebMD

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

Some well-being activity options include: health coaching, disease management, wellness challenges and other online well-being programs.

All incentives earned by participants are considered taxable income to the subscriber and are reported to employers semiannually. COBRA participants will see some taxes withheld from their incentive.

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

211 Health Plan & Vendor Contacts

Health plan and benefit vendor addresses and phone numbers are listed in the health benefits *materials online*. Your employees are encouraged to contact health plans using the resources listed on this page with specific questions regarding such topics as referral policies, benefits, filing of claims and/or provider networks.

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

212 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 health benefits section. See the Certificates of Coverage (refer to section 202). Questions regarding COB should be directed to the health plans.

213 Administration of Benefit Maximums

213 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 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.

213 B) If a PARTICIPANT changes the level of coverage (e.g., single to family), 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, or to another local employer, regardless if they remain covered by the same insurer.

213 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.

214 Errors

214 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. See 901A 10.

214 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.

214 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 back PREMIUMS are paid. Coverage then may be obtained only under the deferred coverage provisions of 701 G.

214 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 as a result 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.

214 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 submit an application 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.

215 Premium Refunds due to Errors are Limited

In the event an **employer** erroneously continues to pay the PREMIUM for an **employee** who terminates employment or is on a leave of absence, refunds of such PREMIUMS shall be limited to no more than two months of PREMIUMS paid prior to the current month of coverage. However, if the last dependent loses eligibility due to age, then retro adjustments to premiums may go back 6 months based upon the date the EMPLOYEE files the application. Also see 901G.

216 Limited Premium and Claim Adjustments

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

217 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).

Chapter 3 — New Participating Employer Information

301 Large Group (50+ employees) Underwriting and Surcharges

301 A) Effective January 1, 2009, large (50+ employees) local governments seeking to participate in the local group health insurance program are subject to group underwriting and may be assessed a surcharge based on their risk as recommended by ETF's actuary. The 90-day underwriting process that begins with receipt by ETF of all materials described on the checklist from the *How to Become a Participating Employer under the Wisconsin Public Employer's Group Health Insurance Program* (ET-1139). At least 40 days prior to the EFFECTIVE DATE, ETF must receive from the EMPLOYER all EMPLOYEE and ANNUITANT applications for which coverage will begin on the EFFECTIVE DATE.

This process has been approved by the BOARD. The surcharge is applied when a group's risk is determined to be detrimental to the existing pool. Surcharge rates are applied to all non-Medicare rates, including for retiree family contracts that contain a member who is non-Medicare. Surcharge rates are passed on to the health plan and prescription drug plan to cover anticipated claims.

Surcharge amounts are usually reduced for the calendar year following the group's initial period. For example, a group joining on January 1 with a 30% surcharge can expect to see their rate drop to 15% the second year and be eliminated at the start of the third year. However, surcharge amounts are reviewed annually by the BOARDS's actuary and the foundational rate may be increased at of the start of a calendar year. In the example above, this means that the second year surcharge amount may be greater than 15% due to the annual renewal process.

Administration of the underwriting process is done, and assessment of the surcharge is determined by the BOARD's actuary. The surcharge determination cannot be appealed. ETF reserves the right to separately rate underwritten groups larger than 2,000 total members, as recommended by the actuary.

Underwriting compares the claims experience of the employer's members over the last 2 to 3 years to the pool of currently insured employees in the local Group Health Insurance Program. If the claims experience (risk) is higher than the claims experience in the pool, the increased risk is off-set by a surcharge rate of up to 80% of the average cost of the local health plans. For information on codes, see Appendix B.

301 B) In order to participate (for large groups after underwriting) the governing body of an EMPLOYER shall adopt a resolution for an offered program option in a form prescribed by ETF. An EMPLOYER may elect to provide different program options (see 201) separately to collective bargaining units as approved by ETF.

301 C) The EFFECTIVE DATE of coverage shall be the beginning of the quarter (for large employers, following the 90-day underwriting process).

301 D) If the number of EMPLOYEE applications received does not represent the minimum participation level of at least 65% of the eligible EMPLOYEES or for small EMPLOYERS as defined under Wis. Stat. § 635.02 (7), the minimum participation level in accordance with Wis. Adm. Code § INS 8.46 (2), the resolution shall become void. Eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level.

302 Groups with 40 to 49 Employees - Underwriting and Surcharges

Employers interested in joining the WPE Group Health Insurance Program that have between 40 and 49 WRS employees are subject to the following procedure:

302 A) Will have a validated WRS employee roster generated by ETF staff to confirm WRS employees upon initial inquiry to ETF. This is recommended to occur 180 days prior to the group's anticipated effective date.

302 B) The employer must provide their resolution and all of their employee's completed health insurance applications a minimum of 60 days before the effective date. If ETF does not obtain these materials by the 60-day deadline, ETF will re-run the WRS roster. If the number of employees has increased to 50 or more, the employer will be considered a large group. The enrollment process will stop, and the group will not be able to join until the following quarter. The group will have to go through the underwriting process as seen in section 301, as they now are a large group. It is advised that the employer should retain their current health insurance if they expect to increase to 50 or more WRS employees and are not able to have all of their materials submitted to ETF correctly and completely by the 60-day deadline.

302 C) Any EMPLOYER who joins the program with a surcharge shall be required to remain in the program a minimum of three years effective when group participation begins.

303 Initial Group Enrollment

303 A) Eligible EMPLOYEES who are not insured under the EMPLOYER'S current group health plan at the time the resolution to participate is filed, or those insured for single coverage who are enrolling for family coverage, shall be subject to enrollment limitations.

1) Employees must choose the Access Plan during initial enrollment if:
    a. The Employer does not currently cover its employees with group health insurance plans.
    b. The employee is not insured under the Employer's current health insurance program.
    c. The employee is insured for single coverage and wants to enroll in family coverage.
    d. The employee is hired after the Resolution of Inclusion and before the effective date.

    In addition, the deferred coverage provisions of section 701 G apply.

These limitations will not apply to PARTICIPANTS insured under another group health insurance plan administered by ETF. Those insured through the employer's group coverage at the time the resolution is filed who do not meet the definition of eligible employee under this

program may elect continuation coverage for up to 36 months or the length of time continuation coverage would be available under the previous insurer, whichever is less.

303 B) EMPLOYEES who are on a leave of absence and not insured under the EMPLOYER'S plan are eligible to enroll only under section 701 G if they returned to active employment. For ANNUITANTS and EMPLOYEES on leave of absence to be eligible under this section, they must be insured under the EMPLOYER'S current group health plan while on leave or as an ANNUITANT.

303 C) ETF may allow any EMPLOYER to offer a non-participating plan to a group of its EMPLOYEES if it can be demonstrated to the satisfaction of ETF that:

(1) collective bargaining barriers require such other coverage; and
(2) there will be no adverse impact to the program; and
(3) that the minimum number of all of the EMPLOYER'S EMPLOYEES who are eligible under Wis. Stat. § 40.51 (7), including those who are in the non-participating health plan, become insured under the program of the BOARD to meet the required participation levels as defined in 301 above.

303 D) A Large EMPLOYER (more than 50 employees who are eligible under Wis. Stat. § 40.51 (7) may indefinitely retain a second plan, as described in 302 C) above, or temporarily retain a second plan for up to four years due to timing of collective bargaining or the merger or division of municipalities by executing the appropriate Resolution to Participate provided the EMPLOYER also meets the 65% participation requirement as described in 301 above. The EMPLOYER may later enroll the EMPLOYEES in the collective bargaining unit that did not enroll during the EMPLOYER’S initial enrollment period due to the EMPLOYER retaining a second plan or due to the timing of collective bargaining. The EMPLOYER must notify ETF, in writing, of this enrollment at least 30 days prior to the EFFECTIVE DATE of coverage for these EMPLOYEES. These EMPLOYEES may elect any available plan if they enroll with no lapse of coverage when their coverage under the other plan terminates.

303 E) An ANNUITANT shall be covered if a completed ETF application form is received as specified in section 301.

Chapter 4 — Eligibility

401 Employee, Annuitant and Continuant Eligibility

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

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

401 B) All Wisconsin Retirement System (WRS) eligible employees, including part-time employees, retirees and survivors (see Chapter 14) are eligible for group health insurance and must be offered coverage if the employer elects to provide coverage under the Wisconsin Public Employers (WPE) Group Health Insurance Program. This includes:

(1) Active WRS participating employees.
(2) Any retired employee who:
  a) was insured by an employer who was and continues to be in the program; and
  b) who is on an immediate annuity, receives disability retirement, duty disability (see 1101B 2), or Long-Term Disability Insurance (LTDI) benefits, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1). An immediate annuity means the annuity effective date is within 30 days of the termination date.
(3) Rehired WRS annuitants who elect to return to active WRS coverage.

401 C) Non-WRS employers covered by a Section 218 agreement with the Social Security Administration who participate in the WPE Group Health Insurance Program must offer the coverage to the following eligible employees. Retirees and survivors are also eligible and must be offered coverage.

(1) Employees covered by any WRS employer before July 1, 2011 must be:
  (a) Expected to work 440 hours for teachers and educational support staff, and 600 hours for all others; and
  (b) Expected to work at least one year (365 consecutive days, 366 in leap year)

from their date of hire.

(2) Employees who were never in the WRS or were covered by any WRS employer on or after July 1, 2011 must be:

(a) Expected to work 880 hours for teachers and educational support staff, and 1,200 hours for all others; and

(b) Expected to work at least one year (365 consecutive days, 366 in leap year) from their date of hire.

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

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

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

401 F) Employers may provide payments to employees in lieu of coverage under the WPE Group Health Insurance Program. See section 208.

401 G) Double coverage, where an insured member is covered twice under a State and/or WPE contract, is not permitted. For example, a SUBSCRIBER cannot also be covered as a DEPENDENT and a DEPENDENT cannot be covered under two contracts. See 402 B) for more information.

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

402 Dependent Coverage Eligibility

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

(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:

(i) Children, stepchildren, and legal wards 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.

(f) 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 10).

(g) Effective 2019, 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.

402 B) Coverage for Spouse and Dependent

(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin or a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family 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. Upon an EMPLOYER'S request, ETF may approve at its discretion a special enrollment opportunity for affected employees due to a change in policy for coverage of spouses.

(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 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.

403 Employer Premium Contribution Eligibility

Employer contributions must begin no later than the first of the month following the employee's completion of six months of qualified employment with the present employer or at an earlier date, if mutually agreed upon by the employer and employee. Employer premium contributions must be in line with one of the three health insurance premium contribution structures described in Chapter 2 (subchapters 204 and 205) of this manual.

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

404 Determining Effective Dates for the Employer Premium Contribution

404 A) Employees wishing immediate coverage upon becoming WRS eligible may submit a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) within 30 days of their hire date. Coverage is effective the first of the month following receipt of the application and the employee is responsible for the entire premium amount until such time as they are determined to be eligible for the employer contribution. See also 501B) (2)(b).

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

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

> **Example:** A teacher is hired (signs a contract) on June 27 and begins employment on August 29 (WRS begin date). In the event the employer receives the completed *Health Insurance Application/Change Form* on or prior to August 1, the coverage effective date is August 1. Should the employer receive the completed *Health Insurance Application/Change Form* after August 1 and on or prior to September 1, the coverage effective date is September 1.
>
> **Note:** Employees failing to enroll when first eligible must wait until the next annual open enrollment period to enroll unless they experience a life event prior to that period. (Refer to Chapter 6 for other enrollment opportunities.)

405 WRS Previous Service Check

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

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

A. Access the Previous Service Benefit Inquiry application on ETF's Online Network for Employers (ONE) site at: https://etf.wi.gov/employers/wisconsin-retirement-system/etf-web-applications-employers

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

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

406 Rehired Employee Coverage

406 A) Any insured EMPLOYEE who terminates employment with an EMPLOYER participating under Wis. Stat. § 40.51 and is re-employed by the same EMPLOYER within 30 days in a position eligible for health insurance 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.

406 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. Also, see Chapter 12.

Chapter 5 — Initial Enrollment

501 Initial Enrollment and Effective Dates

501 A) Immediately upon hire, employers must provide newly eligible employees with the:

- current annual health benefits materials online or the *Health Benefits Decision Guide* for the program option(s) you offer,
- *Health Insurance Application/Change* (ET-2301) form, if requested or your employees are not able to enroll online, and
- Notice of Privacy Practices and COBRA: Continuation of Coverage for Group Health Insurance notices (to meet federal COBRA and HIPPA notice requirements).

These are available on the ETF website and updated annually.

If the employee is a single parent (including divorced employees), they must provide documentation such as a birth certificate or paternity acknowledgement to add dependent children. If documentation is not on file for currently covered dependents, even if they were previously insured dependents, it will be requested and must be provided. A Social Security number or Individual Taxpayer Identification Number (ITIN) is required for any dependent over the age of 1 for tax purposes. If the dependent does not have an SSN or ITIN, an employer developed affidavit should be completed by the member or parent and submitted to the employer.

All eligible employees must either enroll online via myETF Benefits 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 502).

> **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.

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

501 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 or electronic enrollment through ETF's enrollment system (MEBS) is received by the EMPLOYER within 30 days of the date of hire, coverage to be effective as of the first day of the month that occurs during the 30-day period. New WRS employees will be responsible for paying the full premium until employer contributions begin.

(2) For EMPLOYEES who request coverage when they become or before they become eligible for the employer contribution:

(a) An EMPLOYEE shall be insured if a completed ETF application form or electronic enrollment through MEBS is received by the EMPLOYER within 30 days of the date of hire, with coverage to be effective upon becoming eligible for EMPLOYER contribution. The effective date of the employer contribution shall not be later than the first of the month following the completion of six months service with the employer under the WRS. In order to avoid penalties that may be assessed if coverage is found to be 'unaffordable' under federal health care reform, you may want employer contributions to begin no later than the first of the month preceding the employee's completion of 90 days of qualified employment.

(b) Employees who chose coverage beginning as soon as possible have the option of changing health plans and/or coverage levels effective on the first of the month that the employer premium contribution begins.

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

501 D) PARTICIPANTS may not be double covered in the State and/or WPE group health insurance program.

501 E) For employees whose spouse is also an eligible state or local employee or /annuitant, who does/did not work for/retire from the same local employer as the employee, there are several options available.

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

(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.

502 Declining (Waiving) Coverage

502 A) An employee declining to enroll in the Group Health Insurance Program when initially eligible must complete (mark appropriate box declining coverage, sign, and date) a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually). Employees should be reminded that once declined, election of coverage at a later date is limited to the onset of qualifying events creating enrollment opportunities (refer to subchapter 503), or during the annual health benefits open enrollment period for an effective date of January 1 of the following year.

502 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 entirely, 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 entirely. The unrestricted enrollment opportunity is not available if a person remains eligible for coverage under a plan from their employer that replaces the previous plan without interruption of that person's coverage.

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

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

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

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

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

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

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

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

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

503 Enrollment Opportunities for Employees who Previously Declined or Canceled Coverage

503 A) Employees who have declined coverage during a designated enrollment period can elect coverage during the next health benefits open enrollment period for an effective date of January 1 of the following year. An EMPLOYEE who deferred coverage may enroll if he or she has a new DEPENDENT as a result 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 health benefits webpages, called the Life Events Guide.

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

Under federal law and by this contract, the following constitute qualifying 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 of other coverage when the following circumstances:

(a) Coverage under another health insurance plan ends;
(b) Coverage under medical assistance (Medicaid) ends;
(c) Coverage as a member of the US armed forces ends;
(d) Coverage as a citizen of a country with national/universal health-care coverage comparable to the Access Plan (non-HDHP) ends;
(e) Complete loss of employer contribution for another health insurance program.
(f) Divorce.
(g) End of COBRA coverage.

Those who lose eligibility for the other coverage or the employer's entire premium contribution for the other coverage, may take advantage of a 30-day enrollment period, beginning on the date the other health-insurance coverage terminates. This does not include voluntary cancellation of the other coverage. For example, non-payment of premiums, including for COBRA, is considered a voluntary loss of coverage.

A *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually), or online application via myETF Benefits, and other information documenting the loss of coverage or employer premium contribution must be received by the employer within 30 days of the date the other coverage or the employer premium contribution ended. If all documentation is not readily available, submit the application and other items within the 30-day window. Follow up as soon as possible with any additional, required documents. Coverage will be effective the first of the month following receipt of the application. Copies of the required documentation (described below) must be submitted to ETF for approval.

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

Coverage is effective on the day following the last day of the other coverage if filed within 30 days of the event. For example, if coverage ended on May 13th with the other plan, coverage under the WPE plan would begin on May 14th. 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 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 their spouse provides a COBRA form from the spouse's former employer stating why coverage ended that is dated prior to the termination date, and the former insurer issues a letter after the termination date stating that coverage terminated on a preceding date), that assortment of documentation is acceptable.

The documentation on letterhead must include:

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

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

(2) **Marriage/Birth/Adoption/National Medical Support Notice/Paternity/Legal Custody Change:** Employees who declined coverage under the Group Health Insurance Program have an opportunity to enroll in single or family coverage if they have a new dependent as a result of marriage, birth, adoption or placement for adoption, a court ordered National Medical Support Notice, or paternity. If documentation is required and not readily available, the employee should submit the application to the employer before receiving the required documentation to secure the effective date of the enrollment opportunity.

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

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

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

(d) For National Medical Support Notice – coverage is effective on the first of the month following the receipt of the application by the employer or the date specified on the Medical Support Notice. The application should be received within 30 days of the court ordered support notice.

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

(3) Increase in employer contribution for employees who change classification or appointment: Employees such as less than half-time employees who initially decline health insurance coverage, have a new enrollment opportunity each time their hours increase that results in an increase in employer contribution. These employees may enroll in any plan without restriction and have 30 days from the date the employer contribution increases to file online via myETF Benefits or submit a *Health Insurance Application/Change Form* to the employer. Coverage is effective the first of the month following the employer's receipt of the application.

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

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

(5) If an active employee (including on a leave of absence) deferred coverage and wants to preserve post-retirement EMPLOYER premium contribution for later use, they must enroll in the ACCESS Plan 30 days prior to retirement. If an employee wants to retire as of April 15, they need to be insured in the Access Plan as an employee as of April first, then their retiree coverage would begin as of May first. The application must be submitted no later than the first day coverage would be effective.

(6) **Elimination of Opt-Out Provision:** EMPLOYEES who previously declined coverage for payment, have a special enrollment opportunity within 30 days of the employer's ceasing of the opt-out provision.

504 Applying for Coverage

Employer Responsibilities:

504 A) Verify the employee's eligibility for group health insurance coverage (refer to subchapter 401). See Life Change Events and Documentation Requirements ET-2846.

504 B) Provide the employee with the annual *Health Benefits Decision Guide* and the *Health Insurance Application/Change Form* (ET- 2301). The annual *Health Benefits Decision Guides*, available on the ETF website and updated annually (please see ET-2128, ET-2158, ET-2168, and ET-2169) provide information on what's changing, health insurance rates, uniform benefits and plan availability for the plan year. Inform the employee of the deadline for submitting the application. Employees may also submit their application online via myETF Benefits 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.

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

504 C) After the employee submits their application (paper 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. The employer can edit the member's transaction if there is a problem or deny the transaction and ask the employee to complete the enrollment again.
(2) If submitted via a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually), the employer will have to process the enrollment in the myETF Benefits System for the member. The employer must review the completed form before approving the application by completing the Employer Section 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 Email.
(d) Five-digit Group Number – The five-digit number assigned to local employers (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) – State only
(i) Employment Status – 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) Date WRS Eligible Employment or Appointment Began or Hire Date – The month, day and year the employee began WRS employment with the employer. For rehired employees, enter the rehire date.
(m) Employer Received Date – The date the employer received the completed application. It is important that this date be accurate in order to determine if the application was received timely.
(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).

505 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 or clinic 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, 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.

506 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 209 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 health benefits materials under the *Resources* tab at etf.wi.gov.

Chapter 6 — Changing Coverage

601 Life Event Changes

601 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 health benefits webpages on the Life Events Guide include:

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

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

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

601 C) Changing the participant's gender of record in myETF Benefits requires the participant to submit a copy of the *Address/Name/Gender Change* form (ET-2815) to the employer or ETF. The member must submit the request for any dependent under the age of 18. ETF

systems are currently only able to accept male and female for gender. ETF is typically able to process requests within 30 days of receipt of receipt.

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

1. **Active employees:**
   a. Submit the document to human resources or benefits person at work. The employer will submit the information to ETF for processing.
   b. ETF may reach out to the employer to report the active employee gender change if the ET-2815 is received at ETF without indication that the employer has updated their own records.
2. **Active employees' dependents:**
   a. Submit the document to human resources or benefits person at work. The employer will submit the information to ETF for processing; **or**
   b. Submit the documents directly to ETF following the instructions for retirees below.
3. **Retirees and dependents:** Submit the documents directly to ETF using one of the methods below.
   a. Securely via Box through ETF's website
   b. U.S. Postal Service: WI Dept of ETF, P.O. Box 7931, Madison WI 53707-7931
   c. In Person: WI Dept of ETF, 4822 Madison Yards Way, Madison, WI 53705-9100
   d. Fax to 608-267-4549

602 Changing Plans Due to a Residential Move

When a SUBSCRIBER moves for a minimum of three months, they have an enrollment opportunity to change health plans, even if their current plan remains available in the county to which the SUBSCRIBER moved. (A move from one medical facility to another medical facility is not considered a residential move.) The relocating SUBSCRIBER must go online to myETF Benefits and submit a request to change health plans or submit a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) to their employer (ETF for annuitants) within 30 days before or after the move. If the employee moved to a state that does not border Wisconsin, they should select the Access Plan. Coverage will be effective with the new plan the first of the month on or after either the submission of the electronic change by the employee in myETF Benefits or the receipt of the *Health Insurance Application/Change Form* by the employer.

If the application to change plans is not received within 30 days before or after the move, the SUBSCRIBER cannot change health plans until the annual health benefits open enrollment period or until they experience another qualifying event as outlined later in this Chapter.

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

603 Changing Health Plans

603A) The following SUBSCRIBERS may change HEALTH PLAN after the event if an application is submitted within 30 days of the event. Coverage with the new HEALTH PLAN will be effective the first day of the calendar month, on or after the date the EMPLOYER receives the application. See also 501B) (2)(b). An insured EMPLOYEE, ANNUITANT or CONTINUANT who is:

1. Adding one or more DEPENDENTS to the policy due to marriage, birth, adoption, placement for adoption, National Medical Support Notice, establishment of paternity, guardianship or legal custody change
2. Dropping one or more DEPENDENTS from a policy due to a divorce
3. Having an involuntary loss of other coverage (for example, being laid off, fired, or someone who quit and isn't eligible to keep group coverage) or complete loss of EMPLOYER contribution for the other coverage (including loss of a dependent's coverage or employer contribution toward other coverage)
4. An EMPLOYEE gains a significant share of EMPLOYER PREMIUM contribution toward their coverage (for example, half time to full time).
5. An EMPLOYEE loses a significant share of EMPLOYER contribution toward their coverage (e.g. a decrease of 5% or more).
6. For ANNUITANTS only: obtaining Medicare Part A and/or B coverage. Also see 603B.

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

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

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

2. When an employee terminates employment and begins their coverage as an ANNUITANT, and they and/or their DEPENDENT(s) are age 65 or older, the following may happen as long as the member(s) eligible for Medicare enroll in Parts A and B to be effective the first of the month following their termination of employment:
   a. The member(s) will remain with their current health plan but under Medicare coordinated coverage.
   b. The SUBSCRIBER may change health plans when they or a family member

newly enroll in Medicare. Coverage in the new plan begins the first of the month following the date the SUBSCRIBER's application is received by ETF (but no earlier than Medicare's effective date).

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

604 Changing from Single to Family Coverage

Documentation Guidelines: ETF has the responsibility to provide information as needed for federal, state and/or contractual requirements. The employer must exercise the same level of due diligence. The employer/employee relationship is the most effective way to gather the needed information. The employer should document their attempts in requesting the required information.

One example is the law requires SSNs to be reported on federal form 1095-B. Your health insurance company provides federal form 1095-B to your employees and to the Internal Revenue Service. The information from the form will be used by employees to prepare their individual income tax return. As necessary, ETF or the health plan will reach out to verify Social Security numbers of members.

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

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

604 A) An EMPLOYEE can change from single to family coverage in several situations outside of the annual health benefits open enrollment period.

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

(1) Birth.
(2) Adoption.
(3) Placement for adoption.
(4) Marriage.
(5) Receives a National Medical Support Notice or paternity acknowledgment.

(6) Transfer or change of custody.

(7) Establishes a permanent legal guardianship.

(8) Involuntary loss of other coverage.

(9) Loss of entire employer contribution for other coverage.

(10) Has a previously covered dependent older than age 26 who is newly disabled.

(11) An EMPLOYEE who enrolls for single coverage within 30 days following the date of hire, may change to family coverage during the enrollment period offered as a result of becoming eligible for EMPLOYER contribution toward PREMIUM.

(12) An EMPLOYEE enrolled in single coverage who gains more EMPLOYER PREMIUM contribution may change to family coverage within 30 days following the increase in EMPLOYER contribution.

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

604 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 a participating WPE or the state, both may retain or select single coverage with the current plan or one may retain or select family coverage under one of their current plans that will cover the other spouse and any eligible dependents. Double coverage of an individual in either or both the state and local group health insurance program is not permitted.

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

The SUBSCRIBER also has the opportunity to change health plans within 30 days of the marriage, provided their application is submitted within those 30 days. The change in health plan will be effective the first of the month on or after receipt of the application to change health plans or the electronic submission of the request to change health plans.

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

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

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

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

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 30 days of the event. The change in health plan will be effective the first of the month on or after receipt of the application or electronic submission of the request to change health plans.

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

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

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

former insurer issues a letter after the termination date stating that coverage terminated on a preceding date), that assortment of documentation is acceptable. The documentation on letterhead must include:

(a) Who was covered (must list the name of the member who is requesting this special, late enrollment)
(b) Name of Health Insurer
(c) Subscriber name
(d) Date coverage was terminated
(e) Reason for the cancellation (that is voluntary such as due to non-payment of premium (including for COBRA) vs. involuntary such as being laid off, fired, expiration of COBRA or someone who quit and isn't eligible to keep group coverage)

Note: The employee should complete and apply as soon as possible, even if they have not received the required documentation. Many times, the required documentation will be received outside of the 30-day enrollment window and the employee can secure the enrollment opportunity by submitting the application to the employer prior to receiving the required documentation.

4) Paternity Acknowledgment: When an acknowledgment of paternity is filed within 60 days of the birth, and an application is received or online enrollment performed within the 60-day time frame, family coverage is effective on the date of birth. Beyond the 60-day time frame, coverage is effective the first of the month on or after receipt of the application.

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

5) National Medical Support Notice (NMSN): The NMSN is a federal requirement used to enforce medical support orders for minor children. It is to be used throughout the United States to enroll children in employment related health insurance coverage. NMSN occurs when a court orders the parent in question to provide coverage for their child(ren). Coverage is effective the first of the month on or after receipt of the application **or** the date specified on the NMSN, if one is specified.

The NMSN is a qualified medical child support order; therefore, the employee does not have a choice to not enroll children named in the NMSN. If health care coverage is available and the employee is eligible, the employer is required to enroll the child or children as instructed in the notice. However, the employer must adhere to limitations imposed on withholding as mandated by withholding laws of the state where the employee is principally employed. This is described in the following paragraph.

The employee is required to enroll their eligible children named in the NSMN in any medical insurance the employer has available for them. When the employer gets the NMSN, they will have to determine whether the amount of the employee's child support order and the amount of the medical insurance premium, added together, will

be more than the percent they are allowed to withhold from the employee's paycheck under the federal Consumer Credit Protection Act. If the insurance and child support together equal more than this amount, the employer will not enroll the employee's child(ren) in medical insurance.

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

If an employee chooses to object, the employee must contact the issuing local child support agency as instructed in the NMSN he/she received. The employer must still comply with the NMSN regardless of whether an objection has been made by the employee. In addition to the NMSN (serving as required documentation), the employee must also file a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) to add the children named in the order to coverage. The employer must file an application on behalf of the employee if the employee fails to comply with the NMSN. If the employee refuses to sign the application, the employer must indicate that on, the application.

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

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

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

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

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

605 Changing from Family to Single Coverage

An employee can change from family to single coverage in several situations outside of the annual health benefits open enrollment period, provided they have experienced a family status change/event that allows the change under the plan or they have experienced a HIPAA qualifying life event. An employee can change from family to single coverage if they experience a HIPAA qualifying life event or a status change such as a divorce, their last dependent becomes ineligible for other coverage, all dependents become eligible for and enroll in other coverage, or their last eligible dependent becomes eligible for and enrolls in

other coverage. If an employee's premiums are deducted post-tax or they are an annuitant, they may change to single coverage at any time.

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

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

605 A) Divorce: Employees are required under the Patient Rights and Responsibilities section of the health benefits 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:

(a) in which the employer provides notification of continuation rights (*Continuation - Conversion Notice* [ET-2311]). (Refer also to subchapter 1003.)

or

(b) 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), but one must be provided to any dependents.

Documentation to support the divorce may be required as outlined in the Life Change Events and Documentation Requirements (ET-2846) online. The SUBSCRIBER, as well as the ex-spouse, has the opportunity to change health plans within 30 days of divorce provided their application is submitted within the 30-day time frame. The change in health plan will be effective the first of the month on or after receipt of the application to change health plans or the electronic submission of the request to change health plans.

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

business days, ETF will remove the ex-spouse and any dependents (if applicable) from the contract and issue the Continuation/Conversion Notice (ET-2311) form.

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

605 B) Last Dependent Becomes Ineligible for Coverage: This occurs when the last covered dependent reaches age 26, if not disabled. The employee must notify the employer within 60 days of the dependent losing eligibility. 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 215).

> **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.

605 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. The application to change to single coverage must be submitted within 30 days of the date the dependent(s) enrolled in other coverage. The new coverage will be effective the first of the month after the application is received. If the application is not received within 30 days, the employee is limited to the annual health benefits open enrollment period to remove these dependents.

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

605 D) Employer's contribution toward health insurance premium lowers significantly (5% or more):
An employee whose employer contribution is lowering due to a job appointment change may adjust coverage from family to single. The Health Insurance Application or electronic enrollment request must be submitted no later than 30 days following the appointment change. Coverage will be effective the first of the month following date of contribution change (unless change date is the first of the month, then coverage is effective the first of the month).

606 Adding Dependents

Dependents can be added to an existing family contract outside the annual open enrollment period for the following reasons. A Social Security number or Individual Taxpayer Identification Number (ITIN) is required for any dependent over the age of one for tax purposes. If the dependent does not have an SSN or ITIN, an employer developed affidavit should be completed by the member or parent and submitted to the employer.

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

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

The SUBSCRIBER also has the opportunity to change health plans within 30 days of the marriage, provided the application to do so is submitted within the 30-day time frame. The change in health plan will be effective the first of the month on or after receipt of the application or electronic submission of the request to change health plans.

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

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

The SUBSCRIBER also has the opportunity to change health plans within 30 days of birth, adoption, or placement for adoption (not establishment of legal guardianship), provided the application to do so is submitted within those 30 days. The change in health plan will be effective the first of the month on or after receipt of the application to change health plans or the electronic submission of the request to change health plans.
For employees who terminate after taking incomplete action to add a child (lacking a birth certificate or other required documentation), the former employee will have 90 days to submit the documentation or the change to add the child will be deleted and coverage will not be effective.

606 C) Dependent Involuntary Loss of Other Coverage or Complete Loss of Employer Contribution: If family coverage is in place, an application must be received within 30 days before or after a dependent has an involuntary loss of other coverage (such as being laid off, fired, expiration of COBRA or someone who quit and isn't eligible to keep group coverage or after divorce, dependents who were insured as step-children by the former spouse) or completely loses employer contribution for the other coverage. 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 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 Life Change Events and Documentation Requirements (ET-2846) online.

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

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

expiration of COBRA or someone who quit and isn't eligible to keep group coverage). If loss of employer premium contributions, letter from employer indicating they no longer contribute towards their employee's premium.

606 D) Paternity Acknowledgment: If family coverage is already in place, coverage for the dependent(s) will be effective on the date of birth if an acknowledgment of paternity is filed and an application is received or online enrollment performed within 60 days of the birth. If more than 60 days have elapsed, coverage will be effective on the first of the month on or after receipt of the application.

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

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

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.

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

If an employee chooses to object, the employee must contact the issuing local child support agency as instructed in the NMSN he/she received. The employer must still comply with the NMSN regardless of whether an objection has been made by the employee. In addition to the NMSN (serving as required documentation), the employee must also file a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) to add the children named in the order to coverage. The employer must file an application on behalf of the employee if the employee fails to comply with the NMSN. If the employee refuses to sign the application, the employer must

indicate that on the application.

606 F) Legal Custody Change: If family coverage is already in place, coverage for the dependent(s) will be effective on the date of the event if an application is received or online enrollment performed within 30 days of the event.

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

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

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

606 H) Eligible Dependent Left Off Original Application: If family coverage is already in place, spouses and minor children who were left off the original application can be added to coverage prospectively if the following requirements are fulfilled in compliance with the 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 chapter 503 A 4.

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

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

607 Removing Dependents

Dependents can be removed from family coverage for a limited number of reasons outside the annual open enrollment period. These include the following reasons:

607 A) Divorce: Upon divorce, either a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) or an electronic enrollment request must be processed before the ex-spouse or any stepchildren can be removed from coverage.

Ideally this should be submitted within 30 days of the date the judgment of divorce is entered/final with the clerk of courts.

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

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

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

Covered stepchildren can remain covered at the discretion of the surviving spouse in the event of the employee's death. If the surviving spouse files an application to drop the stepchildren, proof of other insurance must be provided.

607 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.

607 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.

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

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

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

607 F) Adult Dependent Child Eligible for Other Coverage: A dependent child over the age of 19 who becomes eligible for, and elects other coverage, requires that an application to remove this dependent be submitted within 30 days of the event (enrollment in other coverage). For example, if a child marries but obtains coverage through their spouse at a later date such as an open enrollment period, the event is the start of other coverage, not the marriage. A dependent's enrolling in Medicare does not qualify the subscriber to terminate coverage for the adult child outside of open enrollment.

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

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

607 G) Adult Dependent Child gains a dependent: For effective dates beginning January 1, 2021. Adult Dependent Eligible for Other Coverage due to gaining a Dependent: A dependent child over the age of 19 who is eligible for, and elects other coverage due to birth, adoption, paternity or National Medical Support Notice, may be removed as of the date their other coverage begins. If not received within 30 days of the event or notice of the event, the employee will not be able to remove their dependent until the annual open enrollment period, even if this would result in the employee dropping to single coverage as they are their last eligible dependent.

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

607 H) Adult Dependent requests to be dropped from Parent/Subscriber's coverage: For effective dates beginning January 1, 2021 when the subscriber refuses to submit application. A dependent child over the age of 19 who becomes eligible for, and elects other coverage, who does not live with the subscriber, and has concerns about private health insurance information being shared with the subscriber may request to be removed from their parent's plan. The child must provide documentation of the preceding items. The effective date will be the end of the month following date of request.

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

A copy of the court order documenting the termination of the NMSN is required. A *Continuation Conversion Notice (ET-2311)* for the child must be sent.

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

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

608 Reenrollment of Certain Retirees

Retirees who are eligible for post-retirement benefits from their participating former local employer that allow for payment of health insurance premiums in retirement, may re-enroll mid-year in the group health insurance program if they have been continuously covered by their spouse in the State or Local Group Health Insurance Program. See 701 G) (6). If the member is insured by a spouse and they want to change to two singles in the program, they may under this provision.

Chapter 7 — Health Benefits Open Enrollment

701 It's Your Choice Open Enrollment Eligibility

701 A) (1) The BOARD shall establish enrollment periods, called the health benefits open enrollment period, which shall permit eligible EMPLOYEES, ANNUITANTS and CONTINUANTS to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51 (7). Unless otherwise provided by the BOARD, the 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) or a dependent who does not qualify as a tax dependent, transfer the coverage from one spouse employee to the other, transfer a dependent's coverage from one divorced employee parent to another, or change from single-to-family or family-to-single coverage without limitations.

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

(4) An EMPLOYEE who returns from leave of absence (as defined under Wis. Stat. § 40.02 (40)) during which coverage lapsed and which encompassed the entire previous open enrollment period will be allowed an enrollment 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.

701 B) Health Benefits 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.

701 C) Participation in the Health Benefits Open Enrollment Period:

Two requirements must be met to make a change or enroll during open enrollment:

(1) To enroll, the employee must be eligible for and be enrolled in the WRS or be an employee of a non-WRS employer enrolled in the WPE Group Health Insurance Program for Non-WRS Employers. To make a change, the employee must be currently insured in the WPE Group Health Insurance Program; ***and***

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

(3) (a) The employee must enter the change request online into the myETF Benefits system or provide the *Health Insurance Application/Change Form* (ET-2301) available on the ETF website and updated annually to the employer within the designated health benefits open enrollment period.

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

701 D) Distribution of health benefits materials*:*

The annual *Health Benefits Decision Guides,* available on the ETF website and updated annually (please see ET-2128, ET-2158, ET-2168, and ET-2169) provide information on what's changing, health insurance rates, uniform benefits and plan availability for the plan year. The guides are forwarded to local employers that participate in the WPE Group Health Insurance Program prior to the open enrollment period for distribution to all eligible employees, insured and uninsured (including those on leave of absence and layoff). ETF has guides mailed directly to ANNUITANTS and CONTINUANTS. There is a limited supply of paper annual *Health Benefits Decision Guides* available; employers are encouraged to direct employees to the health benefits webpages that include the electronic version of the guides found on ETF's website at: etf.wi.gov/publications/insurance.htm. The annual *Health Benefits Decision Guides* must be distributed in a timely manner.

701 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 *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 Annual health benefits enrollment box

checked as the reason for submitting the application.

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

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

701 G) Employee's employment and/or health coverage ends after submitting an enrollment election:

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

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

701 H) Deferred Coverage Enrollment

(1) Any EMPLOYEE actively employed with an EMPLOYER participating under Wis. Stat. § 40.51 who does not elect coverage during the enrollment period provided under section 501 or who constructively waives coverage under section 214 C or who subsequently cancels coverage elected under chapter 5 or 602, 603, 803 B, 703 B and 701 A (1), (3) (4) and 701 C (2) (b)., may be insured only by electing coverage during the IT'S YOUR CHOICE open enrollment period as provided in section 701 A (1).

(2) An EMPLOYEE or ANNUITANT enrolled for individual coverage, though eligible for family coverage may only elect family coverage during the open enrollment period, except as provided in chapter 5 or 602, 603, 703 B and 701 A (1), (3) (4) and 701 C (2) (b).

(3) An insured EMPLOYEE or ANNUITANT is permitted to change among IYC HEALTH PLANS during an open enrollment period offered under sections 602, 603, 703 B and 701 A (1), (3) (4) and 701 C (2) (b).

(4) An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40) who is not enrolled for coverage, may enroll in the ACCESS PLAN 30 days prior to retirement for the purpose of using post-retirement EMPLOYER premium contribution. If an employee wants to retire as of April 15, they need to be insured as an employee in the ACCESS PLAN as of April first, then their retiree coverage would begin as of May first. The application must be submitted no later than the first day coverage would be effective.

(5) Retirees who were insured as an employee immediately prior to termination of employment and who canceled their health insurance upon retirement or later, may return to coverage with their former, participating employer and enroll for coverage during the open enrollment period with an effective date of the first of the next calendar year if, within 30 days of termination of employment they:

(a) began receiving a monthly annuity or

(b) took a lump sum benefit which would have been an immediate annuity if paid as an annuity under Wis. Stat. § 40.25 (1).

(6) Retirees in 701 G) (5) who are eligible for post-retirement benefits from their participating former local employer that allow for payment of health insurance premiums in retirement, may re-enroll mid-year in the group health insurance program as follows if they have been continuously covered by their spouse in the State or Local Group Health Insurance Program:

a) When their spouse involuntarily loses employer contribution (for example, due to being laid off, fired, or quit and isn't eligible to keep group coverage) for State or participating Local group health insurance coverage and the application is filed within 30 days of the event, or

b) In anticipation of their spouse exhausting their State sick leave credits. If so, the local retiree may file an application during the open enrollment period for delayed enrollment, to be effective on a date specified for the future. This date would coincide with the exhaustion of the spouse's State's sick leave credits. For example, if sick leave credits were going to be exhausted ending in May, the local retiree would file an application with a future effective date of June 1.

702 Withdrawing/Rescinding Open Enrollment Elections

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

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

(1) Either forward one copy of the application with "Rescind" written across the top or a copy of the employee's written request to withdraw/rescind the application to ETF.

(2) Retain the original copy of the rescinded application for the employer's records.

(3) ETF will update myETF Benefits by deleting the initial open enrollment 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 904) or through the late enrollment process, also prospectively (refer to subchapter 704).

703 When a Health Plan is not Available at Open Enrollment

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

703 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 that event, a new application is not required, annual employer news via ETF E-mail Updates, and the annual *Health Benefits Decision Guides* will include instructions.

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

Subscribers whose plan will no longer be available and who fail to submit an application selecting an available plan during the health benefits open enrollment period are deemed to have canceled coverage and must apply through the late 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.

704 Late Open Enrollment Applications

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

A. Employee submits application after the end of the open enrollment period.
B. Employer rejects and returns late application to employee with instructions on requesting a review. A sample letter informing an employee of this process is found in subchapter 705.
C. Employee submits a written request (letter or email) for ETF to review to the employer no later than April 15 following the open enrollment period. Approved requests prior to January 31st will be retroactively effective to January 1. Requests approved after January 31st will be effective prospectively to the first of the following month.
D. Employee includes in the letter or email the facts or circumstances relating to the reason(s) their application is being filed late and the remedy being sought.
E. After January 1, the employer develops a cover memo, letter or email addressed to ETF detailing the process used to distribute health benefits materials and information to employees, the date of receipt of the employee's health benefits application, and any pertinent facts that either supports or does not support the employee's request.
F. Employer sends a copy of the employee's late *Health Insurance Application/Change Form*, the original employee's letter or email requesting a review, and the employer cover memo, letter or email to:

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

These materials and information can also be scanned and emailed to: ETFSMBEmployerInsurance@etf.wi.gov.

Emails must be sent encrypted to comply with HIPAA standards; if you cannot send encrypted email, please mail or fax only. The subject line should be titled "Late Health Application".

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

705 Late Open Enrollment Review Sample Letter

Below is a sample letter from the employer informing an employee of the review process for a late *health* application.

(DATE)

(EMPLOYER NAME AND ADDRESS IF NOT ON THE LETTERHEAD)

Dear (EMPLOYEE NAME):

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

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

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

Chapter 8 — Leave of Absence

801 Definition of a Leave of Absence (LOA)

801 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.

801 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 calendar days for at least 50% of the employee's normal work time. If the employee does not complete 30 consecutive calendar days of duty, the employee is not deemed to have returned from leave and coverage will continue as an employee on leave of absence.

801 C) An employee on LOA is subject to the same eligibility and enrollment provisions as an active employee. The amount of EMPLOYER contribution toward PREMIUM for EMPLOYEES on approved leave of absence or LAYOFF shall be at the discretion of the EMPLOYER.

802 Coverage Does Not Lapse While on a Leave of Absence

802 A) Insured employees on an unpaid leave of absence (LOA) choose whether to continue health insurance coverage during their LOA. Employee coverage remains active as long as premiums are paid when due. After any EMPLOYER contribution, the insured EMPLOYEE is responsible for payment of the full PREMIUM that must be paid in advance. Each payment must be received by the EMPLOYER at least 30 days prior to the end of the coverage period for which PREMIUMS had previously been paid.

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

- If the employer has paid for May coverage, we do not let failure to collect the employee's share invalidate that month's coverage.
- If not collected, the following month's coverage (June) should be terminated due to failure to pay.
- If the employer pays the month before coverage starts and they have not been able to collect the employee's contribution in advance of coverage, coverage should cancel for the first full month they received no payment from the member. Retroactive

terminations are not accepted.

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

(1) The maximum length of time coverage can be continued for an employee on LOA is 36 months per Wis. Stat. § 40.02 (40). After that, coverage may be continued beyond 36 months if the approved leave is due to a union service leave provided by Wis. Stats. § 40.02 (56) and 40.03 (6) (g) and/or under COBRA. (Refer to Chapter 9 for information on COBRA.)

(2) Employer contributions made toward premium payment while an employee is on a LOA is at the discretion of the employer.

(3) Regardless of if the employee is paying the entire premium or an employee share, premiums must be paid in advance of the coverage month. This can be done by either a deduction from the last payroll check or by direct payment to the employer, e.g., personal check. Again, the employer must receive premium payments in advance of the coverage month. Also see 802A.

(4) Employees on a LOA remain active on the employers' invoice. Employers will be billed the premiums on their monthly invoice for each respective coverage month the employee remains on a LOA. Payments received from an employee on a LOA are to be made payable to the employer.

(5) Employers must provide open enrollment information to employees on a LOA prior to the beginning of the designated open enrollment period. This includes an employee on a union-service leave (see 802A 1).

(6) Employees continuing coverage while on LOA are not required to complete a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) upon return to work.

803 Coverage Lapses While on a Leave of Absence

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

If the employee files an application to cancel coverage they are not eligible to enroll upon return to work. This is considered a voluntary termination. EMPLOYEES who cancel coverage cannot re-enroll until the next open enrollment period or when a life event occurs (e.g. marriage, birth, etc.), whichever occurs first. Refer to Chapter 4, subchapter 403 for other enrollment opportunities.

803 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.

803 C) If an employee allowed their health insurance coverage to lapse while on an approved LOA, the following applies upon returning to work and the employee chooses to reinstate coverage:

(1) Military leave: Employee must resume employment within 180 days after release from active military service, and complete and submit an application to their employer within 30 days after returning to employment to enroll in coverage. Coverage is effective upon the date of re-employment. This is sooner than 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.

(2) Non-military leave: The employee's coverage effective date is the first of the month on or following receipt of the application by the employer. The application must be filed within 30 days of the 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.

(3) 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.
   (a) Employee may change coverage level if a qualifying life event occurred during their LOA (e.g. marriage, birth, etc.). Refer to Chapter 4, subchapter 403 for information about other enrollment opportunities.
   (b) Employee who moved while on a LOA may change health plans upon return to work.
   (c) Employee who returns from a LOA that encompassed the entire previous open enrollment period and files an application within 30 days of returning to work, may make changes to the coverage they had prior to their LOA.

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

(5) 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.

(6) EMPLOYEES shall also have enrollment opportunities if the EMPLOYEE or a DEPENDENT loses eligibility for another health insurance plan or the EMPLOYER's contribution toward it while on leave of absence. 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. 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.

804 Coverage During Layoff

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

(1) Employer contributions toward premium payment during layoff are at the discretion of the employer.

(2) 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 union service leave under Wis. Stats. § 40.02 (56) and 40.03 (6) (g) and/or under COBRA.

(3) Premiums, whether the entire monthly premium or the employee share 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. Premium payment can be either by deduction from the last payroll check or by direct payment to the employer, e.g., by personal check. Also see 802A.

(4) Employees on layoff are included on the employer's monthly invoice along with active employees and employees on LOA. Any payments received from employees on layoff should be made payable to the employer and included in your monthly premium remittance to ETF.

(5) Employees on layoff during an entire open enrollment period must be given an Open Enrollment opportunity. This includes an employee on a union-service leave (see 804A 2). Open Enrollment information should be sent to those employees who are on layoff prior to the beginning of the designated Open Enrollment period.

(6) Employees are not required to complete a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) upon their return to work.

804 B) The following applies to employees on layoff status who allow health insurance coverage to lapse and choose to reinstate coverage:

(1) Upon return to work, the employee is limited to the same health plan and level of coverage they were enrolled in prior to their LOA. See (a), (b) and (c) that follow for exceptions to this requirement.

(a) Employee may change coverage level if a life event occurred during their LOA (e.g. marriage, birth, etc.). Refer to Chapter 5, subchapter 503 for information about other enrollment opportunities.

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

(c) Employee who returns from a LOA that encompassed the entire

previous open enrollment period and files an application within 30 days of returning to work, may make changes to the coverage they had prior to their LOA.

(2) The EMPLOYEE who did not file an application within 30 days of returning to work cannot re-enroll in coverage until the next open enrollment period or when a life event occurs (e.g. marriage, birth, etc.), whichever occurs first. Refer to Chapter 5, subchapter 503 other enrollment opportunities.

805 Coverage During Appeal of Discharge

805 A) An insured EMPLOYEE who has exercised a statutory or contractual right of appeal of 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.

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

(1) The employer must receive the first premium payment within 30 days of discharge.

(2) Future premium payments must be made through the employer and must be received in advance of the coverage month.

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

(4) The employee must continue to be reported along with active employees on the employer's monthly invoice. Any payments received from employees appealing a discharge should be made payable to the employer and included in the employer's monthly premium remittance to ETF.

805C) 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.

805D) If the final decision is adverse to the employee, the date of termination shall, for purposes of health care coverage, be the end of the month in which the decision becomes final. This may include by expiration without appeal of the time within which an appeal might have been perfected, or by final affirmation on appeal.

If the discharge is for reasons other than gross misconduct, the employee is eligible to continue health insurance for the balance of 18 months from the original termination date

(the balance of the continuation period). If the discharge is for gross misconduct, the employee is only eligible for conversion coverage and should contact the health plan for information on benefits, rates and policy provisions. (Refer to Chapter 10 for information about continuation and conversion.) In either case, a *Continuation-Conversion Notice* (ET-2311) must be provided to the employee using the original discharge date.

Chapter 9 — Cancellation and Termination of Coverage

901 Individual Termination of Coverage

ETF offers a resource to help employers advise employees who are terminating employment, including retirees. It is the Termination Checklist for Local Employees (ET-2500l).

901 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 is allowed to continue coverage while on a leave of absence or LAYOFF, as provided in sections 801 B, 802 A, 803 B and C (4) and 804 A 2.

(4) The end of the month in which a notice of cancellation of coverage is received by the EMPLOYER or by ETF in the case of an ANNUITANT or CONTINUANT for whom the EMPLOYER has no reporting responsibilities, or a later date as specified on the cancellation of coverage notice. If the ANNUITANT or CONTINUANT contacts the HEALTH PLAN directly to cancel coverage, the HEALTH PLAN is to reject the cancellation and immediately notify the ANNUITANT or CONTINUANT to submit a written cancellation notice to ETF.

(5) The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, etc.). As required by Wis. Stat. §632.897, if family coverage remains in effect and the EMPLOYEE fails to notify the EMPLOYER of divorce, coverage for the ex-spouse ends the last day of the month in which notification of continuation of coverage rights occurs (see 1001A). The

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

(6) The expiration of the continuation period for which the PARTICIPANT is allowed to continue under 901 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 901 C) below. Terminations due to enrollment in medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or TRICARE may be retroactive to the effective date of coverage upon request by the subscriber and determination by ETF.

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

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

(10) The first day of the month following ETF's written notice to a SUBSCRIBER who is ineligible for coverage but, due to EMPLOYER or ETF error, was enrolled for coverage. The ACA requires that an employee receive a full month of coverage before coverage is terminated unless there is fraud or gross misconduct in order for the employee to find other coverage. Also see 901 G) below.

(11) The effective date of the termination of EMPLOYER participation for all PARTICIPANTS for whom coverage was secured as a result of the EMPLOYERS participation.

(12) 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.

(13) Upon a significant reduction in employer's contribution toward health insurance (5% or more). An employee whose employer contribution is lowering due to a job appointment change may cancel coverage. The event is the first of the month on or following the appointment change. The Health Insurance Application or electronic enrollment request must be submitted no later than 30 days following the appointment change.

Note: If the employee's spouse is an eligible Local or State employee, the couple may change the listed subscriber to the spouse who is getting a greater share of employer contribution. This event does not permit a change of health plans.

901 B) No refund of any PREMIUM under 901 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 for which PREMIUM has been collected or deducted. 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.

901 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.

901 D) No person other than a PARTICIPANT is eligible for health insurance BENEFITS. The SUBSCRIBER'S rights to group health insurance coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the ACCESS PLAN.

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

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

901 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 the current or alternate primary care physician, disenrollment efforts may be initiated by the HEALTH PLAN or the BOARD. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. Coverage may be transferred to the ACCESS PLAN only, with options to enroll in IYC HEALTH PLANS during subsequent health benefits enrollment periods. Re-enrollment in the HEALTH PLAN is available during a regular enrollment period, which begins a minimum of 12 months after the disenrollment date.

901 F) In the situation where the EMPLOYER violates the terms of the CONTRACT, coverage for all its PARTICIPANTS, including ANNUITANTS and CONTINUANTS, terminates the first of the month following notification from ETF of 30 days or more.

901 G) Except in cases of fraud or where an individual makes an intentional misrepresentation of material fact, under federal law, an EMPLOYER must not retroactively cancel (also called rescind) coverage, except to the extent attributable to a failure to pay timely premiums towards coverage. This rule also applies to ANNUITANTS. It is not considered a rescission where, due to administrative delay in record-keeping, the EMPLOYER retroactively cancels coverage back to the date of termination of employment as limited by section 215.

902 Ending Coverage

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

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

- complete a spouse-to-spouse transfer,

- death of the subscriber,
- disability approval (non-ICI),
- termination of employment or
- employee's request to cancel coverage.

Refer to the chart below for specific limitations and requirements surrounding these termination scenarios.

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

Reason	Coverage End Date	Comments
Cancel Coverage	Refer to subchapter 904	Employee is voluntarily ending coverage. Refer to subchapter 803 regarding Internal Revenue Code (IRC) Section 125 pre-tax and post-tax requirements. For example, when SUBSCRIBER and all eligible DEPENDENTS are newly eligible for, and enrolled in, other coverage or the employee premium share has increased significantly. If employee does not pay required premiums while out on a leave of absence (LOA), this is a cancellation, voluntarily ending coverage.
Termination of Employment	End of the calendar month in which the employee terminates employment.	Employee's coverage is an involuntary loss of coverage. If employee is terminating employment because they are retiring (refer to Chapter 11), going on an unpaid LOA or layoff and are starting an immediate annuity.
Termination of Employment prior to effective date of coverage	The application is void and any premiums paid or deducted will be refunded.	
Cancel Spouse-To-Spouse Employment	Refer to subchapter 904	Employee voluntarily ending coverage. Cannot complete a cancellation mid-year without an allowable status change under the plan language (contract) or HIPAA qualifying life event if premiums are deducted pre-tax.
Disability Approval (Non-ICI)	Coverage is continued as an annuitant without lapse upon approval of a disability benefit.	This is an employer entry in myETF Benefits. No application to end coverage is required from employee. ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs. Refer to subchapter 903.
Death of Subscriber with Single Coverage	End of the calendar month in which the death occurred.	Refund any premiums paid in advance for coverage beyond the end of the month in which death occurred.
Death of Subscriber with Family Coverage	Coverage under the employee's contract continues through the last day of the month for which the premium has already been deducted.	Do not refund any premiums unless authorized by ETF.

903 Changing from Active to Annuitant Coverage

Retiring insured employees are eligible to continue health coverage if they receive an immediate annuity upon retirement (monthly or lump sum benefit), WRS disability retirement, or duty disability benefits (Refer to Chapter 11).

When an employee retires, the employer should leave their coverage active in myETF Benefits. ETF staff will end the contract when the Local Employer Verification of Health Insurance Coverage (ET-4814) is received.

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

B. Other retirees who wish to continue coverage may make premium payments through their annuity or with payments directly to the plan.

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

In all cases, they must also complete the *Local Employer Verification of Health Insurance Coverage* (ET-4814).

904 Cancelation of Coverage

When an employee wishes to cancel coverage for any of the voluntary reasons listed in subchapter 901, they cannot complete their request mid-year without an eligible status change that is allowed under the plan language (contract) or under HIPAA if the employee premium is being deducted on a pre-tax basis under Internal Revenue Code (IRC) Section 125.

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

Event	Eligibility Requirements	Coverage End	Comments
Pre-Tax Employee Terminating Employment	*Health Insurance Application* or myETF Benefits request must be submitted no later than the month employment terminates. The event date is the date employee terminates employment.	End of the month following receipt of the application/myETF Benefits request or the event date, whichever is later.	The coverage end date for a cancelation request is always the end of a month. Retroactive cancelations are not allowed.
Pre-Tax Employee Going on an Unpaid LOA	*Health Insurance Application* or myETF Benefits request must be submitted no later than the month employee goes on a LOA. The event date is the date employee begins a LOA. An affirmative choice to cancel coverage by submitting an application invalidates the right to re-enroll at the end of the LOA. To retain re-enrollment rights the employee should allow coverage to lapse due to non-payment. At the time the employee ceases paying their contribution or the entire premium while on unpaid LOA, the employer must terminate their coverage in myETF Benefits. No application is required and none should be requested for a lapse.	End of the month following receipt of the application/myETF Benefits request or the event date, whichever is later. For lapses, coverage termination should be entered at the time payment is not received from the employee. Coverage ends the end of the month for which payment was received.	An employee who continued coverage during a LOA is eligible to receive the employer share of the monthly premium for the current coverage month plus for 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, but this invalidates the right to re-enroll upon return from LOA. Coverage end date for a cancelation request is always the end of a month. Retroactive cancelations are not allowed.

Event	Eligibility Requirements	Coverage End Dates	Comments
Pre-Tax Family Status Change (e.g., spouse to spouse)	An allowed family status change under the plan language (contract) or under HIPAA must occur to allow cancellation to enroll under spouse's coverage as an employee. *Health Insurance Application/Change Form* or myETF Benefits request must be submitted within 30 days of the IRC Section 125 status change, the event.	End of the month following receipt of an application/myETF Benefits request or the event date, whichever is later.	Refer to Chapter 6 for status changes allowed under the plan language (contract) and HIPAA. Documentation may be required. If an allowed family status change has not occurred, an employee can submit an application in October, November or December requesting coverage to be canceled effective December 31. Coverage end date for a cancelation request is always the end of a month. Retroactive cancellations are not allowed.

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

Event	Eligibility Requirements	Coverage End Dates	Comments
Premiums Deducted Post Tax	*Health Insurance Application* or myETF Benefits request must be submitted.	Coverage end date is the end of the month following the application received date or the myETF Benefits request date, whichever is later. If the application received date or the myETF Benefits request date is the last day of a month, coverage ends on the receipt/request date.	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 cancelations are not allowed.

Chapter 10 – COBRA, Continuation and Conversion

1001 Overview of COBRA, Continuation and Conversion

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), insured participants and their eligible dependents covered under the Wisconsin Public Employers Group Health Insurance Program have options available to them for the continuation or conversion of health insurance coverage in the event eligibility for group coverage ends. COBRA requires that the WPE Group Health Insurance Program offer subscribers (employees/ members) and their covered dependents (qualified beneficiaries) temporary extension of identical coverage at the group rate for a maximum of 18 months (36 months under certain circumstances) following specific events, referred to as “qualifying life events” (refer to subchapter 1002). The following provides an overview of Continuation and Conversion.

1001 A) Continuation:

Wisconsin statutes (Wis. Stat. § 40.51 (3-4), § 632.897) incorporate and extend the federal COBRA benefit noted above. Under this subsection, authority is given to the BOARD to reinforce and broaden continuation rights under certain circumstances.

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

Note: One commonly encountered distinction between federal and state law occurs in late-reported divorce. Under federal law, divorcees are entitled to 36 months of COBRA following the divorce event. (For example, a divorce reported on month 34 after the event would only leave the ex-spouse with a balance of 2 months.) However, state law guarantees a minimum of 18 months’ continuation regardless of event date. As a result, state law rules are followed and the ex-spouse would be entitled to continuation for months 34 through 51.

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

1001 B) Conversion:

Conversion coverage is available to participants who have been covered under the WPE Group Health Insurance Program under terms negotiated with the health plan. Participants may elect to convert to a 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.

1002 Persons Eligible for Continuation (Qualified Beneficiaries)

Under federal and state laws, when group health insurance coverage would otherwise end because of a life event known as a “qualifying life event,” employees and their covered dependents become “qualified beneficiaries” and must be offered continuation coverage (refer to subchapter 1005 for employer responsibilities).

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

1002 A) Insured 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 11, 12, and 13). COBRA should be offered to insured employees even if they terminate before 30 days of work have passed.
2) Completion of the maximum prepayment periods of 36 months while on a leave of absence or layoff. (Refer to Chapter 8).

1002 B) The spouse of an employee with family coverage in the WPE Group Health Insurance Program becomes a qualified beneficiary as a result of any of the following qualifying life events:

1) Death of spouse (employee). Employers do not need to provide a *Continuation - Conversion Notice* [ET-2311] as the survivor's coverage will automatically continue. (Refer to Chapter 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 divorce is entered/finalized.

3) Spouse (employee) loses coverage for reasons listed above under section 1002 A.

1002 C) Each eligible dependent child of an employee with family coverage in the WPE Group Health Insurance Program becomes a qualified beneficiary as a result of any of the following qualifying life events:

1) Death of parent/stepparent. Employers do not need to provide a *Continuation - Conversion Notice* [ET-2311] as the survivor's coverage will automatically continue. (employee; refer to Chapter 14 on Employee Death).
2) Dependent eligibility status ceases under the WPE Group Health Insurance Program (Refer to the chart in subchapter 1006 for examples).
3) Parents become divorced resulting in loss of eligibility.
4) Parent (employee) loses coverage for reasons listed above in A.

1002 D) An eligible dependent of a minor dependent (grandchild) of an employee with family coverage in the WPE Group Health Insurance Program becomes a qualified beneficiary when losing eligibility as a result of the minor dependent (parent) turning age 18. Coverage for the dependent of a minor dependent terminates at the end of the month in which the dependent child turns 18.

1002 E) An eligible disabled dependent, over age 26, of an employee with family coverage in the WPE Group Health Insurance Program becomes a qualified beneficiary upon loss of disabled status. Coverage terminates at the end of the month in which it is determined the disabled status ceases.

1002 F) If an employee, within the initial 18 months of COBRA coverage, is granted a SSA disability, they may be eligible for an extension of COBRA for up to 29 months. The employee must provide ETF with a copy of the SSA letter that states they have been found to be disabled, within 60 days of the date of the letter.

1002 G) In the event an employee is hired, WRS eligible, and elected insurance coverage that is in force and the employee terminates before completion of 30 days of service the insurance remains in force and the employee **must** be offered COBRA. Coverage as an

active employee will end as of the end of the month of termination.

Note: When a voluntary change in coverage from a family plan to a single plan is done in anticipation of a divorce, the spouse and dependent children are eligible for continuation coverage when the divorce is final. The effective date for continuation coverage in this case is the date of the entry of the judgment of divorce.

This is usually when the judge signs the divorce papers and the Clerk of Courts date-stamps them. In all other cases, voluntary cancellation does not create a continuation enrollment opportunity.

1003 Employee Responsibilities

Employees (refer to subchapter 1002) are responsible for informing the employer of a qualifying life event in which a dependent loses eligibility for coverage under the WPE Group Health Insurance Program. Qualified beneficiaries should notify ETF of these changes.

Application 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 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 independently as a qualified beneficiary of the employee as soon as possible. Coverage terminates the end of the month in which the employer provides the notice of the right to continue coverage (*Continuation - Conversion Notice* (ET-2311) to the ex-spouse and any stepchildren or children of minor stepchildren. In this situation, employers must check with ETF on the length of continuation coverage that is available.

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

as covered dependents on the ex-spouse's family contract.

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

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

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

1004 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 *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually) to ETF. Both forms (an employee need only submit a *Continuation - Conversion Notice* unless requesting a change in coverage) must be sent to ETF (that is, postmarked) no later than 60 days from the termination of their coverage or within 60 days of the date they were notified by their employer, whichever is later. If qualified beneficiaries do not elect continuation coverage within the 60-day period, they lose eligibility to enroll under continuation.
2) Paying premium to the health plan when billed by the health plan.
3) Reporting any changes affecting coverage, for example, address change, birth or adoption. If continuation coverage is elected, changes must be reported to ETF; if conversion coverage is elected, changes must be reported to the health plan.
4) Subscribers and their insured dependents continuing coverage must enroll in Medicare Parts A and B when initially eligible. A copy of the Medicare card must be submitted to ETF. If a qualified beneficiary is eligible for Medicare:
    - ***a) prior to or on*** the effective date of COBRA coverage, they are eligible for Medicare reduced rates.
    - ***b) after*** COBRA coverage begins, COBRA coverage ends for the subscriber or dependent when they enroll in Medicare Parts A and B.
        - i) Qualified beneficiaries not eligible for Medicare remain eligible for COBRA coverage.
        - ii) If Part B becomes effective after the continuation begins, the continuation period ends at the end of the month prior to when Medicare Part B becomes effective.

1005 Employer Responsibilities

1005 A) Within five days of being notified of the "qualifying life event," the employer is responsible for notifying qualified beneficiaries of their right to continue group coverage or convert to individual coverage by providing them with the following documents:

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

   Note: A continuation notice must be provided within the five-day period even when it is determined the qualified beneficiary is not entitled to continuation coverage, for example, notice of the qualifying life event was not provided to the employer within the required time period (refer to subchapter 1006 for information on providing notice).

   The employer must indicate on the continuation notice that the qualified beneficiary is not eligible for COBRA by marking the correct fields.

   In the case of divorce, confirm the address of all qualifying beneficiaries.

1005 B) The employer is responsible for informing qualified beneficiaries of the following:

1) If electing continuation coverage, the completed *Continuation - Conversion Notice* and *Health Insurance Application* forms must be sent to ETF (i.e., postmarked) no later than 60 days after the date of the notice or 60 days after coverage ends, whichever is later.
2) If electing continuation coverage, the health plan will bill the continuant(s) directly.
3) If electing continuation coverage and the continuants are moving for more than three months, they are eligible to change to another health plan without restrictions, provided the application is received within 30 days after the move. The application must be returned to the employer if the change would be effective before the termination of coverage paid through the employer; otherwise, the application must be returned to ETF. If the qualified beneficiary lives in a county different from that of the subscriber, they are also eligible to change plans at the time they begin continuation coverage.
4) See section 603 for other reasons to change carriers.

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).

1006 Notice Requirement Illustration Chart

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

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

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

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

Employee Terminates Employment	03/15	03/31	N/A	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.

1007 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 or be moving, the qualified beneficiary may elect a health plan in their county of residence when enrolling in continuation coverage, even if the subscribers' health plan is available in the qualified beneficiary's county. Continuants are allowed to change health plans during the annual open enrollment period or following a residential move.

Continuation coverage may be in effect for up to 18 months following termination of employment (36 for divorce, death and dependent loss of eligibility). However, continuation coverage may be terminated early 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.

If COBRA coverage is terminated early for any reason, it may not be reinstated. Voluntary termination of coverage is effective prospectively from the date notice is provided to ETF.

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 11 — Retirement or Disability

1101 Coverage – Requirements to Continue

Coverage under the Local Group Health Insurance Program may be continued when an employee receives a WRS retirement or disability benefit (upon termination of employment). 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 WPE Group Health Insurance Program contract.

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

1101 A) Retirement Benefit

When an employee retires, the employer should leave their coverage active in myETF Benefits. ETF staff will end the contract when the Local Employer Verification of Health Insurance Coverage (ET-4814) is received stating that the subscriber wants to cancel coverage.

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.*** A *Local Employer Verification of Health Insurance Coverage* (ET-4814) must be submitted to ETF, signed by the employer, indicating whether the employee elects to cancel health coverage.

Group health insurance coverage will automatically be continued if the employee retires with an *immediate annuity* under Wis. Stat. § 40.02 (38) and the EMPLOYER submits verification

of insured status. 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.

A person who canceled coverage but is otherwise eligible for insurance and who is eligible and applies for an immediate annuity under Wis. Stat. § 40.02 (38), may have their WPE 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 WPE'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.

1101 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 health insurance program or
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 have their coverage reinstated even if, during the period preceding the benefit approval:

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

This provision does not apply if the employee files a *Group Health Insurance Application* to terminate health insurance coverage.

Once the WRS disability retirement or duty disability benefit is approved, the previously insured EMPLOYEE whose coverage lapsed or who was covered under COBRA will be offered a new opportunity to enroll. ETF will notify the employer. (Refer to Chapter 8.) ETF will also send the employee a letter and a *Health Insurance Application/Change Form Retirees & COBRA Continuants* (ET-2331) offering coverage under the Local 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 month on or after the date the application for health insurance has been received.

1102 Medicare Enrollment

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

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

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

1103 Premium Payment

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

1103 A) Employer Paid Annuitant - Premiums are paid to ETF by the employer when the employer pays any portion of the premium for the annuitant.

1103 B) Annuity Deduction - Premiums are paid from a monthly retirement or disability retirement benefit annuity Wis. Stat. §40.63 if the annuity is sufficient to cover the entire premium.

1103 C) 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 annuitant, and the annuitant will pay premiums directly to the health plan.

Note: 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.

1103 D) 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).

1104 Completing Employer Verification of Health Insurance Coverage

A *Local Employer Verification of Health Insurance Coverage* (ET-4814) must be submitted to ETF for each employee, even when the employer is paying all or part of an annuitant's monthly health premium. The form is also required for a surviving spouse/dependent of a deceased insured employee or employer-paid annuitant.

To complete this form, the employer fills out Part A of the form. The employee or survivor then completes Part B of the form and submits to ETF.

If the employer has paid the annuitant's premium (see 1103 A), but will no longer do so, Part C will need to be completed as well. The employer should fill out Part C on the original ET-4814 submitted to ETF. Contact ETF if a copy of the original in needed. Submit the completed ET-4814 to ETF at least two months prior to premium contributions ending.

It is the responsibility of the annuitant to submit a written request to ETF if they wish to cancel health insurance coverage when the employer contribution ends.

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Chapter 12 — Rehired Annuitants

1201 Eligibility

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

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

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

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

1) If their last termination date was ***prior to July 2, 2013*** and if the annuitant elects to participate in the WRS, the annuity is suspended effective the first of the month following ETF's receipt of the *Rehired Annuitant Form.* If the annuitant does not elect WRS participation, their WRS annuitant status continues uninterrupted.
2) If their last termination date was ***on or after July 2, 2013***, the annuity is suspended effective the first of the month following their rehire date.
3) If the minimum break in service has not been met, the annuity is invalid and considered a benefit paid in error; the annuitant would be re-enrolled in the WRS with no break.

The annuitant remains enrolled in the WRS until they again retire and reapply for an

annuity and annuitant benefits they are eligible for as a result of their most recent position worked.

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

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.

Regardless of whether an employer participates in the WPE Group Health Insurance Program or not, an annuitant returning to active WRS coverage is no longer eligible for annuitant health coverage while employed as a rehired 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 even after they retire again.

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

1202 Coverage

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

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

As premiums paid through the annuity are deducted one month in advance, insurance is paid for one month beyond the annuity suspension date. ETF will assist the employer in determining the date the rehired annuitant should be added to active coverage. A *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually), or online enrollment through myETF, electing coverage must be received by the employer within 30 days following the WRS participation begin date. When the employee retires again, refer to Chapter 12 for instructions on continuation of health insurance coverage, as the former annuitant is now considered an active

employee.

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

1203 Disability Annuitants

Participants Under Normal Retirement Age
A WRS participant who is receiving a disability retirement benefit under Wis. Stat. §40.63 and who has not reached normal retirement age cannot actively participate in the WRS until they are no longer eligible for the disability annuity (i.e. the participant is medically certified as no longer disabled). However, if the participant is re-employed, their disability annuity will be suspended if they earn more than a set “earnings limit” during a calendar year. Eligibility for annuitant health and/or life insurance coverage continues during the period of annuity suspension.

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

ETF notifies both the employee and the employer of the WRS coverage begin date, defined as the first of the month after the disability termination date. Employers are notified of their obligation to provide the employee with a Health Insurance Application/Change ((ET-2301) available on the ETF website and updated annually) form.

ETF will coordinate between ending annuitant coverage and beginning active coverage if the individual elects coverage. New applications must be filed with the employer within 30 days after the date the employee resumes active status under WRS.

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

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.

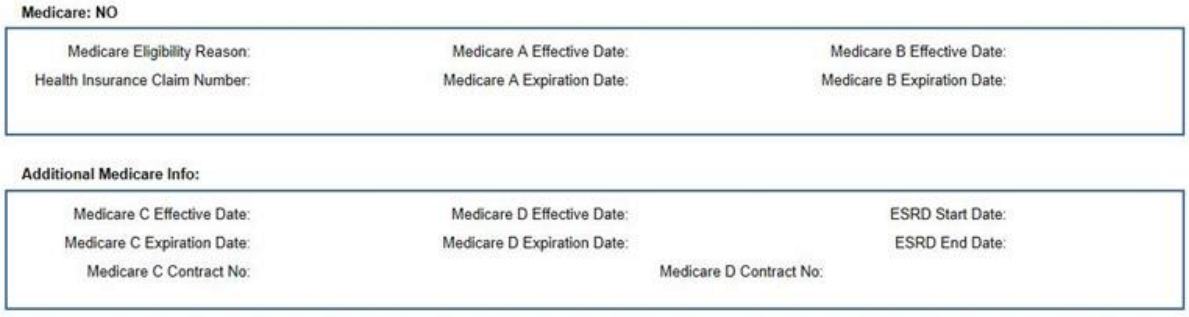
Note: Employees age 65 and older are automatically enrolled in Medicare Part A coverage when they sign up for their social security benefit.

1301 B) myETF Benefits:

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

The employer or employee can enter the information into myETF Benefits.
Please have the employee provide a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually).

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



1301 C) Premium Rates:

1) Active employees (non-annuitants) and their dependents are not required to enroll in Medicare Part B when first eligible and do not receive the Medicare reduced premium rate in the event they do enroll in Medicare. The coverage types of Medicare Single, Medicare Family - Some and Medicare Family - All are not listed for active employees because they are not eligible for the Medicare reduced

rates, as the WPE Group Health Insurance Program pays primary on claims for these employees.

2) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, who become insured under federal plans for hospital and medical care (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD. The employer can subsidize different amounts for different classes of retirees, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensations (e.g. salaried versus hourly). The employer cannot vary the premium subsidy for retirees within a given class of retirees.

   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, or under an employer group number in the case of an employer paid annuitant. See also 1301 F.

1301 D) Employees age 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 participating EMPLOYER. The reduction in PREMIUM is available only when the coverage is provided under an ANNUITANT group number.

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

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

See also 1102 for information about deferring Medicare Enrollment.

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 their insured dependents eligible for coverage under Medicare must enroll and remain enrolled in Parts A and B when first eligible due to age or disability per Wis. Stat. § § 40.51(7) and 40.52 (2). Annuitants and their insured dependents failing to be enrolled 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. 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 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 solely as a result of the death.

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

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

   The prescription drug coverage under this program is Medicare Part D coverage. In addition, supplemental "Wrap" coverage, which pays secondary to the Medicare Part D plan, is also provided. A retiree's monthly health insurance premium includes a portion that applies to this program's coverage. Retirees may choose to enroll in another Medicare Part D plan, but it is not recommended or required. Retirees who choose to enroll in another Medicare Part D plan will be dis-enrolled from ETF's

Medicare Pharamcy Part D plan. However, they will still maintain the supplemental “Wrap” coverage, which will be secondary to the other Medicare Part D plan. There is no partial premium refund for enrolling in another Medicare Part D plan.

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 plan HEALTH PLANs (HEALTH PLANs) to 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

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

1) Verify that the employee was identified to COB&R or other entity through a data match request and review your records concerning each individual to make sure that

you have all the documentation and copies of the documentation from the HEALTH PLAN. *HEALTH PLANs are to respond to COB&R or other entity following the federal procedures*.

2) Contact the HEALTH PLAN's representative to reach their current Coordination of Benefits (COB) person. Make sure that COB person has a copy of the documents and they are working on this with Treasury as a priority. Follow up with the HEALTH PLAN if the matter is not resolved in a timely manner.
3) Contact your legal counsel for assistance.
4) You may need to prepare a letter to the requestor. Talk about this with the HEALTH PLAN's COB person. You may use the attached Sample Letter.

Sample Letter

I am writing in regard to 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 Report an Employee Death to ETF Immediately

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

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

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

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, except as provided for in 1402 D. Coverage shall be effective on the first day of the calendar month following the date of death of the insured ANNUITANT. The surviving spouse may continue coverage indefinitely; dependent children (as defined in 402) may continue coverage as long as they remain eligible under the program.

1402 B) Employers must submit a *Local Employer Verification of Health Insurance Coverage* (ET-4814) to ETF before processing the continuation of health insurance for eligible survivors. There will be no required employer contribution towards the monthly premium, although the employer has the option of offering to cover the survivor as a local paid annuitant if they would have done so for the employee or were doing so for the annuitant, except as provided for in 1402 D.

1402 C) If the surviving spouse and dependents **do not** wish to continue coverage, ETF must receive a signed written request or the *Local Employer Verification of Health Insurance Coverage* (ET-4814), indicating they do not want coverage, can be submitted. Should the surviving spouse (or annuitant) and dependent(s) not elect to continue coverage, coverage will end the last day of the month for which premiums have been paid.

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

Survivors may not add persons to the policy who were not covered at the time of death, unless:

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) or is a child born within 9 months of 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.

1402 D) In the event a law enforcement officer employee with family health coverage dies in the line of duty, the employer must continue to pay health insurance premiums for the surviving spouse and/or eligible dependents as required by 2019 Wisconsin Act 19. Contact ETF for assistance.

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.

2) Enroll as the surviving spouse and retain coverage indefinitely as indicated in subchapter 1302. Premiums may be paid through the employer as local employer-paid, through a WRS annuity or directly by the surviving spouse to the health plan.

Chapter 15 — Invoicing

1501 Viewing Your Invoice

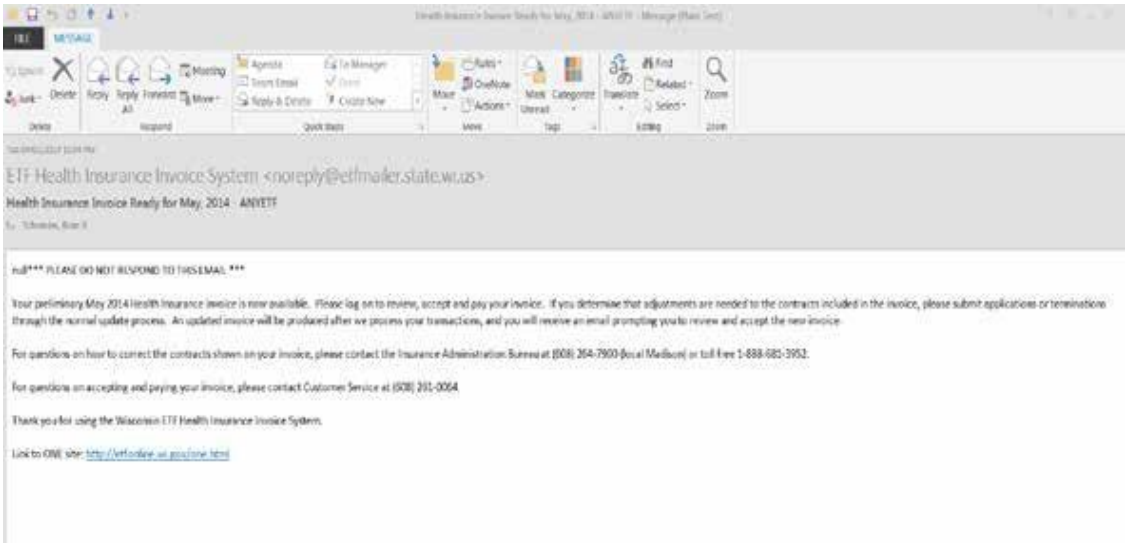
Reports and remittances from employers required in the administration of the group health insurance program shall be submitted to ETF no later than the 24th day of the calendar month for the current month's coverage. The remittance by the employer shall be the amount invoiced by ETF.

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

CURRENT PROCESS (2017)					
	Coverage Month	**ETF Generates Employer Invoices**	**Premiums due from Employers to ETF**	**820 Files loaded to the ftp site for Health Plans**	**Premiums Due from ETF to Health Plans**
Local Active	January 2017	December 1-24, 2016	December 27, 2016	December 27, 2016	January 3, 2017
Local Annuitants	January 2017	December 1-10, 2016	December 27, 2016	December 27, 2016	January 3, 2017

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 local employers. An email is sent to all authorized employer agents and insurance contacts to alert them that an invoice is available for their review. An example of such an email is below:

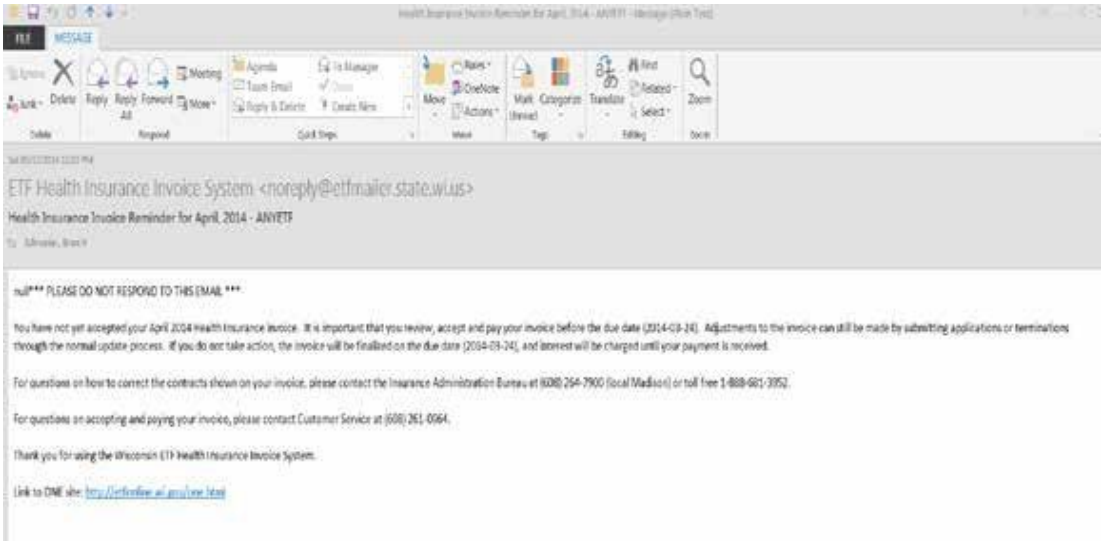


The email address used is the one provided on the *Online Network for Employers Security Agreement* (ET-8928) when requesting access to the myETF Benefits system. The invoice charges premiums for the next calendar month on all health insurance contracts that will be active in that month as of the generation date. Any transactions entered after the invoice generation date will appear on the next invoice.

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

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



The latest date an employer must accept the invoice is the 24th of each month. If the employer invoice is not accepted by 5:45 p.m. on the 24th of each month, any unaccepted employer invoice will automatically be accepted by the myETF Benefits system. Refer to subchapter 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 email contact information by clicking on the *employer email address update* link. If the user is not updating their email contact information, click the '*Continue'* button to move to the Health Insurance Invoice Summary screen.

3) The *Health Insurance Invoice Summary* screen provides the user with the ability to search for the invoice by coverage month and year. Users can review the current coverage month's invoice or previous invoices. This screen also provides employers with the invoice amount, invoice number, invoice date (last date the invoice generated or regenerated), accept date, accepted by, employee share field, initial payment late indicator, and interest amount. The employee share field is a field the employer will be required to complete once it is determined how much of the invoice amount is the employee share.

   At the bottom of the Health Insurance Invoice Summary are the '*Invoice Detail'*, '*Contract Activity'* and '*Accept'* buttons. The '*Invoice Detail'* and '*Contract Activity'* applications can be used in conjunction with the Premium Report to reconcile the invoice; both are discussed in subchapter 1402. The '*Accept'* button is used once the invoice has been reconciled and the employer is ready to accept the invoice and pay the invoice amount. Refer to subchapter 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 access to two reports, the 'Enrollment Report' and 'Premium Report'. In addition, employers have available to them the 'Invoice Detail' and 'Contract Activity' applications.

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.

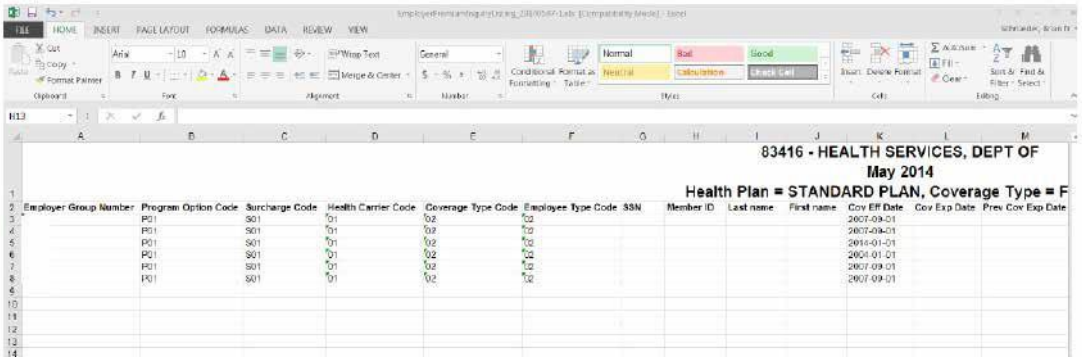
1) Upon logging in to myETF Benefits, hover over the *Health* tab. A drop-down will appear with '*Inquiry'*, '*Member Enrollment'*, '*Premium'*, and '*Termination of Coverage'* visible. Hover over *Inquiry* which will make available the options of *Enrollment Reports* and *Premium Reports* in a drop-down 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.

3) 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.

4) 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.

5) 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.



6) 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.

1502 B) Invoice Detail

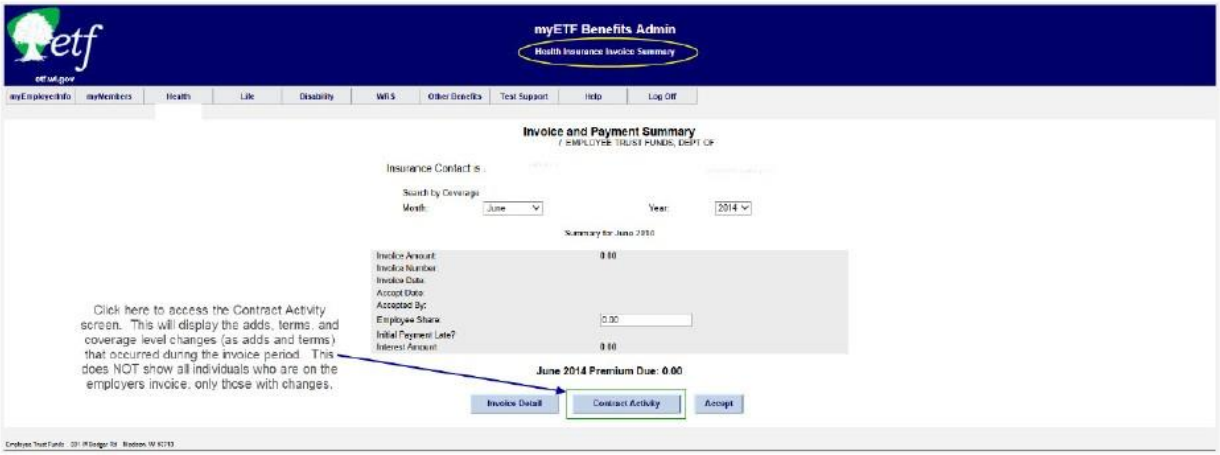
Access to the Invoice Detail application is gained through the Health Insurance Invoice Summary screen. This is reached by clicking on Health, Premium, Employer Invoice as previously shown. Click on the '*Invoice Detail'* button to open the application.

The information displayed is the total number of contracts being billed on the invoice and is broken down by health plan, employee type and coverage level. The application totals the contracts into one group total. This application does not provide specific employee information for whom the employer is being billed.

***Note:** ERA Fee is not applicable to local employers and will not appear on this screen.

1502 C) 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 D) Enrollment Reports – Enrollment Inquiry, Dependent Inquiry and Address Inquiry

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

1503 Accepting and Paying Your Invoice

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.
2. On the next screen, review the invoice details and if everything is okay, click *'Confirm'.* Employers will then receive an email acknowledging the acceptance of the invoice. Once an invoice has been accepted, no further changes can be made to it.
3. If an invoice has not been accepted by the due date, the system will automatically accept it on the employer's behalf that night. The employer will receive an email letting them know that the system has accepted the invoice and they need to submit a payment.
4. Accepting and confirming the invoice does not mean a payment has been initiated.

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

ETF may lock your invoice while making changes to it.

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.

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

Automated Clearing House (ACH):

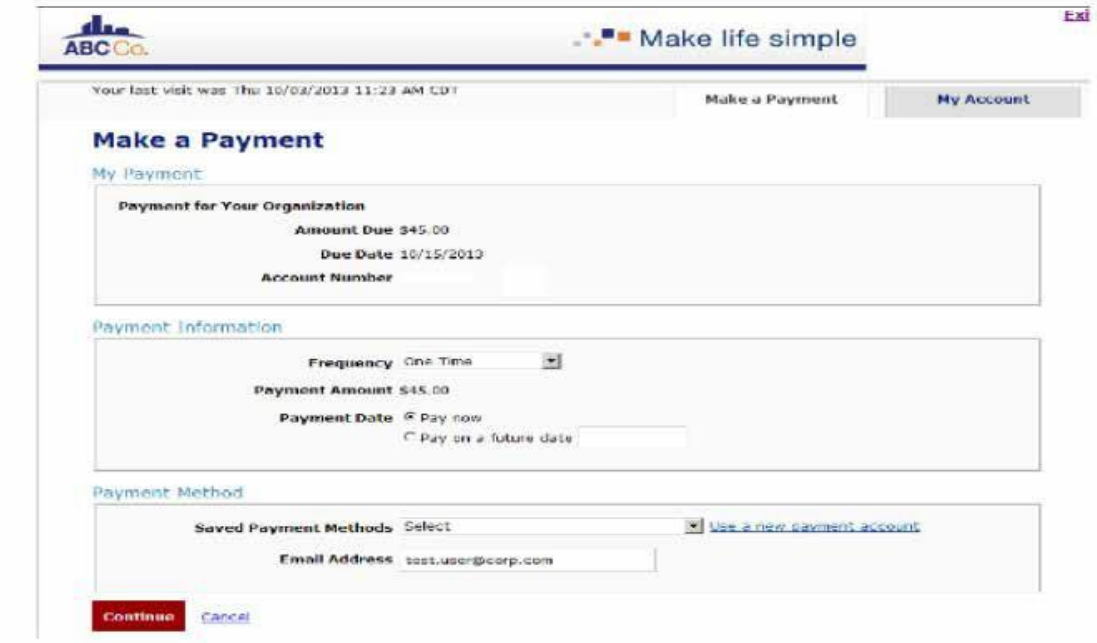
For local employers, after confirming their invoice they will be automatically taken to the US Bank E-Payment Log In screen. They can Log In, Register, or Pay Without Registering.

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

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

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

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



This will have 3 sections:

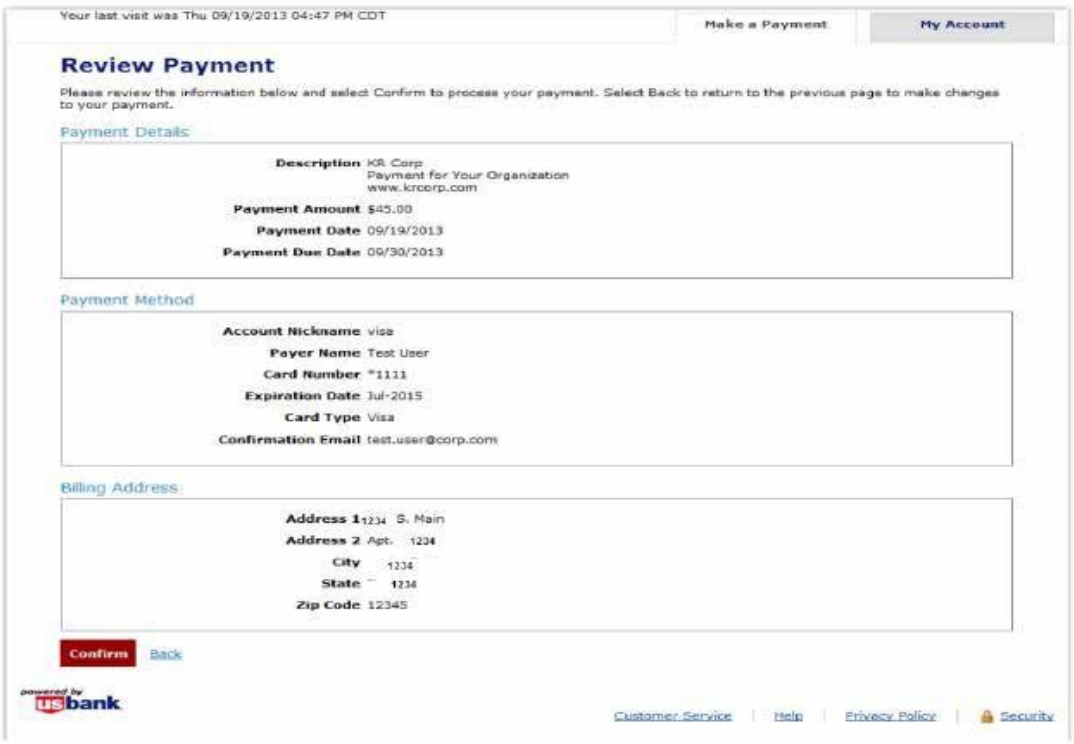
1. My Payment – This will show the Amount Due and Due Date

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

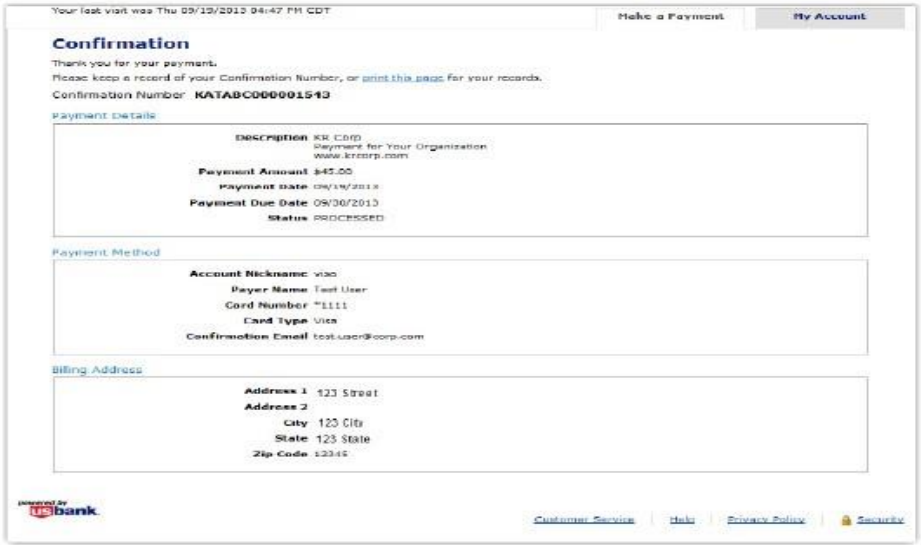
3. Payment Method – If a user is registered this will be the saved banking account.
   a. If a user is paying without registering, the user will need to fill in the banking information.

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

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



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



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

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

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

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

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

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:

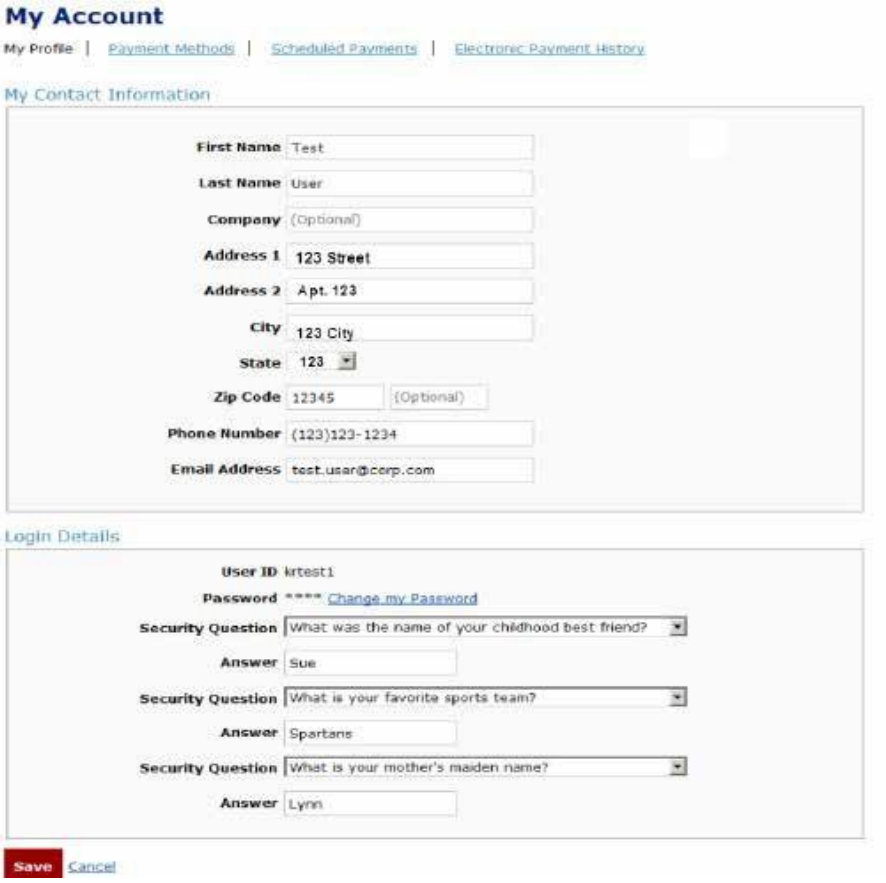
Interest Charge = Invoice Premium Due x Number of days late x 0.04%

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

Other Features - My Account:

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

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



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

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

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 — Terminating Employer Group Participation

1601 Duration of Participation Prior to Termination

Any EMPLOYER for whom the resolution to participate in the local group health insurance program resulted in coverage effective January 1, 1988 or after shall be required to remain in the program for a minimum of 12 months. Any EMPLOYER who files a resolution after December 20, 1990, and who offers a non-participating plan as required by 302 C) shall be required to remain in the program a minimum of three years. Any EMPLOYER who is assessed a surcharge as determined by the underwriting process shall be required to remain in the program a minimum of three years.

1602 Partial Termination of Group not Permitted

The EMPLOYER cannot have a group of employees, for example a bargaining unit, drop from this health insurance program and carry other coverage.

1603 Employer Group Termination

1603 A) The governing body of an EMPLOYER may terminate group health insurance under Wis. Stat. § 40.51 (7), for all PARTICIPANTS for whom rights to coverage were secured by the EMPLOYER'S participation by adopting a resolution in a form prescribed by the BOARD.

1603 B) A certified copy of the resolution in 1603 A must be received in ETF by October 15 for termination to be effective at the end of the calendar year.

1603 C) If the EMPLOYER fails to comply with 1603 A or B above, or if the EMPLOYER fails to maintain the required participation level in the program, ETF may impose enrollment restrictions on the EMPLOYER as it deems appropriate to preserve the integrity of the program. ETF may terminate the EMPLOYER'S participation in the program on the first of the month following notification to the EMPLOYER that it has violated the terms of the CONTRACT. ETF may also restrict the EMPLOYER'S re-enrollment in the program beyond the restrictions set forth in item (4) below.

1603 D) Any EMPLOYER who terminates participation under this section may again elect to participate with an EFFECTIVE DATE not earlier than three years after the date of termination. The EMPLOYER is responsible for notifying ANNUITANTS and CONTINUANTS of coverage termination.

1604 Disenrollment

If participation by an EMPLOYER is approved in accordance with 301 and 302 above, and the subsequent participation falls under the minimum requirement, the BOARD may terminate EMPLOYER participation at the end of the calendar year by notifying the EMPLOYER prior to October 1.

Chapter 17 — Glossary of Definitions

"ACCESS PLAN" means the nationwide health care benefit plan available to all PARTICIPANTS offered by the BOARD as provided by § 40.52 (1).

"ANNUITANT" means any currently insured retired EMPLOYEE of a participating EMPLOYER: receiving an immediate annuity under the Wisconsin Retirement System, or a disability retirement annuity under Wis. Stat. § 40.63, or a long-term disability benefit under Wis. Adm. Code § ETF 50.40, or a disability benefit under Wis. Stat § 40.65, or a person receiving an annuity through a program administered by ETF under Wis. Stat. § 40.19 (4) (a).

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

"BOARD" means the Group Insurance Board.

“CONTINUANT” means any SUBSCRIBER enrolled under the federal or state continuation provisions as described in Article 2.9.

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

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

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

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

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

    c) All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, whichever occurs first, 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 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 acknowledgement 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 Article 503 D.

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

"EMPLOYEE" means a person who is working for pay as an eligible EMPLOYEE as defined under Wis. Stats. § 40.02 (46) or 40.19 (4) (a), of an EMPLOYER as defined under Wis. Stat. § 40.02 (28), other than the state, which has acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its EMPLOYEES.

"EMPLOYER" means an employer who has acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its EMPLOYEES.

"ETF" means the Department of Employee Trust Funds.

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

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

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

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

"IT'S YOUR-CHOICE" see OPEN ENROLLMENT>.

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

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

"OPEN ENROLLMENT" means the yearly period referred to in ETF materials where all members may make changes to their HEALTH PLANS and/or coverage and also to eligible EMPLOYEES to enroll for coverage in any HEALTH PLAN offered in the Group Health Insurance Program. The dates for this time period are set each year by ETF and the Group Insurance BOARD.

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

"PREMIUM" means the rates shown on Attachment A plus the pharmacy rate and administration fees required by the BOARD. Those rates may be revised by the HEALTH PLAN annually, effective on each succeeding January 1 following the effective date of this CONTRACT. The PREMIUM includes the amount paid by the EMPLOYER when the EMPLOYER contributes toward the PREMIUM.

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

Appendix A — Forms and Brochures

Document name	Form number	Link
WRS Administration Manual	ET-1127	/etf.wi.gov/resource/wisconsin-retirement-ystem-administration-manual
State of Wisconsin Group Health Insurance Program Agreement	ET-1136	etf.wi.gov/resource/2022-state-wisconsin-group-health-insurance-program-agreement
WPE Standard PPO Plan Program Option 2 Booklet	ET-2131	etf.wi.gov/publications/et2131.pdf
WPE Standard PPO Plan Program Option 4 Booklet	ET-2162	etf.wi.gov/publications/et2162.pdf
WPE Standard PPO Plan HDHP Program Option 7 Booklet	ET-2170	etf.wi.gov/publications/et2170.pdf
Health Insurance Application/Change	ET-2301	etf.wi.gov/publications/et2301.pdf
Health Insurance Application/Change for Retirees & COBRA Continuants	ET-2331	etf.wi.gov/publications/et2331.pdf
COBRA Continuation Conversion Notice	ET-2311	etf.wi.gov/publications/et2311.docx
Rehired Annuitant Form	ET-2319	etf.wi.gov/publications/et2319.pdf
Converting Your Group Life Insurance to Pay for Health Insurance or Long Term Care Insurance Premiums	ET-2325	etf.wi.gov/publications/et2325.pdf
Group Health Insurance	ET-4112	etf.wi.gov/publications/et4112.pdf
Medicare Eligibility Statement	ET-4307	etf.wi.gov/publications/et4307.pdf
Local Employer Verification of Health Insurance Coverage	ET-4814	etf.wi.gov/publications/et4814.pdf

Appendix B — Codes

B-1 Employee Type Codes

Code	Employee Coverage	Description
06	Local	Eligible local government employee.
09	Local Paid Annuitant	WRS annuitant whose former employer pays all or part of the monthly health insurance premium.
14	Local Annuitant	Retired employee who is eligible for health insurance.
15	Local Surviving Spouse/Dependent	Currently insured subscriber dies while carrying family health insurance coverage.
16	Local Continuant	ETF Use Only - Continuant
18	Local Fallen Officer Survivor	Survivors of Fallen Officers receiving health insurance
22	Local Annuitant Split	Retired employee who is eligible for health insurance and has selected two health plans.
24	Local Surviving Spouse/Dep Split	Used for survivors of currently insured subscriber who dies while carrying family health insurance coverage and has selected two health plans.
25	Local Paid Annuitant Split	WRS annuitant whose former employer pays all or part of the monthly health insurance premium and has selected two plans.
27	Local Continuant Split	Continuant who has selected two health plans.

B-2 Coverage Type Codes

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

B-3 Individual Relationship Codes

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

B-4 Program Option Codes

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

B-5 Surcharge Codes

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

The surcharge code is assigned to large employers (50 or more employees) after the employer submits information to underwriting when enrolling in the Wisconsin Public Employers’ (WPE) Group Health Insurance Program. Employers with 49 or less employees are not subject to a surcharge or underwriting.

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

B-6 Health Plan Codes
2024 CARRIER CODES FOR HEALTH INSURANCE

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

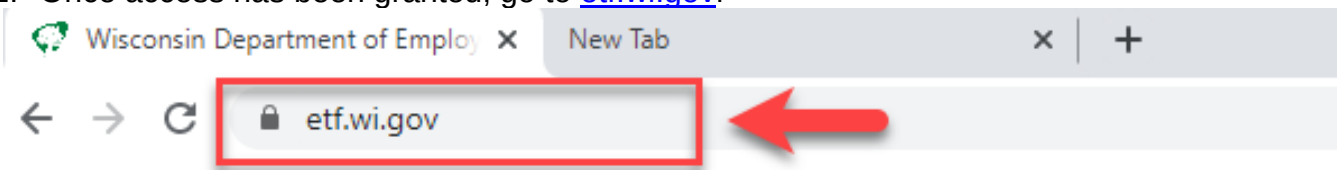
Appendix C — myETF Benefits

C-1 How to Log into myETF Benefits

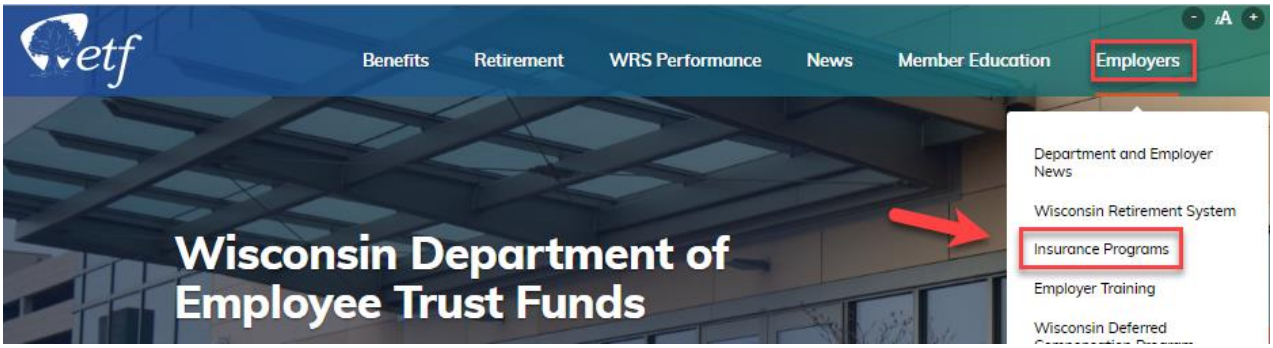
To get started in myETF Benefits you must first obtain access to the system by completing and submitting an *Online Access Security Agreement* (ET-8928) to the Department of Employee Trust Funds, on which you request access to myETF Benefits for Administrators for the following areas:

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

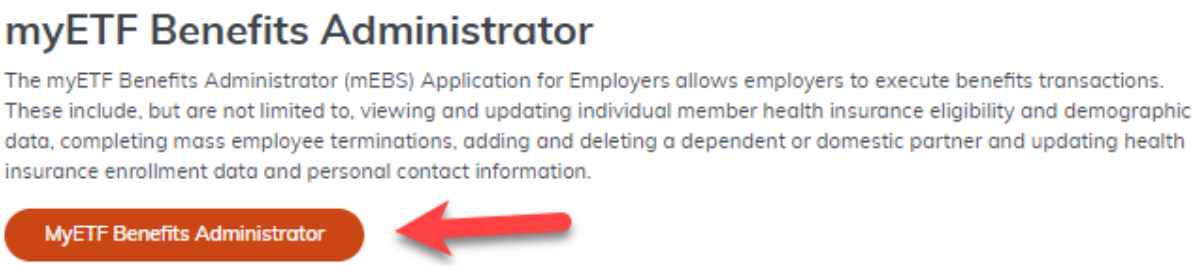
1. Once access has been granted, go to etf.wi.gov.



2. Hover over Employers tab and click on Insurance Programs.

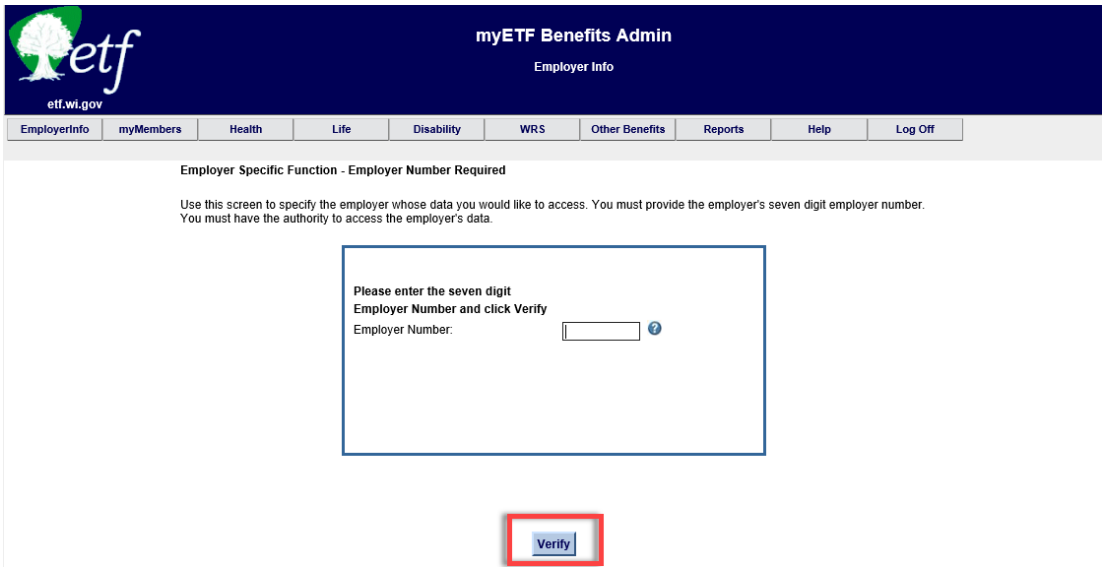


3. Click on MyETF Benefits Administrator.

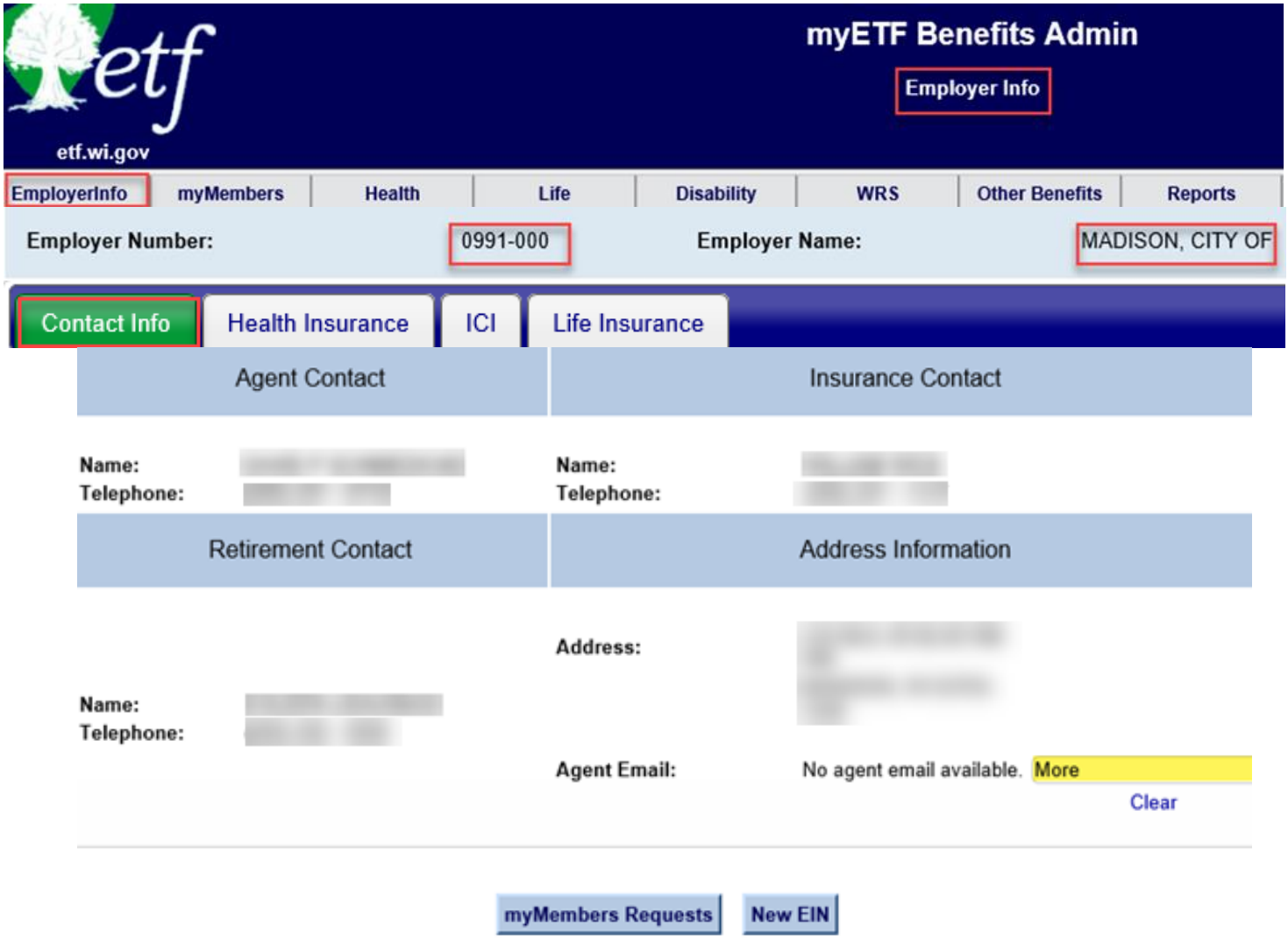


4. Enter your user ID and password.

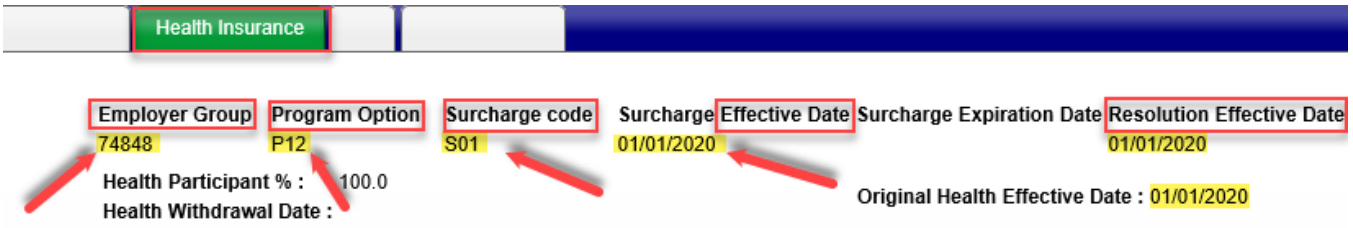
5. Enter your employer number and click Verify.



6. You will be redirected to the EmployerInfo screen, which displays the employer's contact information. Click through the tabs to view your agency's participation in health insurance, income continuation insurance (ICI), and life insurance.

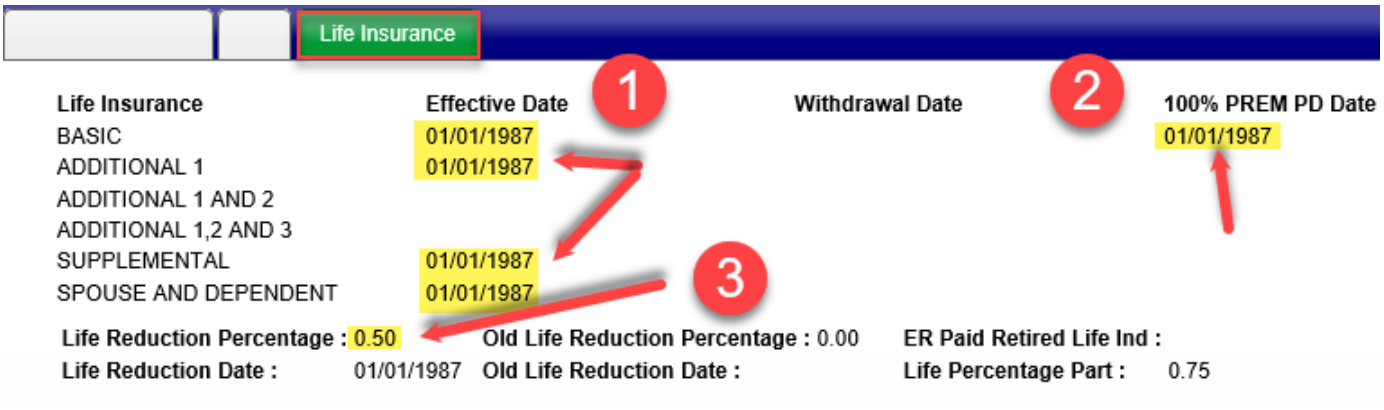


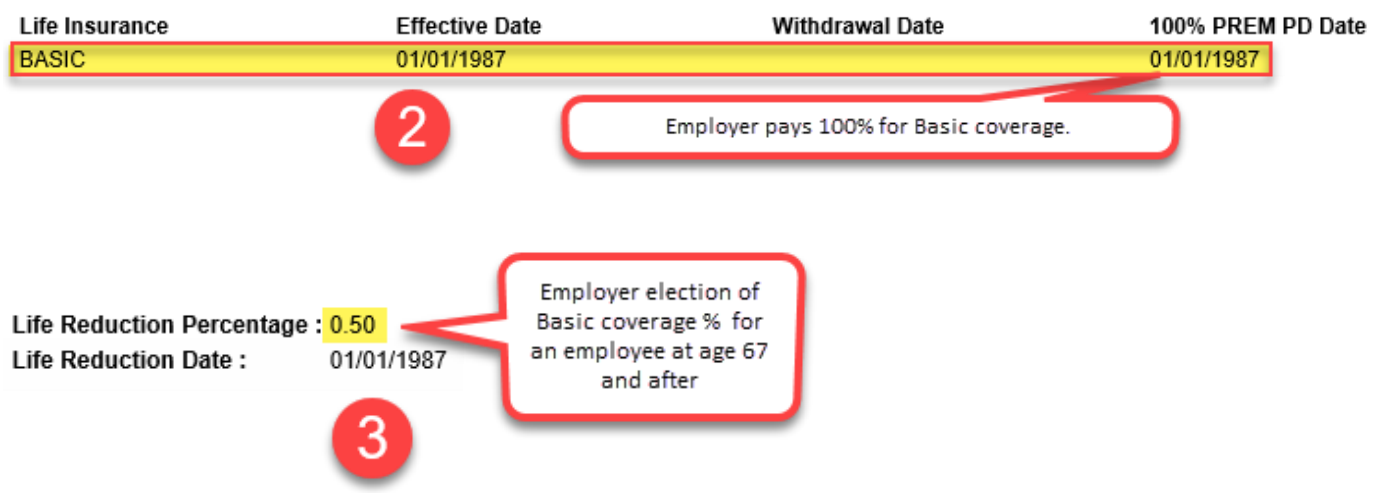
7. Health Insurance tab - If an agency offers WPE Group Health Insurance, this tab will display the employer group number, health insurance program option number the agency offers to their employees, effective date of participation, and other health insurance details specific to the agency. If no information is displayed or a withdrawal date is posted, the agency is not enrolled in WPE Group Health Insurance.



8. Income Continuation Insurance (ICI) tab - If an agency participates in the Income Continuation Insurance (ICI) Program, this tab displays the coverage effective date and the code will display as shown below. If no information is displayed or a withdrawal date is posted, the agency does not participate in the ICI benefit program.

9. Life Insurance tab - If an agency participates in the Group Life Insurance Program, this tab will display the effective date(s) for each level of coverage the agency offers to their employees.
   a. If no effective date, the agency does not offer that level of coverage. Additional information includes;
      i. Identifying which life insurance coverage level(s) the employer pays a percentage of the employee premium and
      ii. The life reduction percentage. If no information is displayed or there is a withdrawal date posted, the agency does not participate in the ICI Program.





C-2 Add Coverage

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

Employer Completes Coding instructions are in the *Employer Health Insurance Administration Manual.*

EIN	Employer name	Payroll representative email
0000-194	Central Payroll	Jane.Doe@centralpayroll.wi.gov

Group number	Employee type	Coverage type	Health plan name/suffix
83900		☐ Individual ☒ Family	Dean

Business Unit *(if applicable)*	Employment status of applicant	Employee deductions
	☒ Full time ☐ Part time ☐ LTE	☒ Pre-tax ☐ Post-tax

Hire date or date WRS-eligible employment or graduate appointment began	Employer received date	Event date	Prospective coverage date
2/4/19	2/27/2019		5/1/2019

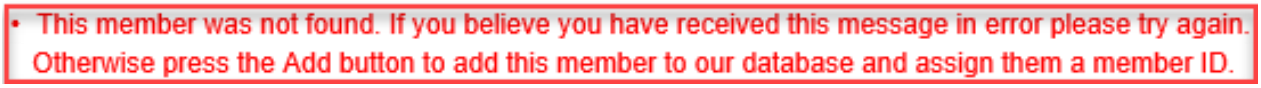
Are you a WRS-participating employer? ☒ Yes ☐ No
Previous service check completed? ☒ Yes ☐ No
Source of previous service check? ☒ Online Network for Employers (ONE) ☐ ETF
Did employee participate in the WRS prior to being hired by you? ☐ Yes ☒ No

Payroll representative signature	Phone number	Date signed
Jane Doe	(608)555-1234	3/1/2019

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

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

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

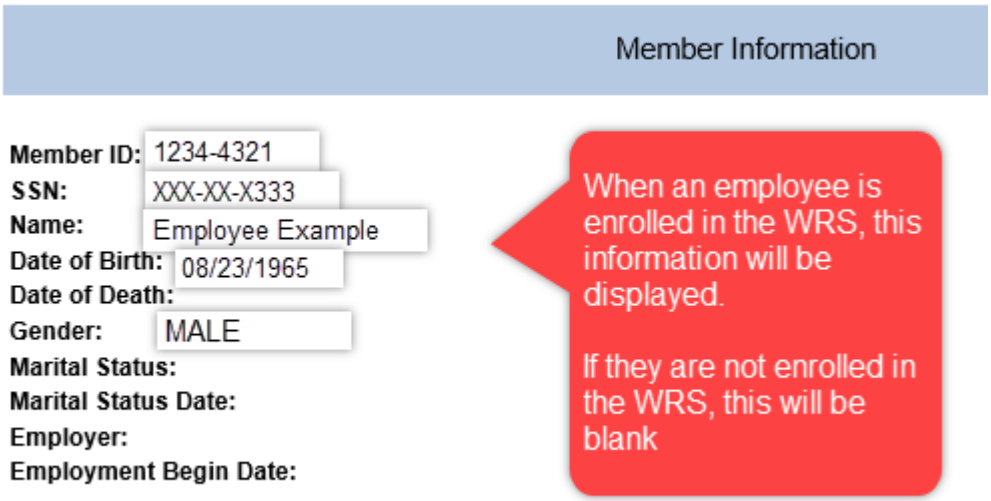


   At this point, the employer can either:

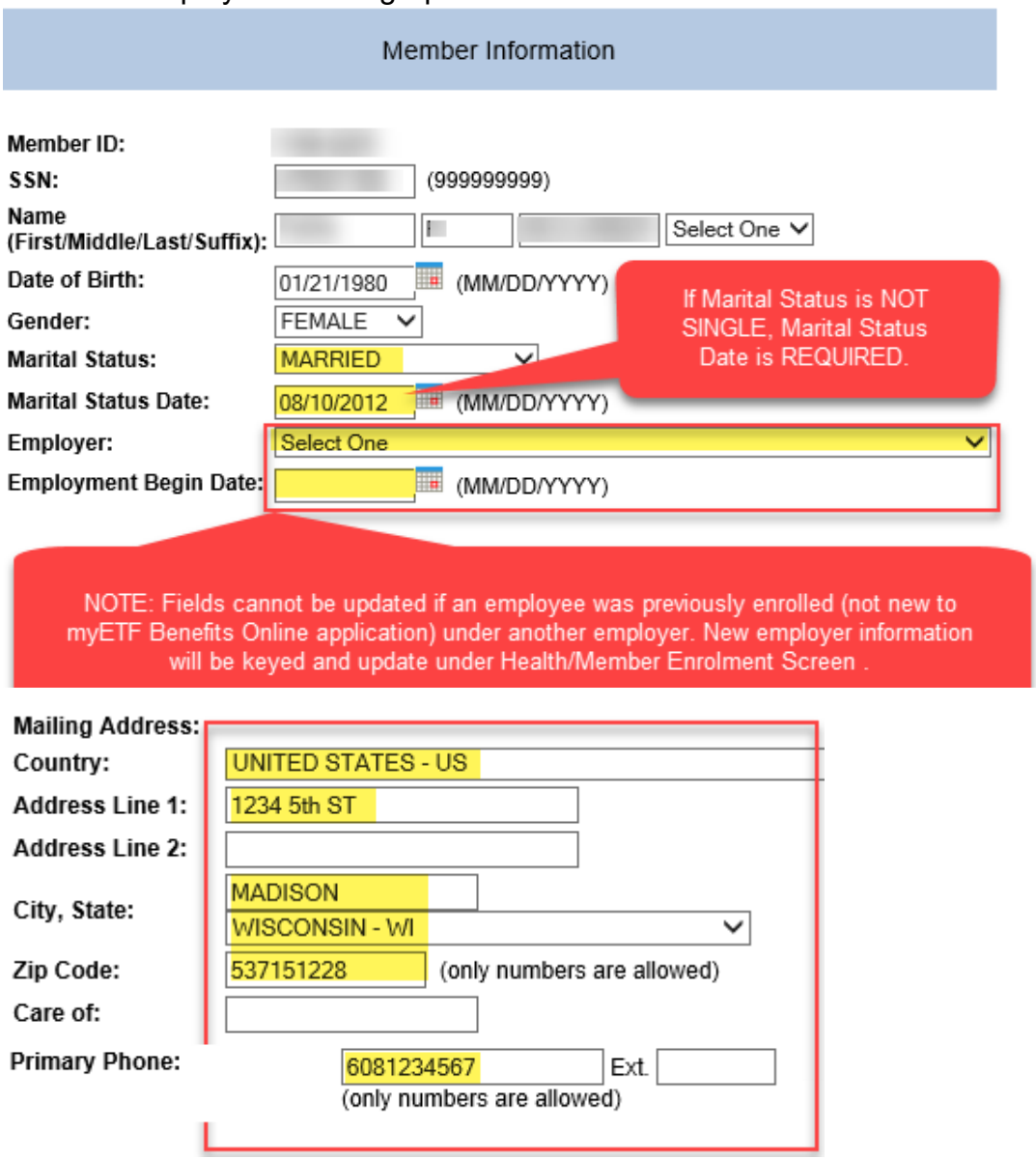
   a. Enroll the employee in the WRS via ETF Web Applications for Employers at etf.wi.gov/employers/wisconsin-retirement-system to create an ETF Member ID, or
   b. Create an ETF Member ID in myETF Benefits

4. If no demographic information appears, click the Add button.

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

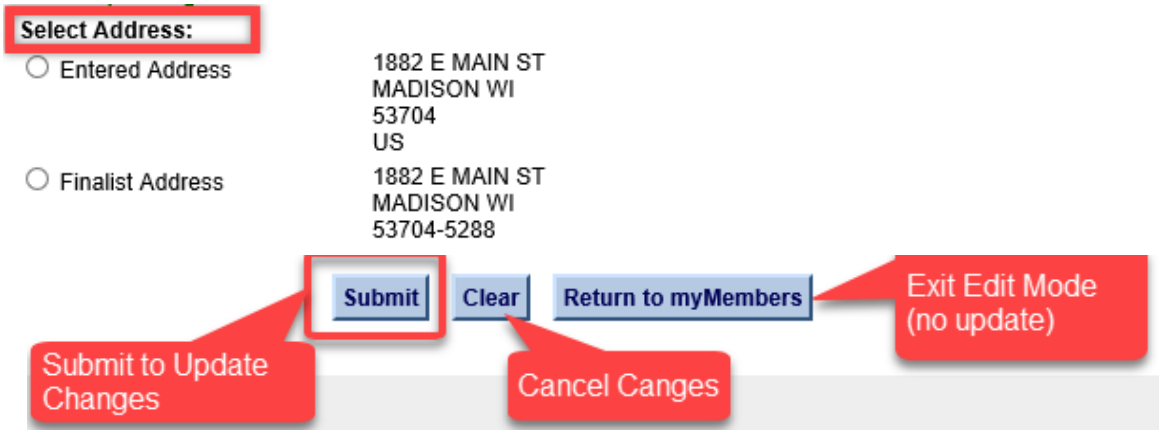


6. Enter the employee's demographic information.

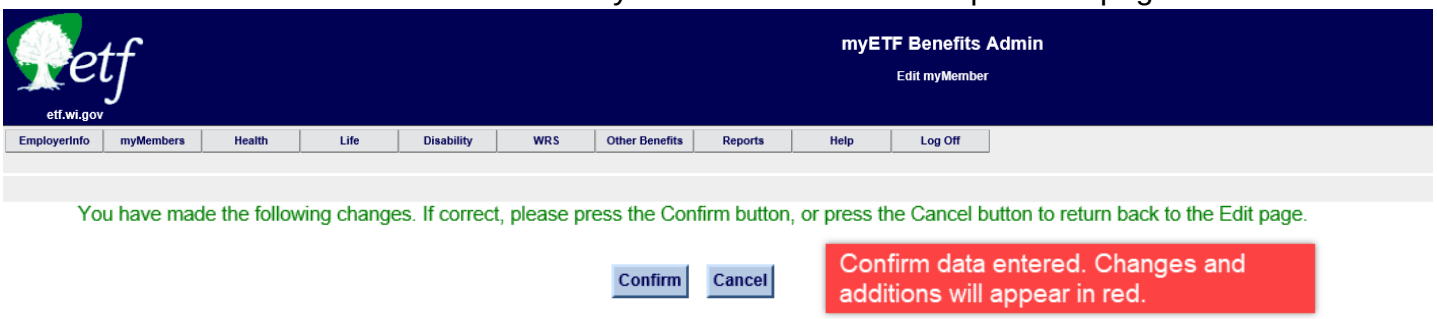


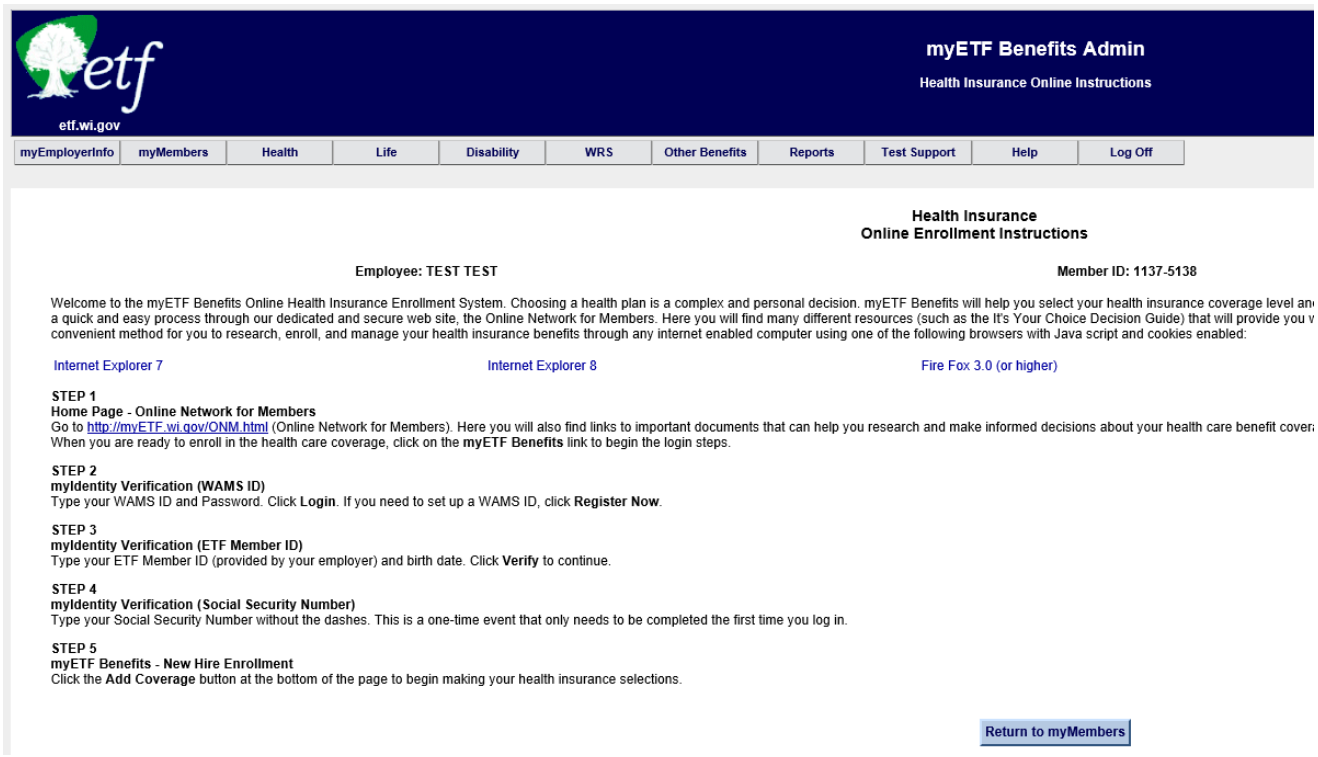
After entering the required information, click Submit.

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



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

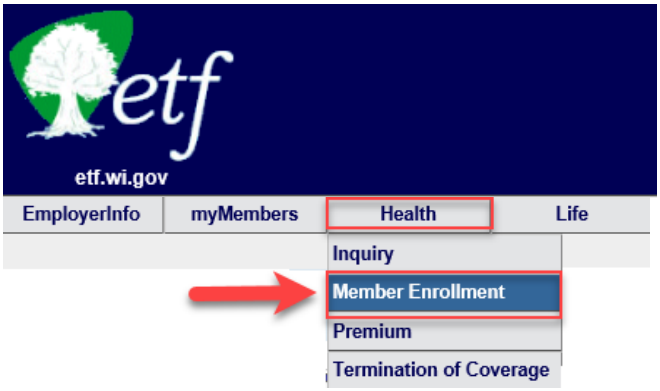




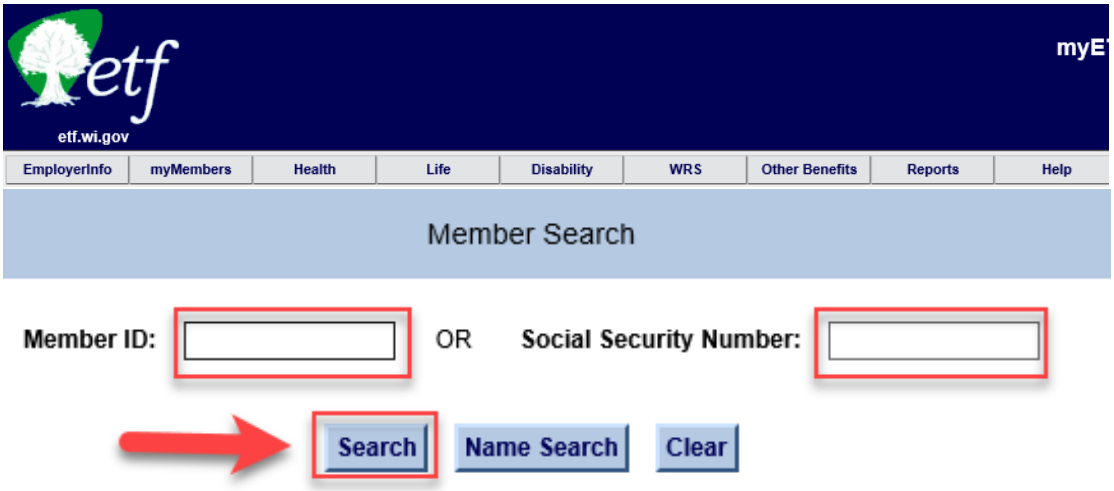
Note: This is the confirmation page you see after adding a member into myETF Benefits who has never been covered by the program with any employer. This confirmation screen provides you the ETF Member ID for this employee, which they will need if they are enrolling through member self-service. The confirmation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

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

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

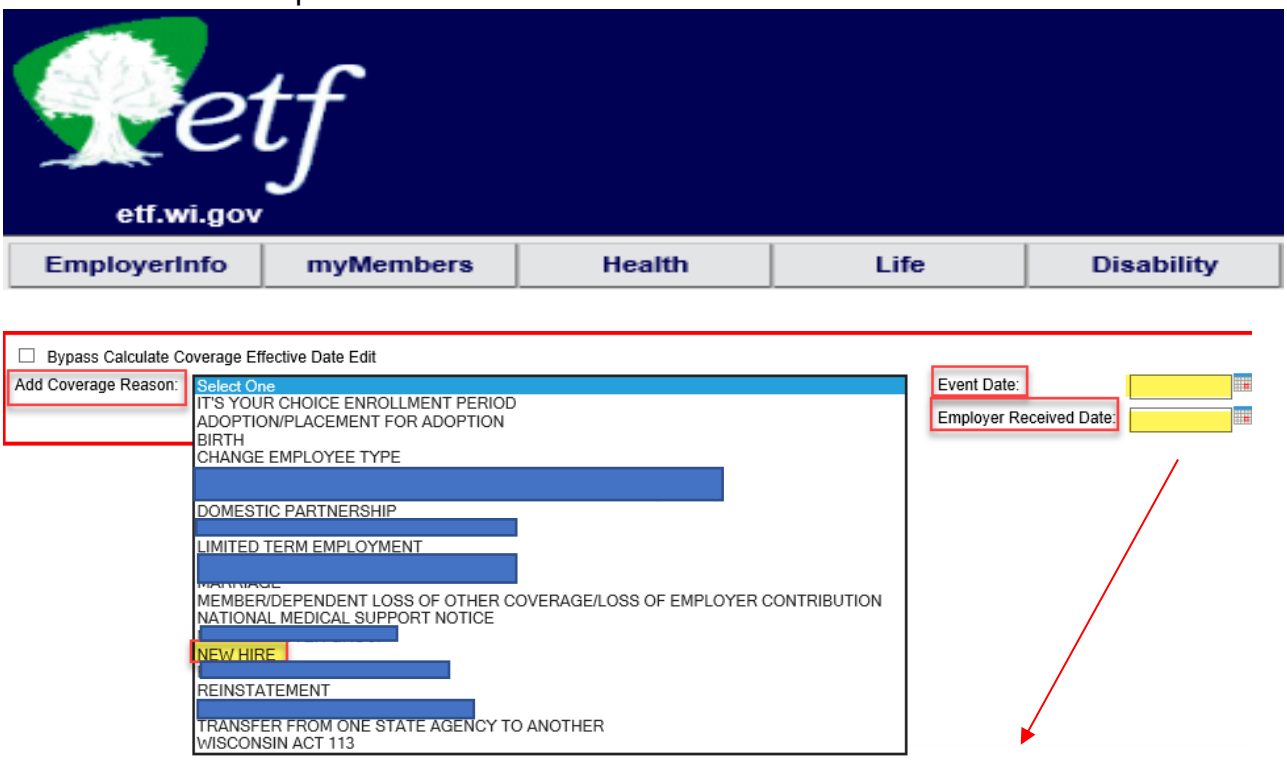


10. Enter the member ETF Member ID or SSN and click Search.

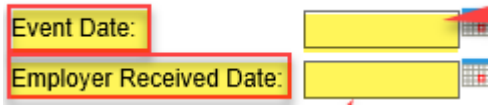


11. The employee's Member ID, SSN, and name will appear below the Member Search bar. Click the Add Coverage button to begin the health enrollment.

12. New Enrollment - Start at the top of the screen. Select the appropriate Add Coverage Reason from the dropdown list.

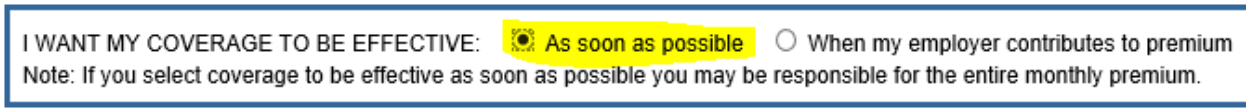


13. Enter the Event Date (hire date or date of life event) and the Employer Received Date. The Event Date and the Employer Received Date determine the coverage effective date.

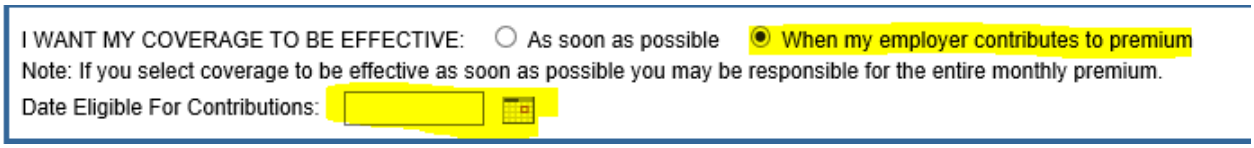


Note: Employer Received Date must be within 30 days of Event Date or the system will not process the enrollment.

a. When the add coverage reason is NEW HIRE, the employee selects “as soon as possible” or “when my employer contributes to premium.” This determines when coverage is effective.
   - If the option “As soon as possible” is selected, an effective date is automatically generated for the first of month on or after the date of hire.

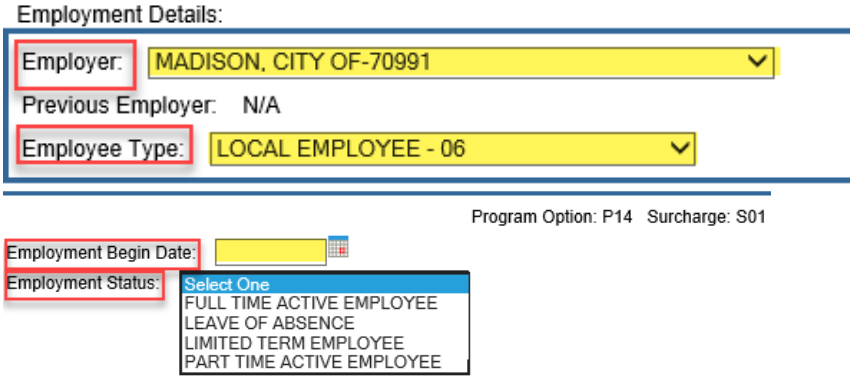


   - If “When my employer contributes to premium” is selected, an employer can enter when coverage is effective. The employer will key the coverage begin date.

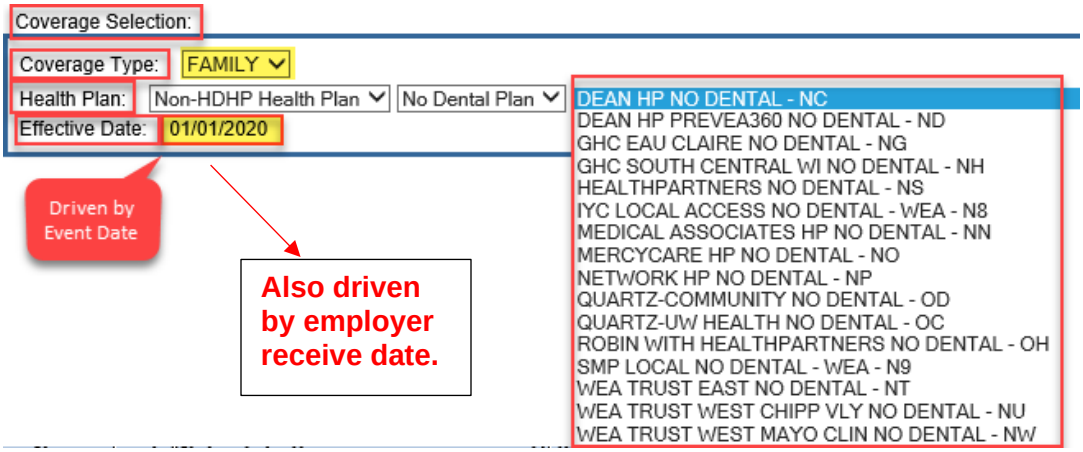


b. If NEW HIRE is not the Add Coverage reason, the system automatically generates a coverage effective date based on the event date and employer receive date.

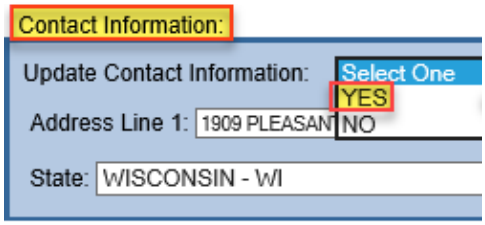
14. Complete the Employment Details section. If it does not default to the correct employer, make the selection from the Employer dropdown.



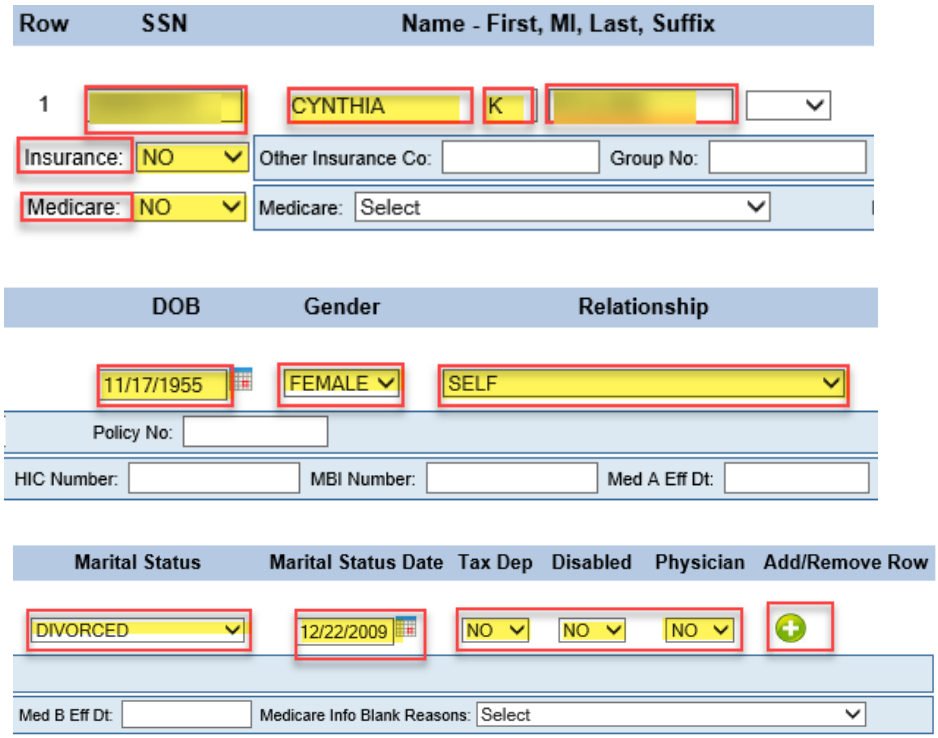
15. Compete Coverage Selection section. If the effective date the system provides is not what the employer expected, the employer may need to call ETF to discuss.



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



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

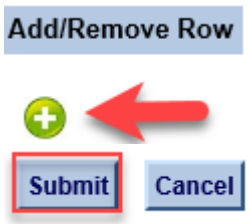


a. Complete the Insurance section for the dependent being added:
   - Select No if there is no other health insurance coverage listed on the application for the member.
   - Select Yes if there is other health insurance coverage listed on the application for the dependent. Enter any information provided about the other insurance in the appropriate fields, which open after Yes is selected.

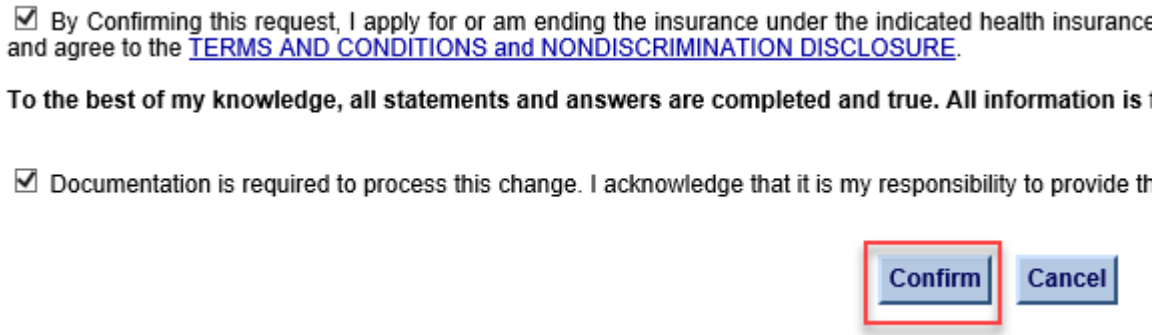
b. Complete the Medicare section for the dependent being added.
   - Select No if there is no Medicare coverage for the dependent.
   - Select Yes if there is Medicare coverage for the dependent. Complete the required Medicare information for the dependent in the appropriate fields, which open after Yes is selected.

c. Complete the “Physician” section for the dependent being added
   - Select No if no Physician is listed on the application. Physician section can be left blank.
   - Select Yes if Physician is listed on the application and complete the fields.

18. To add additional member(s) to the family contract, scroll to the right and click on the green (+) button. Click Submit when all dependents listed on the application have been entered.

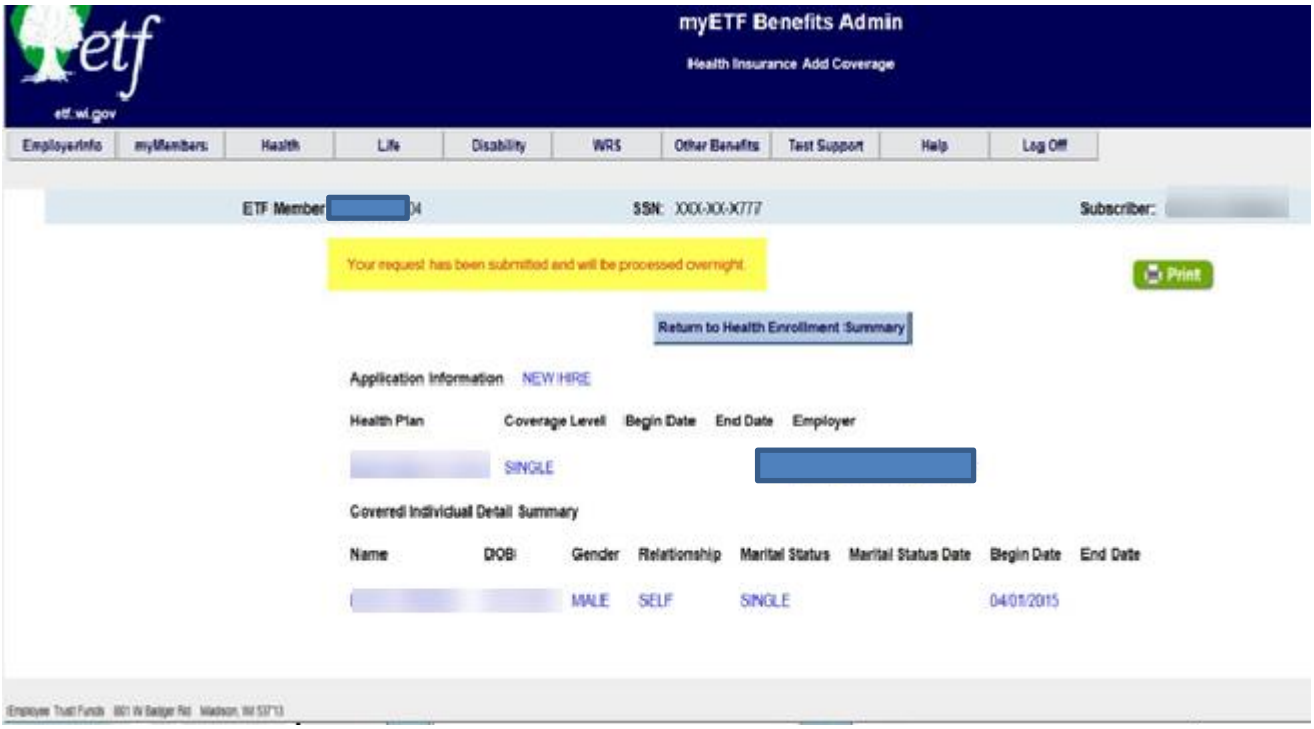


19. Verify the information entered is correct, check the box(es) and click Confirm.



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

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



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

C-3 Add Dependent

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

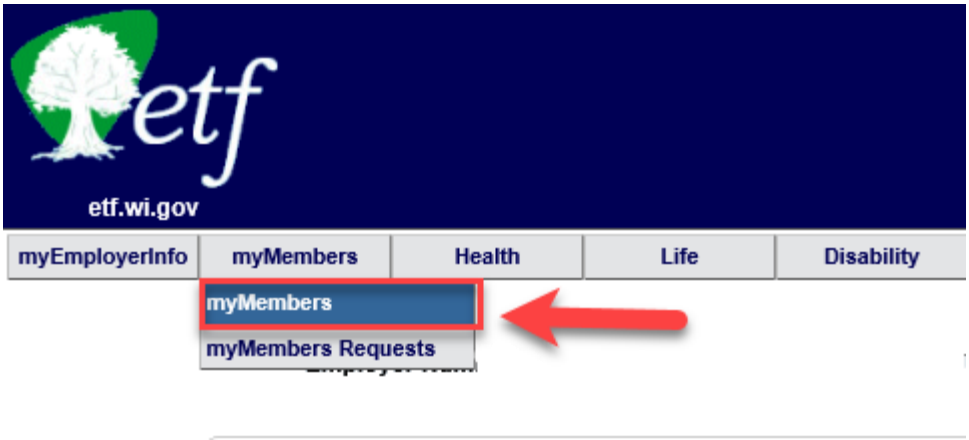
Employer Completes Coding instructions are in the *Employer Health Insurance Administration Manual.*

EIN: 0000-199	Employer name: Central Payroll		Payroll representative email: Jane.Doe@centralpayroll.wi.gov
Group number: 83900	Employee type: →	Coverage type: ☐ Individual ☒ Family	Health plan name/suffix: Dean
Business Unit *(if applicable)*	Employment status of applicant: ☒ Full time ☐ Part time ☐ LTE		Employee deductions: ☒ Pre-tax ☐ Post-tax
Hire date or date WRS-eligible employment or graduate appointment began: 2/4/19	Employer received date: 2/27/2019	Event date: →	Prospective coverage date: 5/1/2019

Are you a WRS-participating employer? ☒ Yes ☐ No
Previous service check completed? ☒ Yes ☐ No
Source of previous service check? ☒ Online Network for Employers (ONE) ☐ ETF
Did employee participate in the WRS prior to being hired by you? ☐ Yes ☒ No

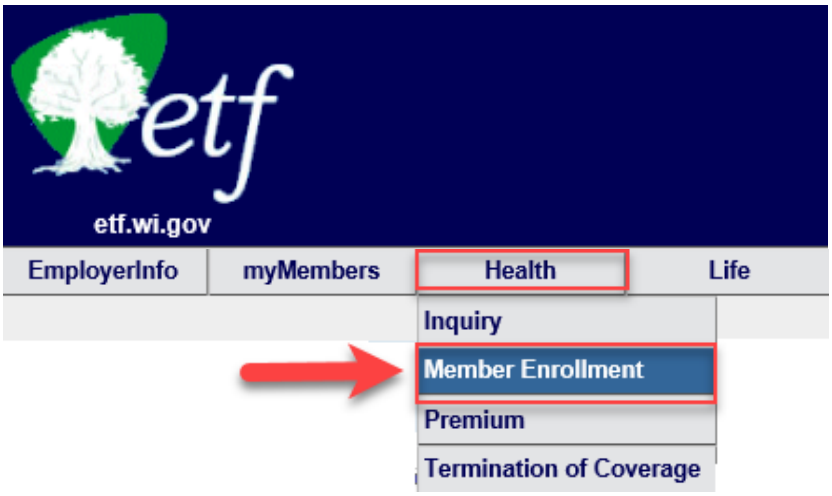
Payroll representative signature: Jane Doe	Phone number: (608)555-1234	Date signed: 3/1/2019

1. Verify the Member's demographic information is correct. Under the myMembers tab, select myMembers.

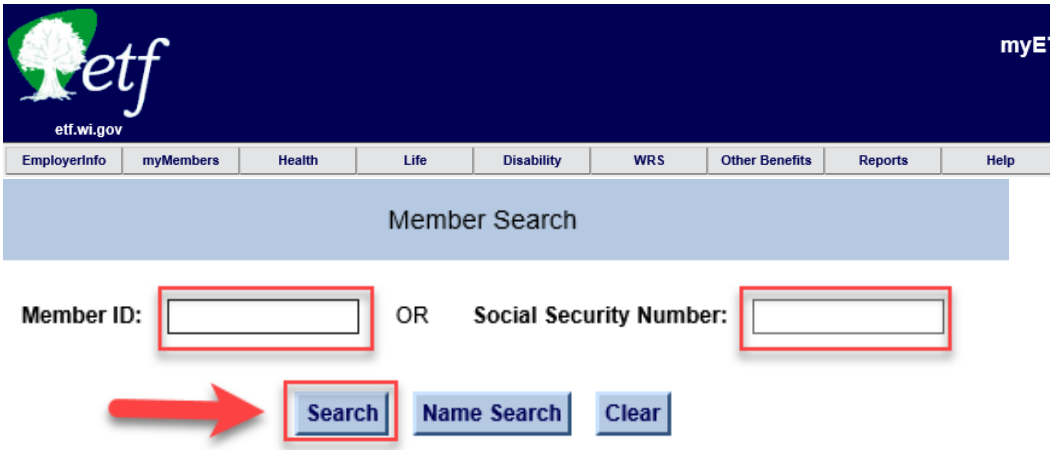


   a. Click the Edit button on the bottom of the screen to update existing information.
   b. When an address is updated, the system will request USPS verification of the address. Always select the Finalist Address.
   c. Once edits are complete, click Submit.
   d. Review the data (all changes and additions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

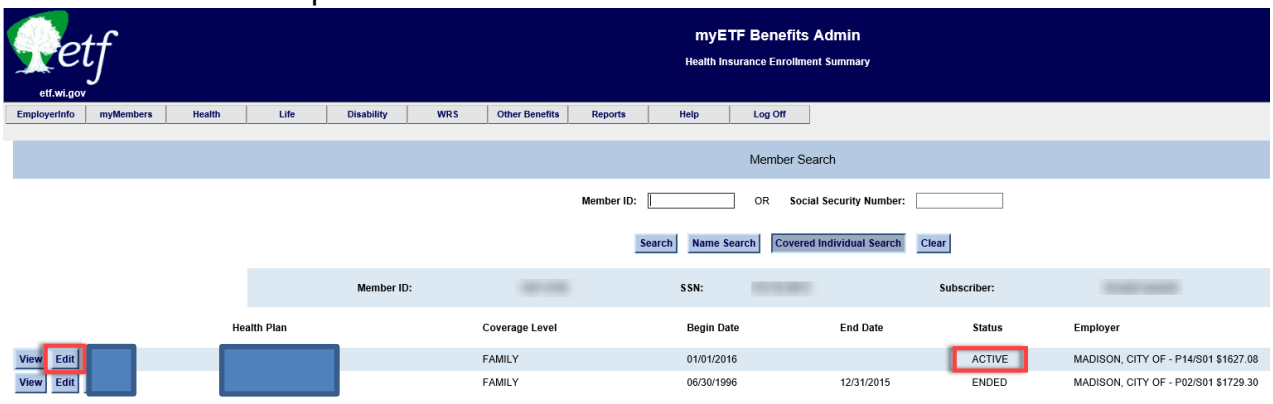
2. **Enrollment Screen:** To enroll a dependent, select Member Enrollment from the dropdown list under the Health tab.



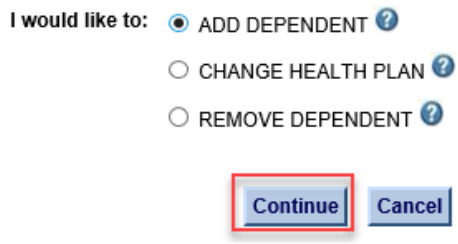
3. Enter the member ETF Member ID or SSN and click Search.



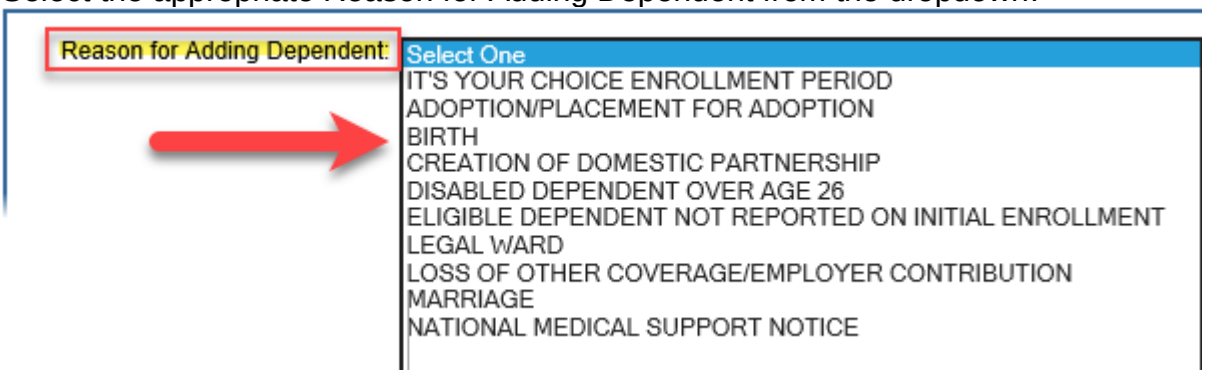
4. When an employee's record returns, click Edit on the line of the Active contract to begin the health enrollment process.



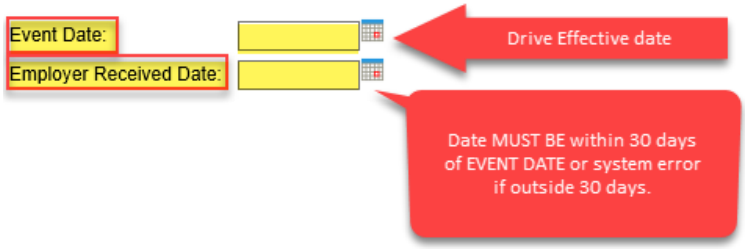
5. Check Add Dependent and click Continue.



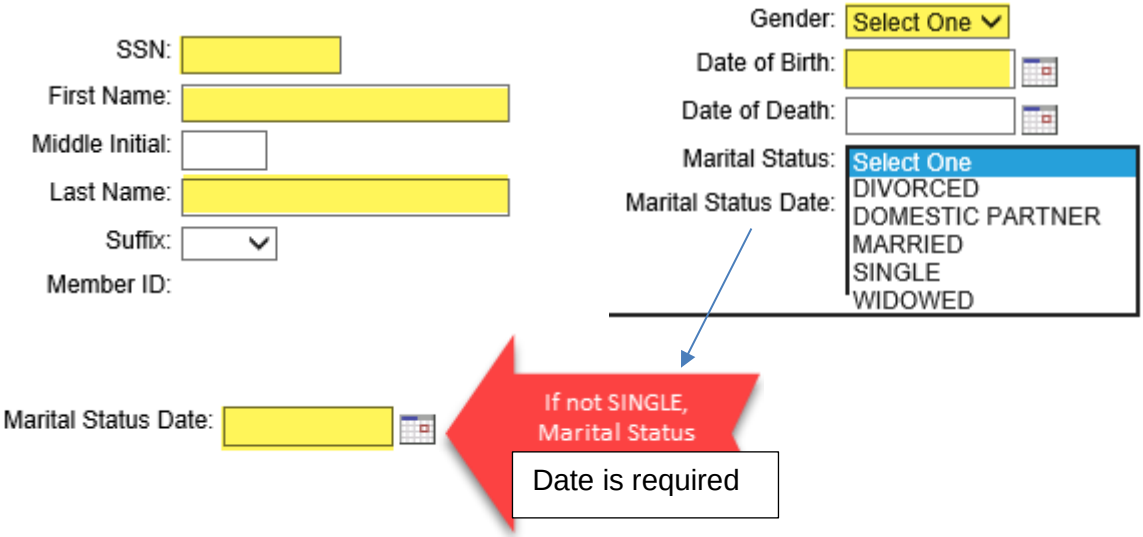
6. Select the appropriate Reason for Adding Dependent from the dropdown.



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



8. Scroll down to the Identification section and enter the information from the health application.



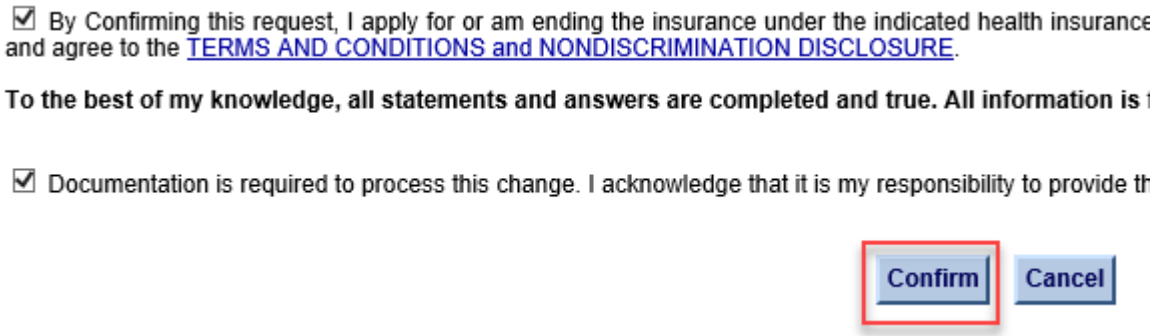
9. Select Yes or No in the Other Health Insurance section.
   - Select No if there is no other health insurance coverage listed on the application for the dependent .
   - Select Yes if there is other health insurance coverage listed on the application for the dependent. Enter any information provided about the other insurance in the appropriate fields which open after Yes is selected.

10. Select Yes or No in the Medicare section for the dependent being added.
    - Select No if there is no Medicare coverage for the member.
    - Select Yes if there is Medicare coverage for the member. Complete the required Medicare information for the dependent in the appropriate fields, which open after Yes is selected.

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

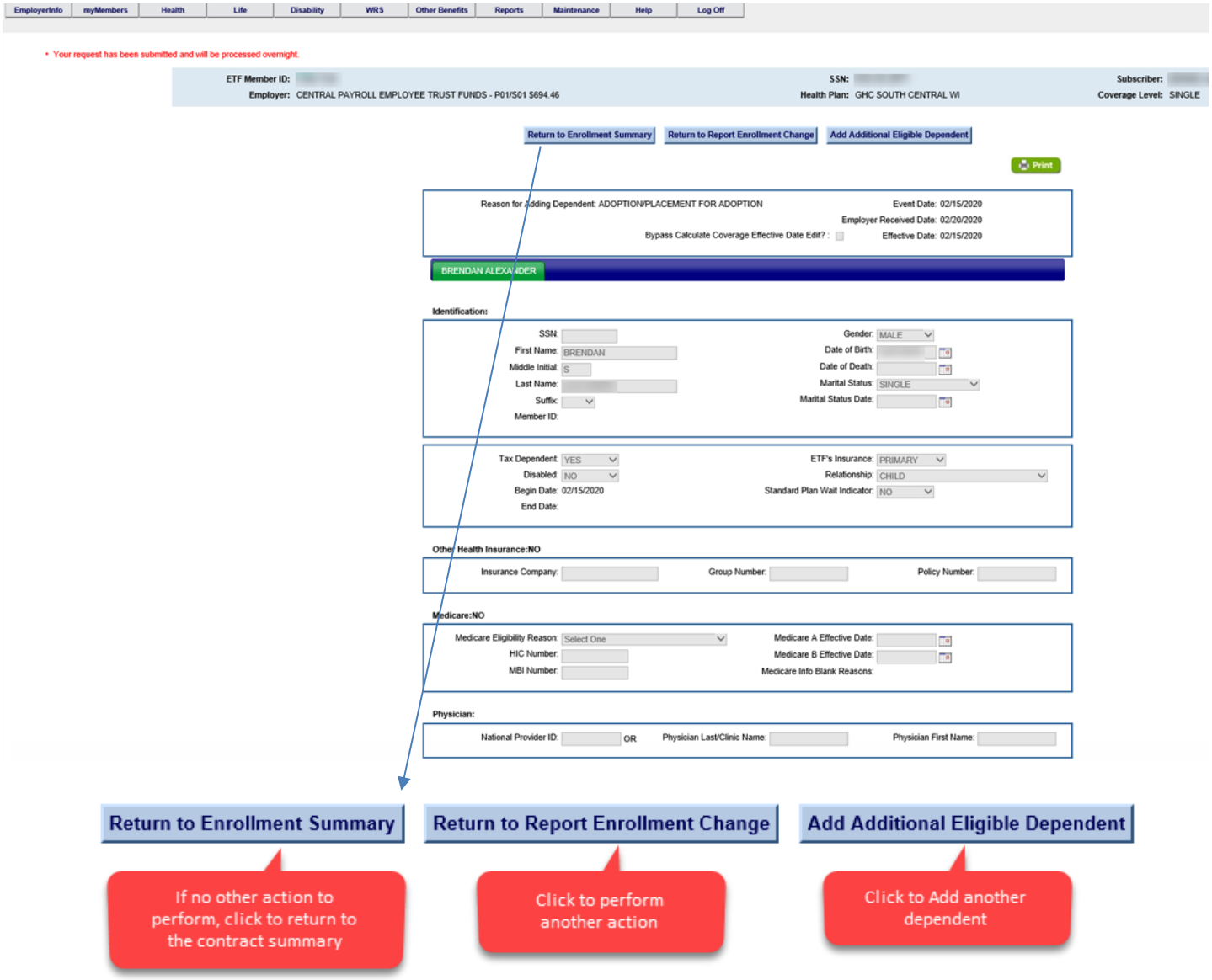
12. Click Submit.

13. Verify data entered, check the box(es) and click Confirm.



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

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



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

C-4 Remove Dependent

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

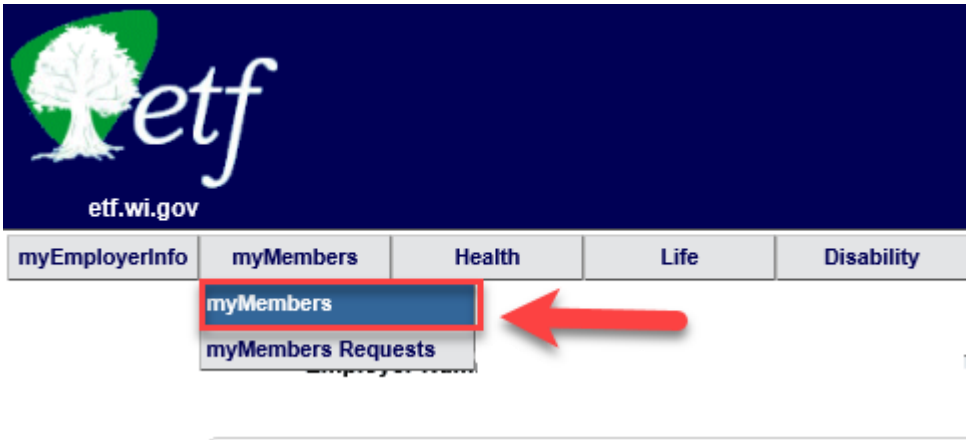
Employer Completes Coding instructions are in the *Employer Health Insurance Administration Manual.*

EIN: 0000-199	Employer name: Central Payroll		Payroll representative email: Jane.Doe@centralpayroll.wi.gov
Group number: 83900	Employee type: →	Coverage type: ☐ Individual ☒ Family	Health plan name/suffix: Dean
Business Unit *(if applicable)*	Employment status of applicant: ☒ Full time ☐ Part time ☐ LTE		Employee deductions: ☒ Pre-tax ☐ Post-tax
Hire date or date WRS-eligible employment or graduate appointment began: 2/4/19	Employer received date: 2/27/2019	Event date: →	Prospective coverage date: 5/1/2019

Are you a WRS-participating employer? ☒ Yes ☐ No
Previous service check completed? ☒ Yes ☐ No
Source of previous service check? ☒ Online Network for Employers (ONE) ☐ ETF
Did employee participate in the WRS prior to being hired by you? ☐ Yes ☒ No

Payroll representative signature: Jane Doe	Phone number: (608) 555-1234	Date signed: 3/1/2019

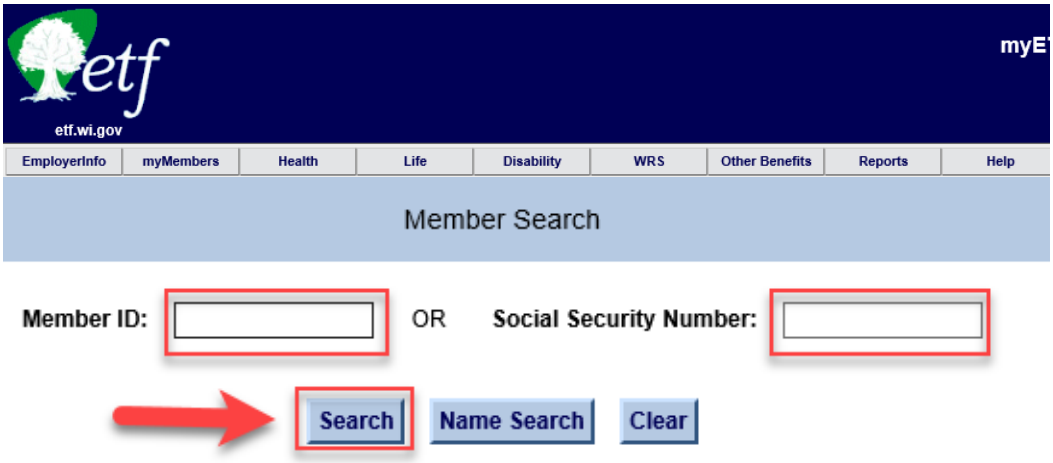
1. Verify the member's demographic information is correct. Under the myMembers tab, select myMembers.



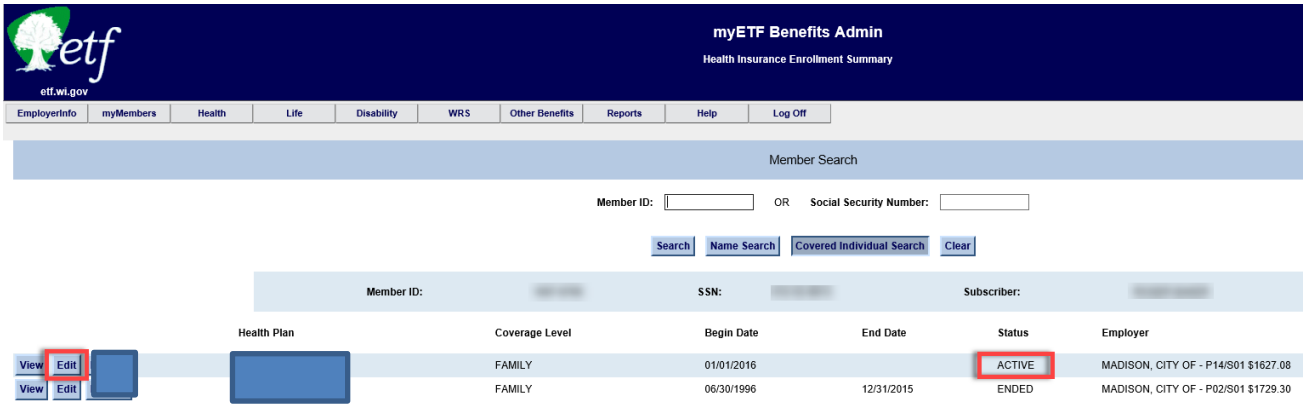
   a. Click the Edit button on the bottom of the screen to update existing information.
   b. When an address is updated, the system will request USPS verification of the address. Always use the Finalist address.
   c. Once edits are complete, click Submit.
   d. Review the data (all changes and additions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

2. To remove a dependent from an existing contract, go to the Health tab and select Member Enrollment from the dropdown.

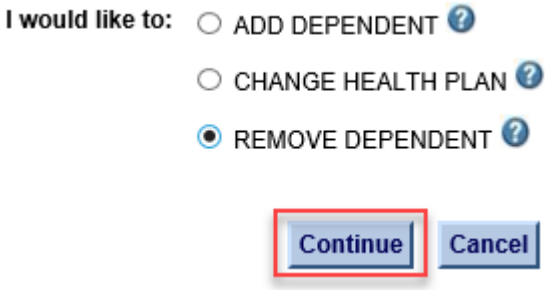
3. Enter the ETF Member ID or SSN and click Search.



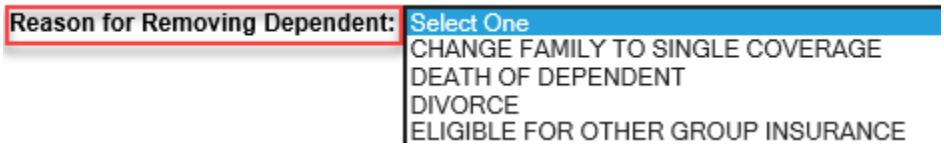
4. When the employee's record returns, click Edit on the line of the Active contract.



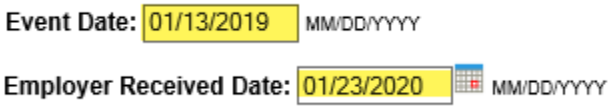
5. On the next screen, select Remove Dependent and Continue.



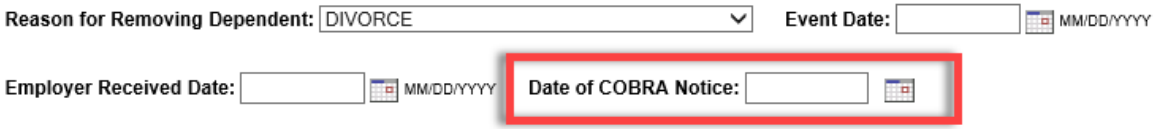
6. Select a Reason to remove the dependent and check the box next to the dependent to be removed. Click Submit.



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



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



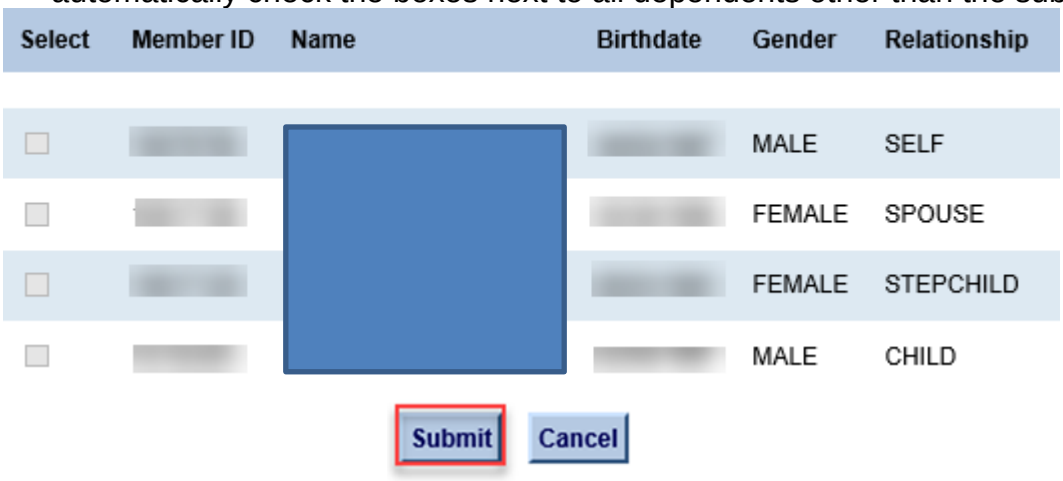
   a. When removing the spouse and stepchildren but maintaining family coverage, and the notification date is not within the same month as the divorce (event), the coverage will end at the end of the month of the COBRA (ET-2311) notification date or the date of the divorce, whichever is later.

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

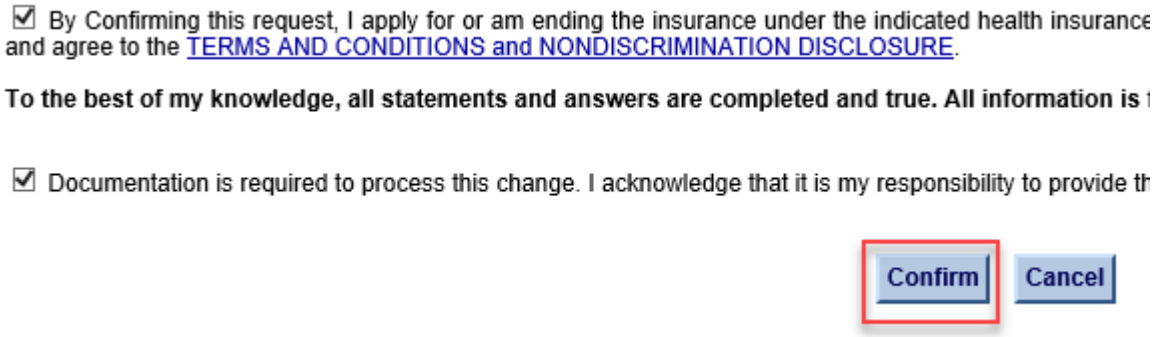
   b. When changing the coverage level from family to single due to divorce, the reason selected in myETF Benefits will be Change from Family to Single Coverage – not Divorce). Coverage will end at the end of the month in which the divorce (event) occurred or the COBRA notification date, whichever is later.

      Example: The divorce occurs 1/21/2020, ET-2301 received by employer on 1/27/2020, and the ET-2311 notification date (the date the ET-2311 was sent to the former spouse and stepchildren) is 1/27/2020. The health contract will terminate on 1/31/2020. The spouse and stepchildren cannot be removed until the divorce is finalized. They are sent COBRA information and applications when they are removed from the plan.

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



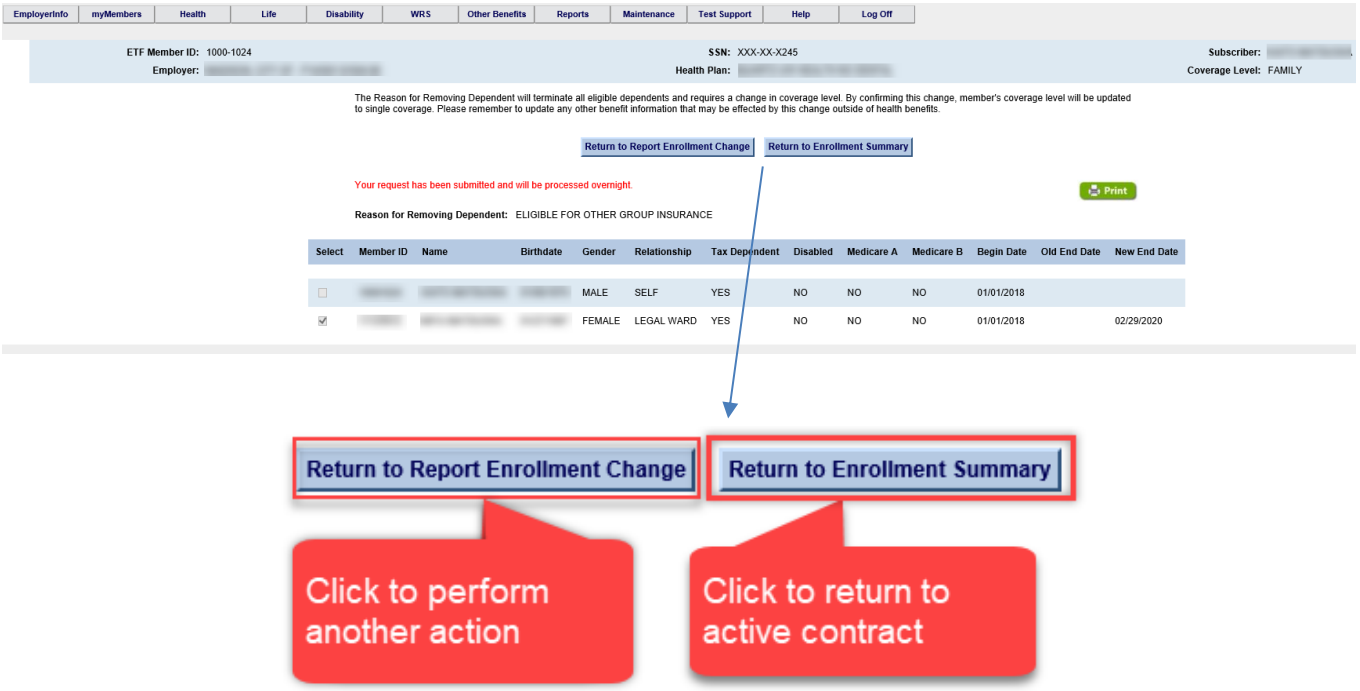
10. Verify the information is correct, check the box(es), and click confirm.



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

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

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



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

C-5 Change Health Plans

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

Employer Completes Coding instructions are in the *Employer Health Insurance Administration Manual*.

EIN: 0000-199	Employer name: Central Payroll	Payroll representative email: Jane.Doe@centralpayroll.wi.gov
Group number: 83900	Employee type: →	Coverage type: ☐ Individual ☒ Family
Health plan name/suffix: Dean		
Business Unit *(if applicable)*	Employment status of applicant: ☒ Full time ☐ Part time ☐ LTE	Employee deductions: ☒ Pre-tax ☐ Post-tax
Hire date or date WRS-eligible employment or graduate appointment began: 2/4/19	Employer received date: 2/27/2019	Event date: →
Prospective coverage date: 5/1/2019		

Are you a WRS-participating employer? ☒ Yes ☐ No
Previous service check completed? ☒ Yes ☐ No
Source of previous service check? ☒ Online Network for Employers (ONE) ☐ ETF
Did employee participate in the WRS prior to being hired by you? ☐ Yes ☒ No

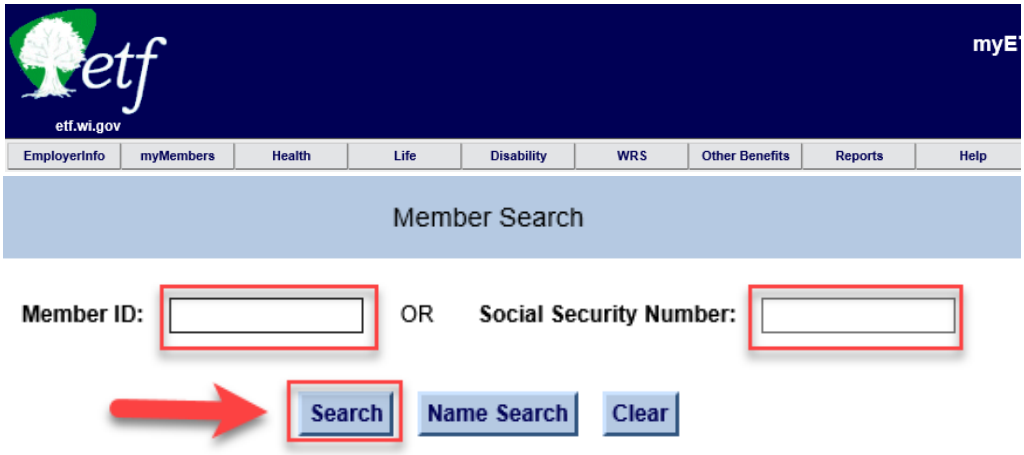
Payroll representative signature: Jane Doe	Phone number: (608)555-1234	Date signed: 3/1/2019

1. Verify the Member's demographic information is correct. Under the myMembers tab, select myMembers

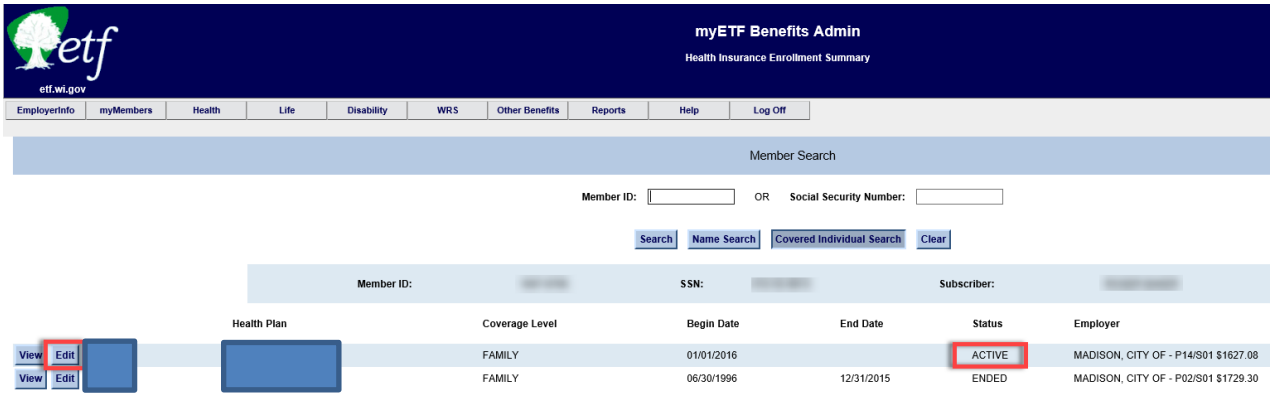
   a. Click the Edit button on the bottom of the screen to update existing information.
   b. When an address is updated, the system will request USPS verification of the address. Always select the Finalized address.
   c. Once edits are complete, click Submit.
   d. Review the data (all changes and additions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

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

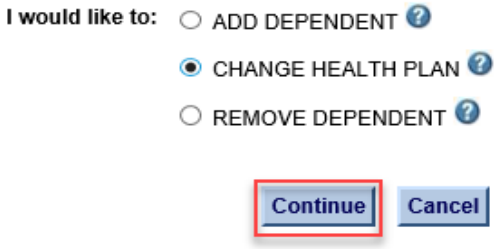
3. Enter the ETF Member ID or SSN and click Search.



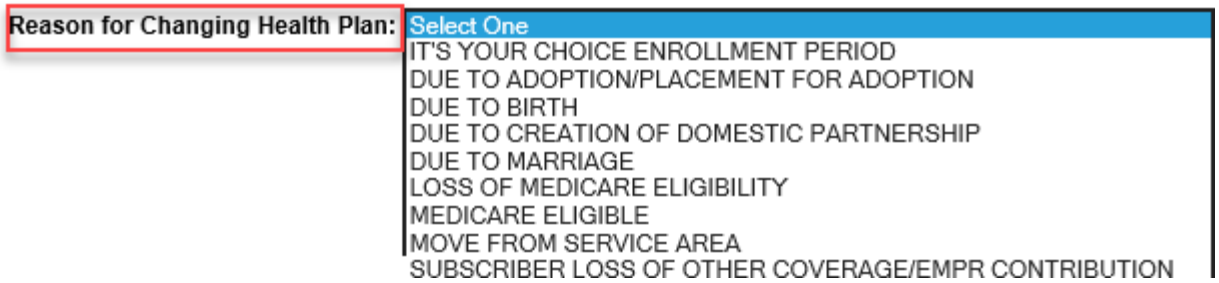
4. When the employee's record returns, click Edit on the line of the Active contract.



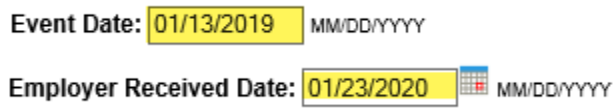
5. On the next screen, select Change Health Plan and Continue.



6. Select the appropriate Reason for Changing Health Plan from the dropdown list.

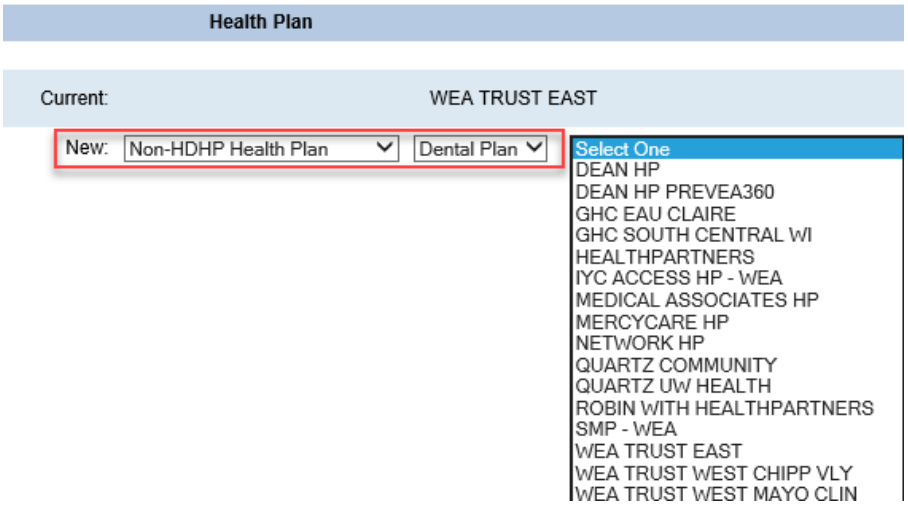


7. Complete the Event Date (date of qualifying life event) and Employer Received Date (date application was received by employer).

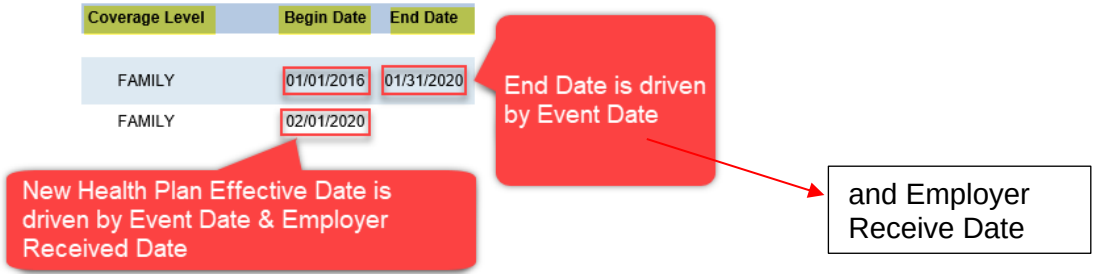


8. If reason is move from service area, select the New Residential County from the dropdown menu. (There is an Out of State/NA option.) Select a health plan from the dropdown list.

   Note: The End Date of the old health plan and the Begin Date for the new health plan automatically generate based on the Event Date and Employer Receive Date provided above.

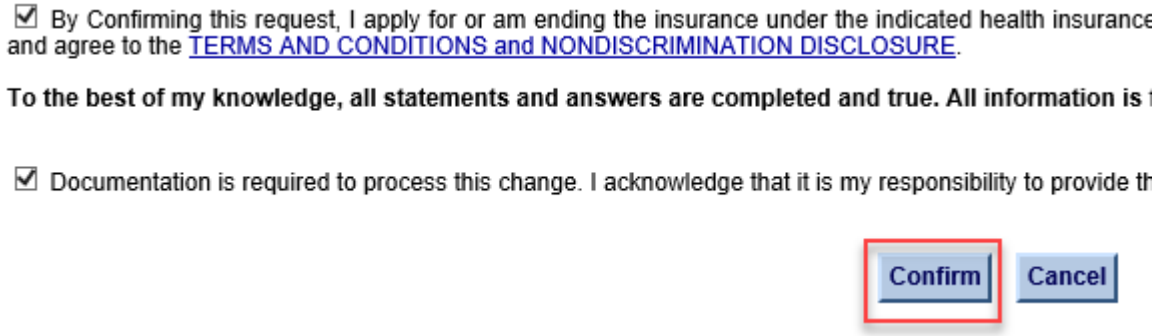


   Note: The End Date of the old health plan and the Begin Date for the new health plan automatically generate based on the Event Date provided above.



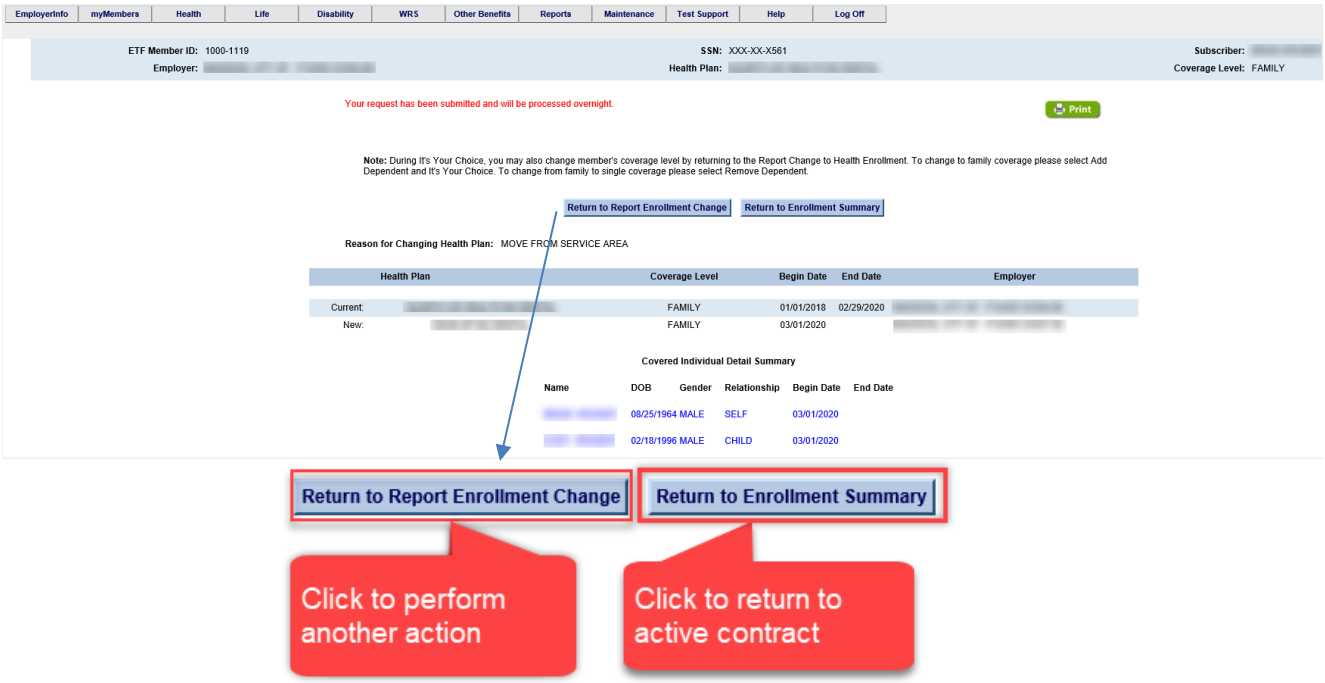
9. Verify the member and dependent information on the bottom of the screen is correct. Make updates, if needed.
10. Click the Submit button

11. Verify the information is correct and click Confirm.



Note: When a second check box displays, documentation is required to be submitted to ETF. The pending contract will go into "Waiting for ETF Approval" status until ETF receives a copy of the required documentation. Once the documentation has been received, reviewed, and approved by ETF, then the transaction will be approved and processed overnight. If ETF does not approve the documentation, the employer will be contacted with the reason why and what, if any, additional documentation is needed for processing. You must have the required documentation in hand, expect to receive it soon, or request it from the employee at that time and submit it to ETF for review and approval.

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



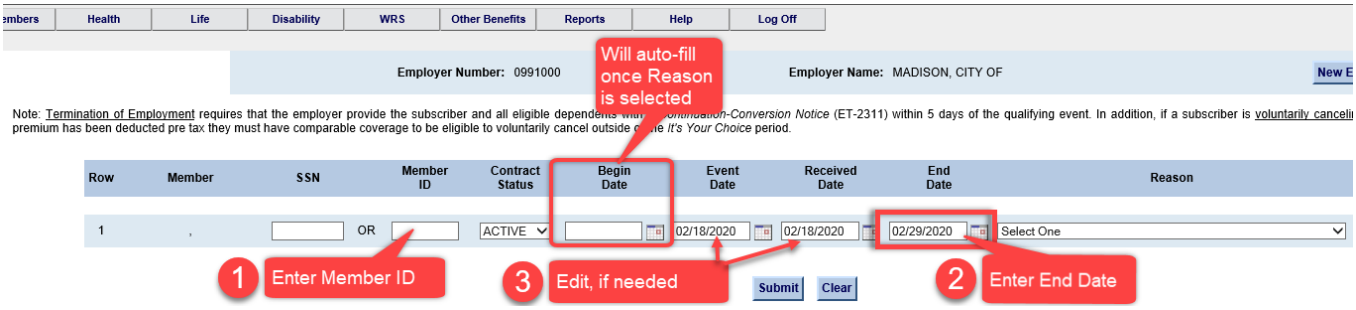
13. Click Return to Enrollment Summary to return to the active contract.
    a. To perform an additional change, click Return to Report Enrollment Change. An example of multiple changes: Add Dependent and Change Health plan, or Remove Dependent and Change Health Plan, must be keyed in myETF Benefits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

C-6 Termination of Coverage

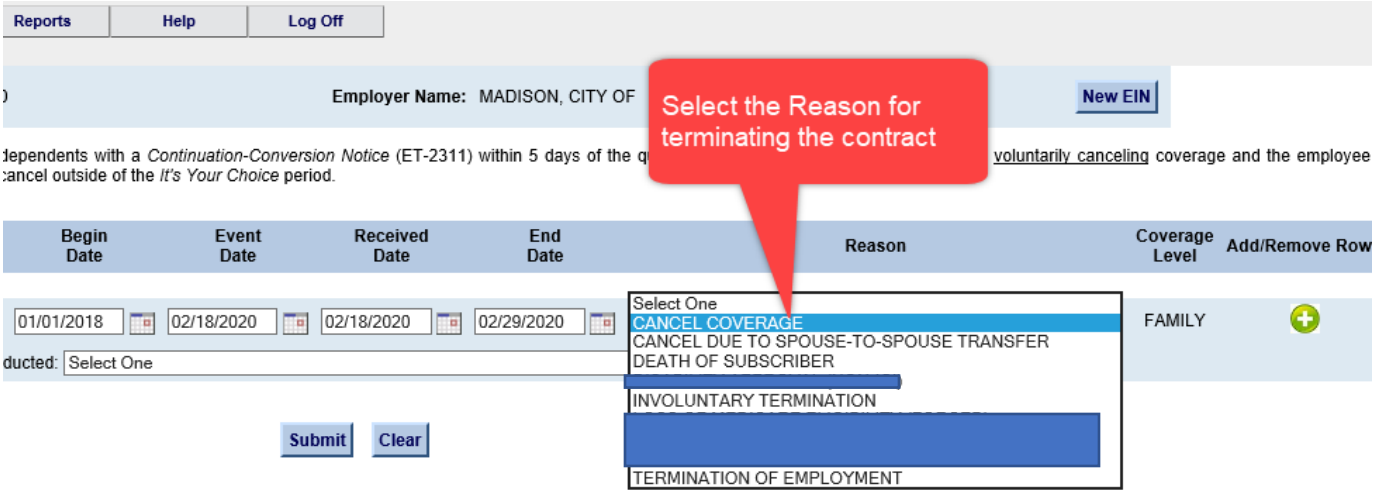
Termination of health insurance coverage can occur for multiple reasons. Some reasons require a *Health Insurance Application/Change Form* ((ET-2301) available on the ETF website and updated annually), such as a Cancel Coverage due to eligibility for other group insurance. The remaining reasons, Death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

1. Hover over the Health tab and select **Termination of Coverage fro**m the dropdown.

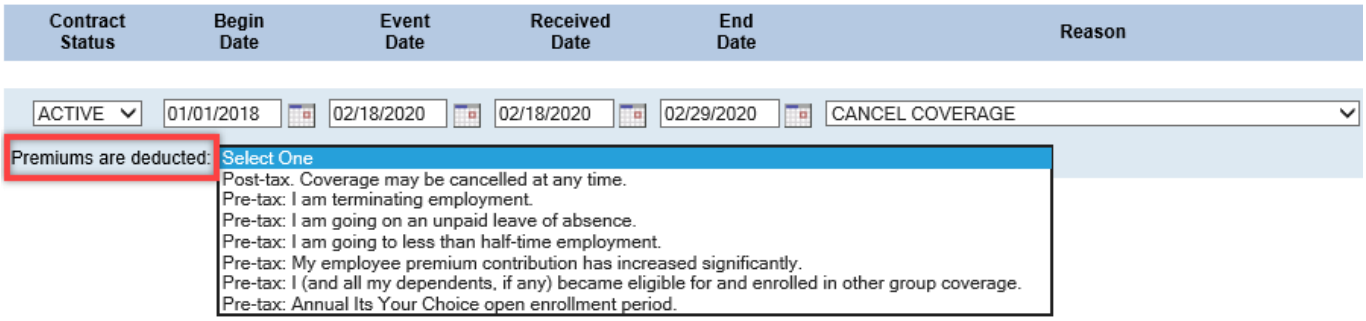
2. Enter the member's SSN or ETF Member ID and tab over to the End Date field to enter the health contract termination date. Next, edit the Event Date and Received Date, if necessary. Leave the Begin date field blank. The begin date will autofill once a Reason is selected.



3. Select the Reason for terminating the contract.



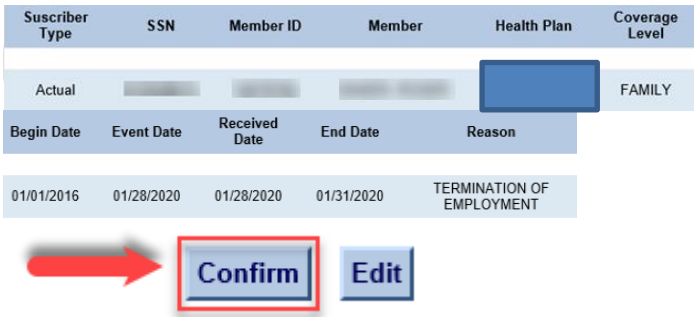
4. When the reasons of Cancel Coverage or Cancel Due to Spouse to Spouse Transfer is selected, a “Premiums are deducted” dropdown menu will appear. Select the appropriate option.



   a. When the other Reasons are selected (i.e. Termination of Employment), the “Premiums are deducted” menu does not generate

5. Click Submit.

6. Verify the information and the termination dates are correct. Click Confirm.

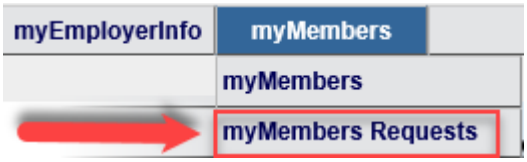


7. To view the termination date on the contract, go to Health and then select Member Enrollment. Search with the Member ID. Employers will see a message in red stating that the **cancel request in Approved Not Applied** status.

C-7 Pending Transactions

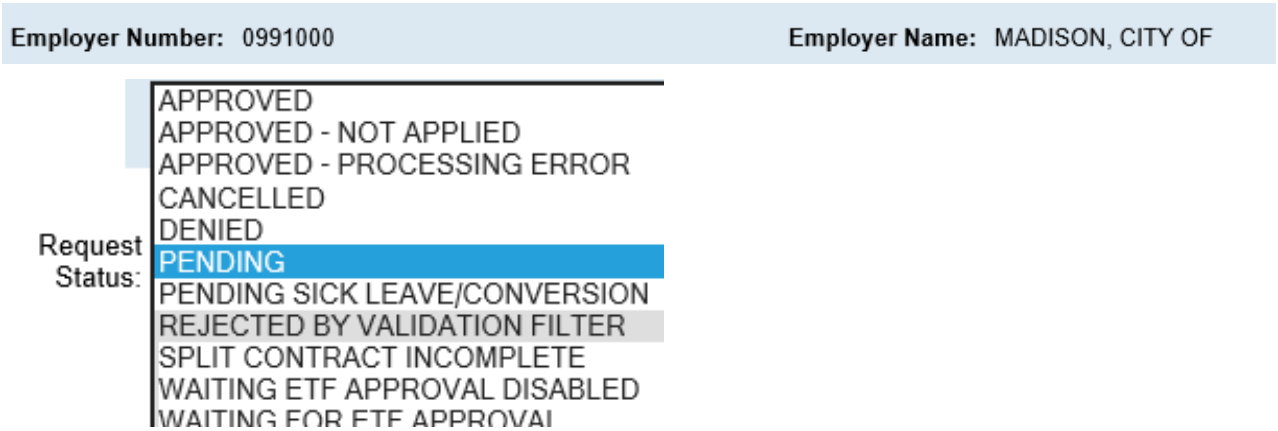
myMembers Requests is home to several processing queues. The changes made to health contracts in myETF Benefits will post to a processing queue when pending ETF approval. If they do not need approval, they will go to a queue to wait for the overnight batch process. There nine queues.

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



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

3. The Members Requests screen defaults to Request Status PENDING. Click down arrow to view all Request Status.



Request Status Defined:

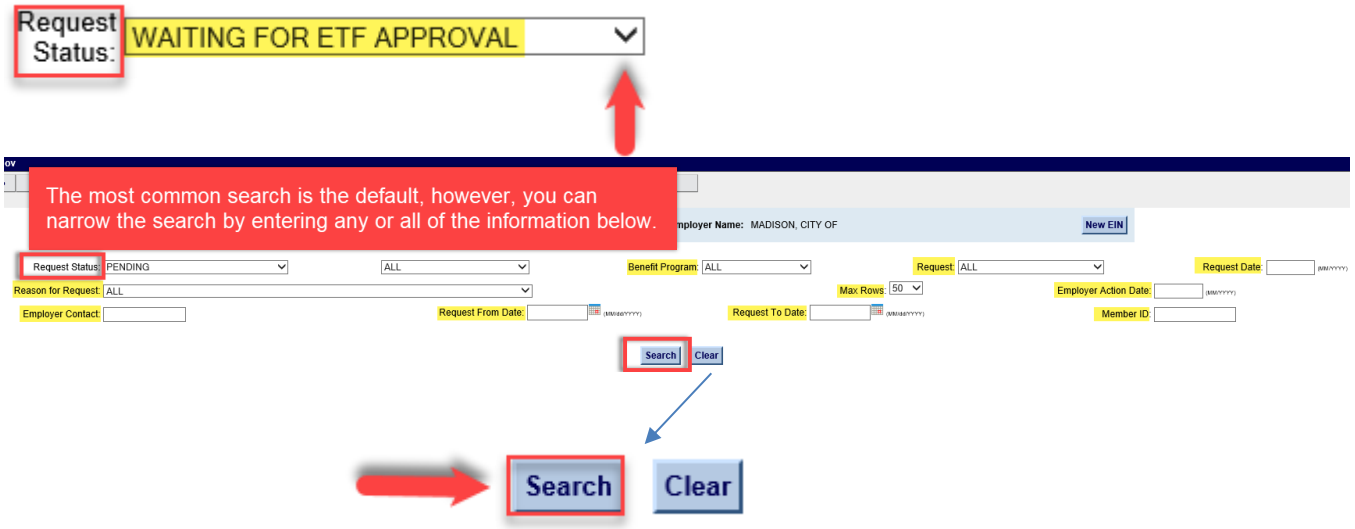
- **Approved:** Approved transactions that are processed and complete.
- **Approved – Not Applied:** Transactions entered same day but do not require ETF approval or ETF has approved and they are pending the nightly batch processing run.
- **Approved – Processing Error:** Transactions that failed the batch processing and may need to be reentered.
- **Canceled:** Transactions that either the employer or ETF canceled prior to the nightly batch run.

- **Denied:** Transactions that failed to meet eligibility requirements or the documentation supplied was insufficient or incorrect.
- **Pending:** If a member (employee) requested a log-in and password and went in and keyed their own changes, then the transaction would go into the “Pending” queue. The Pending queue is the only queue in which the employer can approve a transaction.
- **Waiting for ETF Approval – Disabled**: Transactions with a member adding an adult dependent older than age 26 who is disabled. The transaction will stay in this queue until the disability verification process has been completed and ETF has received a copy of the health plan disability approval letter from the health plan for the dependent.
- **Waiting for ETF Approval:** Transactions that require additional documentation prior to approval. If you had to check two boxes on the confirmation screen, it means that the transaction will go here until ETF receives and reviews the submitted documentation and thus approves the transaction.

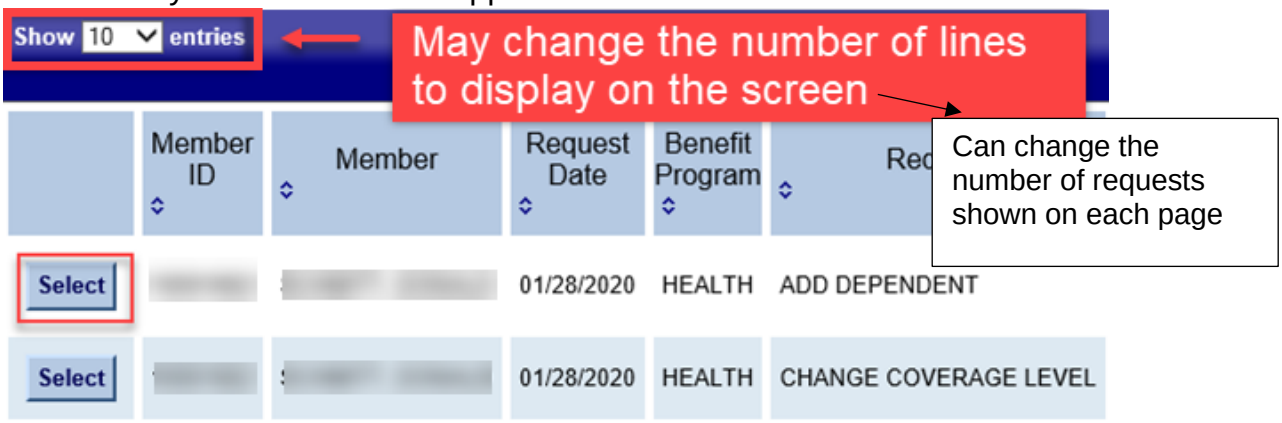
Transactions that are in *Pending*, *Approved-Not Applied*, *Waiting for ETF Approval – Disabled* and *Waiting for ETF Approval* can be edited, if necessary. When Edit is selected, you are returned to the entry screen and you will follow the same submission procedures as before.

Note: Editing a contract does not always work. Sometimes editing a waiting contract instead of canceling and starting over causes more issues with contract Begin and Effective dates.

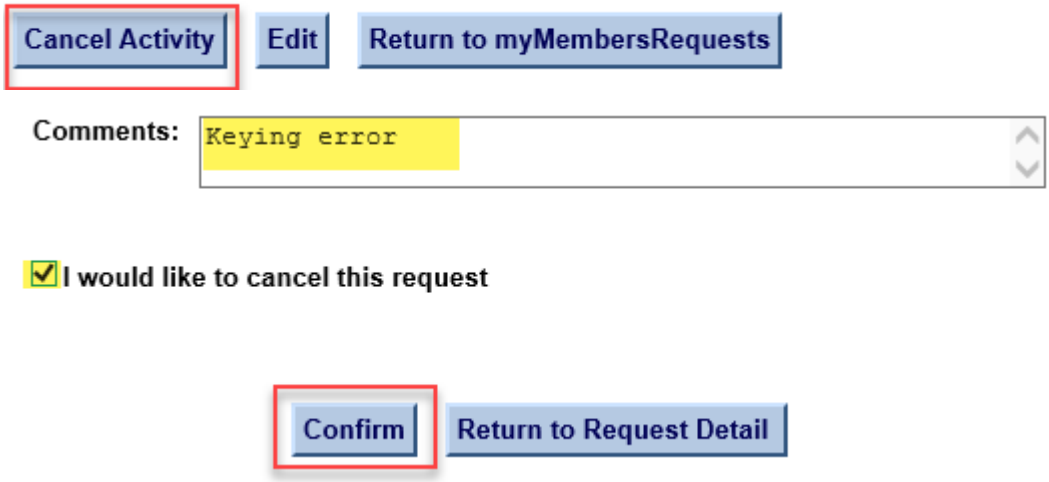
4. Select a Request Status (e.g Waiting for ETF Approval) from the dropdown list and click Search.



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



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



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

7. To Approve a selected transaction in the Pending queue:
   a. Review and verify the information entered is correct:
      i. Click the Approved button and it will automatically take you back out to the queue.
      ii. Click Return to myMembers Requests if you are not ready to approve.
      iii. All approved transactions will go to the Approved - Not Applied queue to be processed in the nightly batch run.
      iv. You can go in the following day to verify the transaction processed correctly by reviewing the employee's information on the Member Enrollment screen.

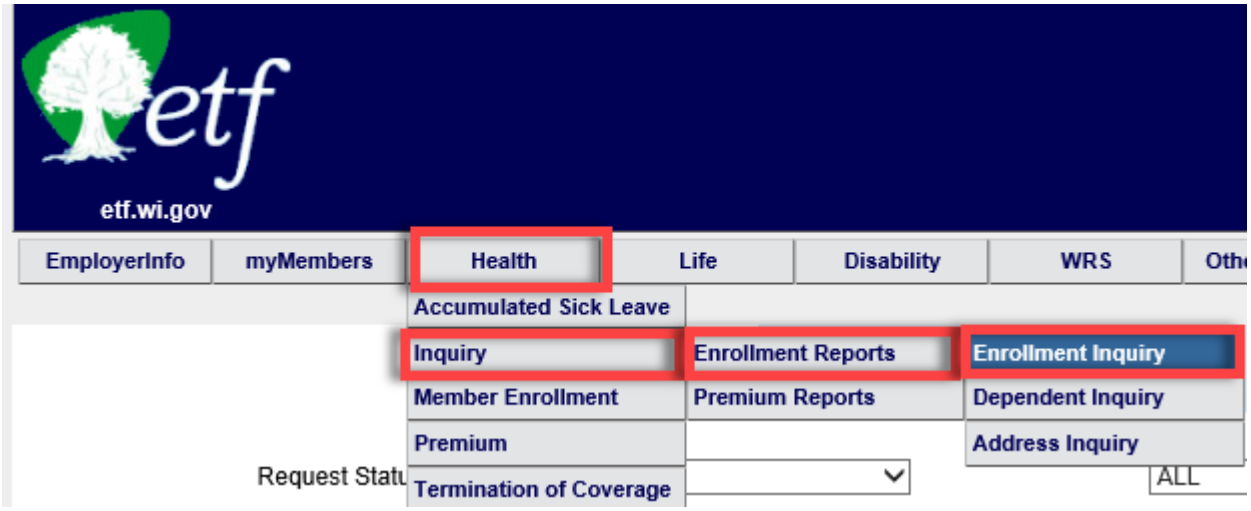
8. To Edit a selected transaction in the Pending queue:
   - Click the Edit button to update any information
   - Click the 'Cancel' button to cancel the transaction, in which case it will need to be re-entered by the member (employee).
   - Enter a reason for the cancellation in the Comments box.
   - Check the box next to "I would like to cancel this request."
   - Click the Confirm button.

9. To Deny a selected transaction in the Pending queue (a review discovered member was not eligible to make the requested change).
    - Click the Deny button.
    - Enter a reason for the denial in the Comments box.
    - Check the box next to “I would like to deny this request.”
    - Click the Confirm button.

C-9 Enrollment Inquiry

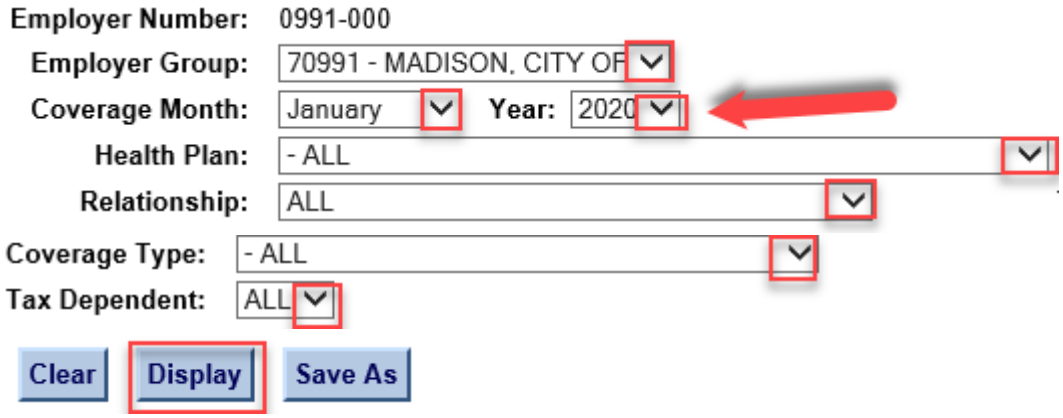
The Enrollment Inquiry is a function of myETF Benefits where an employer can go to view a summary of all of their employees (subscribers) are enrolled in the State Group Health Insurance Program and entered in myETF Benefits. This is a monthly report based on available invoices. This query can either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

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



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

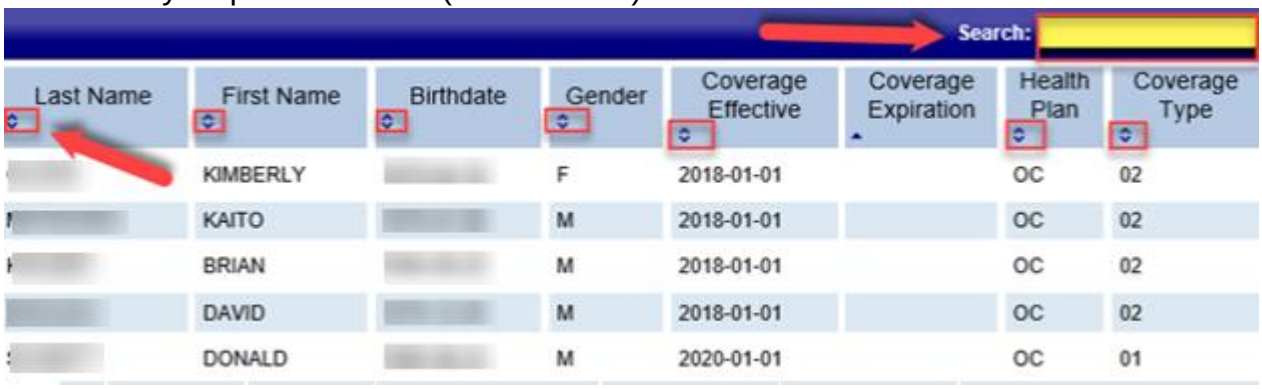
3. Click the dropdown arrow to narrow to your search by month, year, health plan, relationship, and coverage type and then click Display.



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

   b. Search for specific information (employee type, Member ID, SSN, last name, etc.).
   c. Skip to a page, next page, or last page.

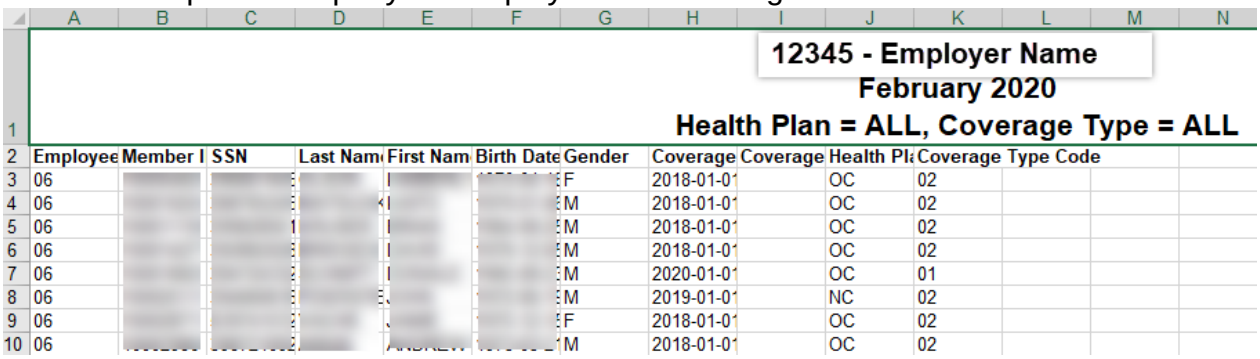
   d. Sort by a specific column (small arrows).



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

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

   c. Select Open. The query will display in the following format:



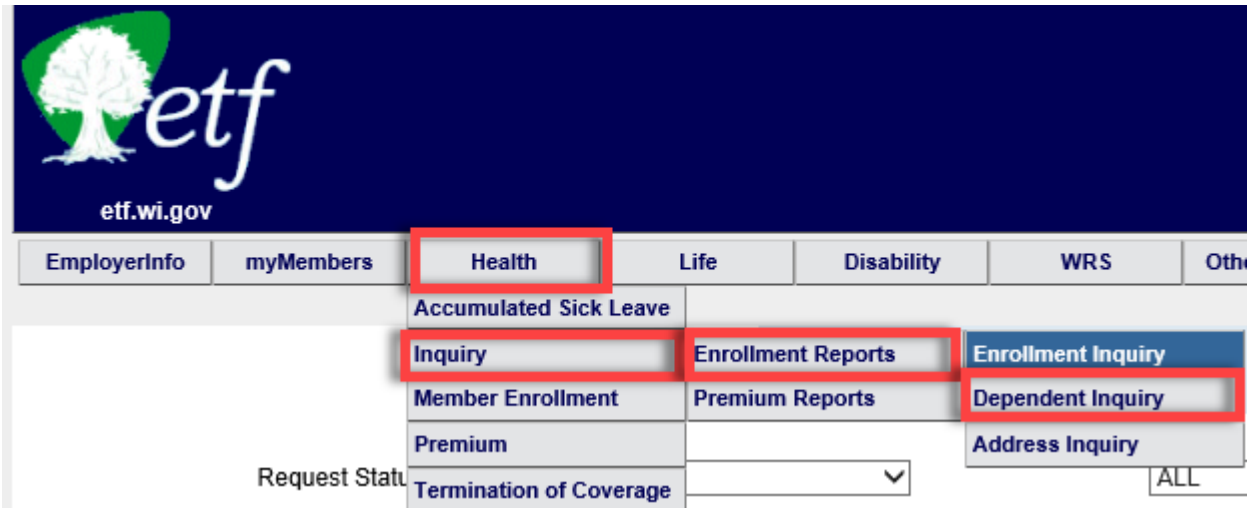
   d. Choose to save the query or exit from Excel. It will not change your query in myETF Benefits.

C-10 Dependent Inquiry

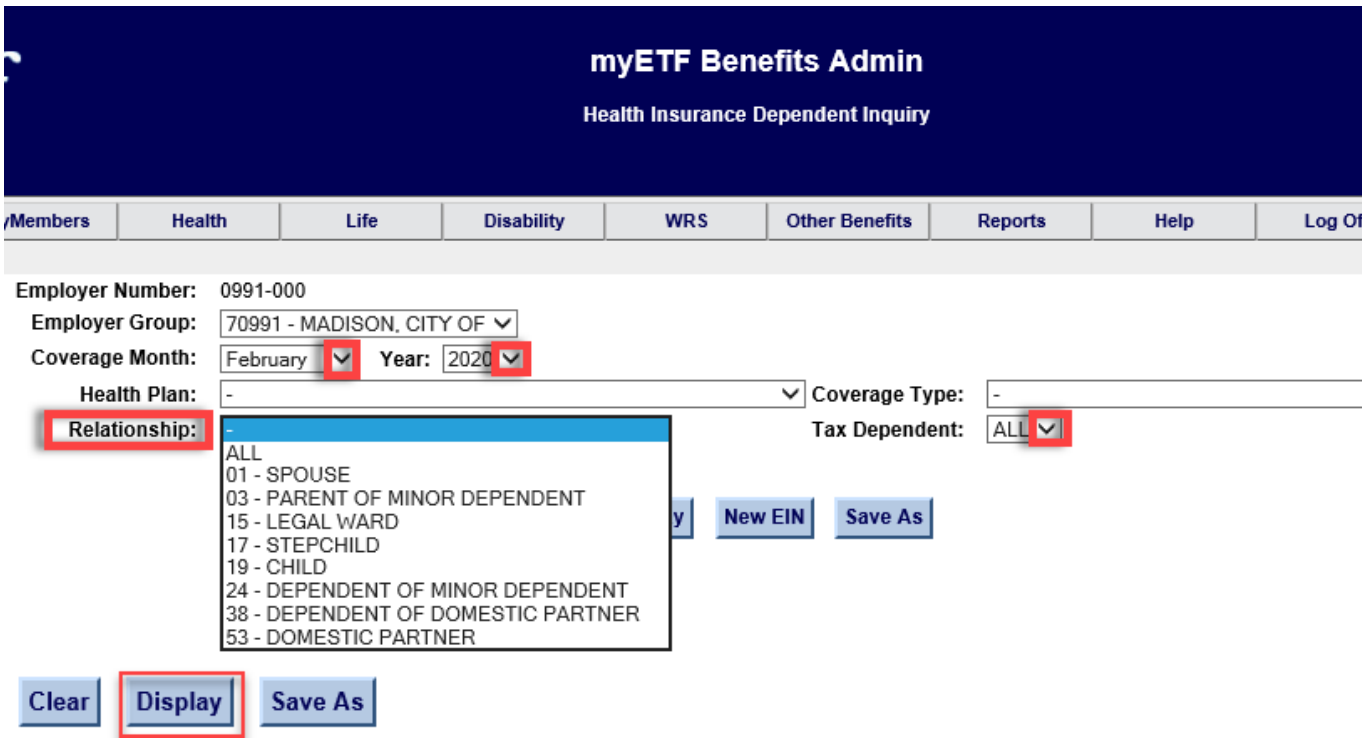
The Dependent Inquiry is a function of myETF Benefits where an employer can go to view a summary of all of their employees (subscribers), and their dependents that are, or have been enrolled in, the group health insurance program and entered in myETF Benefits. This is a monthly report based on available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

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

1. To view Dependent summary, go to the Health tab, hover over Inquiry and then Enrollment Reports, then select Dependent Inquiry.



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



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

   b. Search for specific information (employee type, Member ID, SSN, last name, etc.).
   c. Skip to a page, next page, or last page.

   d. Sort by a specific column (small arrows).

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

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

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

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

Health	Coverage	Employee Type	Sub SSN	Sub Name	Dep SSN	Dep	Dep Name	Dep DOB	Dep Gender	Dep Marital Status	Cov Eff Date	Cov Exp Date	Rel Code	Disabled?	Tax Depe
XX	XX	XX	XXXXXXXXX	LAST, FIRST	XXXXXXXXX	XXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
XX	XX	XX	XXXXXXXXX	LAST, FIRST	XXXXXXXXX	XXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
XX	XX	XX	XXXXXXXXX	LAST, FIRST	XXXXXXXXX	XXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		01	N	Y
XX	XX	XX	XXXXXXXXX	LAST, FIRST	XXXXXXXXX	XXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		19	N	Y
XX	XX	XX	XXXXXXXXX	LAST, FIRST	XXXXXXXXX	XXXXXXXX	LAST, FIRST	CCYY-MM-DD	F	SGL	CCYY-MM-DD		01	N	Y
XX	XX	XX	XXXXXXXXX	LAST, FIRST	XXXXXXXXX	XXXXXXXX	LAST, FIRST	CCYY-MM-DD	F	MAR	CCYY-MM-DD		19	N	Y
XX	XX	XX	XXXXXXXXX	LAST, FIRST	XXXXXXXXX	XXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
XX	XX	XX	XXXXXXXXX	LAST, FIRST	XXXXXXXXX	XXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		19	N	Y

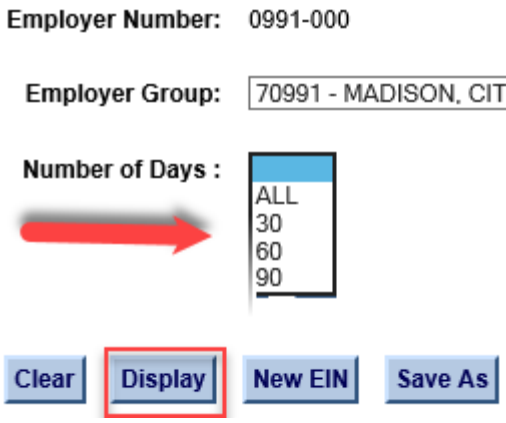
   d. Choose to save the query or exit from Excel. It will not change your query in myETF Benefits.

C-11 Address Inquiry

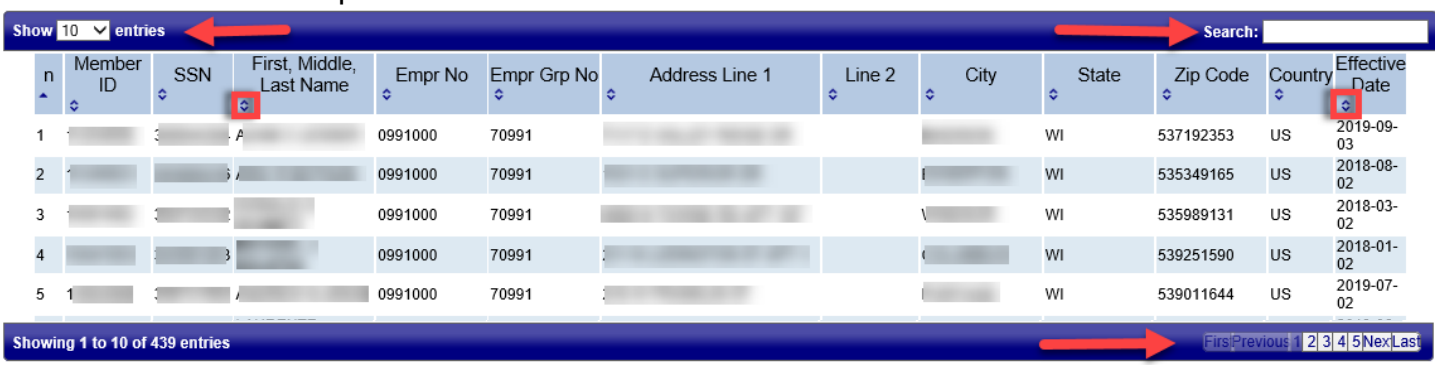
The Address Inquiry is a function of myETF Benefits where an employer can go to view a summary of all subscriber addresses that have been updated. This query can look back 30, 60, or 90 days or can be run to look at all address changes that have been made.

1. To access Address Inquiry, go to the Health tab, hover over Inquiry and then Enrollment Reports and then click on Address Inquiry.

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



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



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

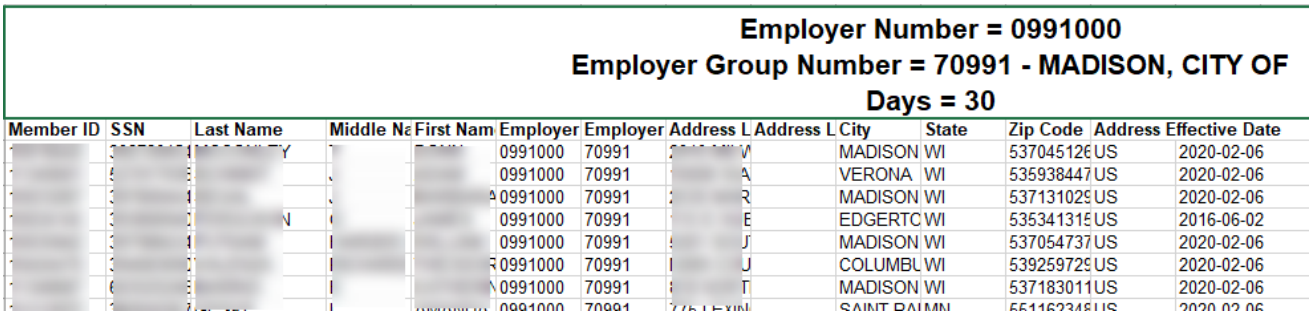
   b. Search for specific information (employee type, Member ID, SSN, last name, etc.) by entering it in the search box.
   c. Skip to a page number, next page, or last page.

   d. Sort by a specific column header by clicking the small arrows.

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

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

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



Employer Number = 0991000
Employer Group Number = 70991 - MADISON, CITY OF
Days = 30

Member ID	SSN	Last Name	Middle Na	First Nam	Employer	Employer	Address L	Address L	City	State	Zip Code	Address Effective Date
					0991000	70991			MADISON	WI	537045126	US 2020-02-06
					0991000	70991			VERONA	WI	535938447	US 2020-02-06
					0991000	70991			MADISON	WI	537131029	US 2020-02-06
					0991000	70991			EDGERTC	WI	535341315	US 2016-06-02
					0991000	70991			MADISON	WI	537054737	US 2020-02-06
					0991000	70991			COLUMBU	WI	539259729	US 2020-02-06
					0991000	70991			MADISON	WI	537183011	US 2020-02-06

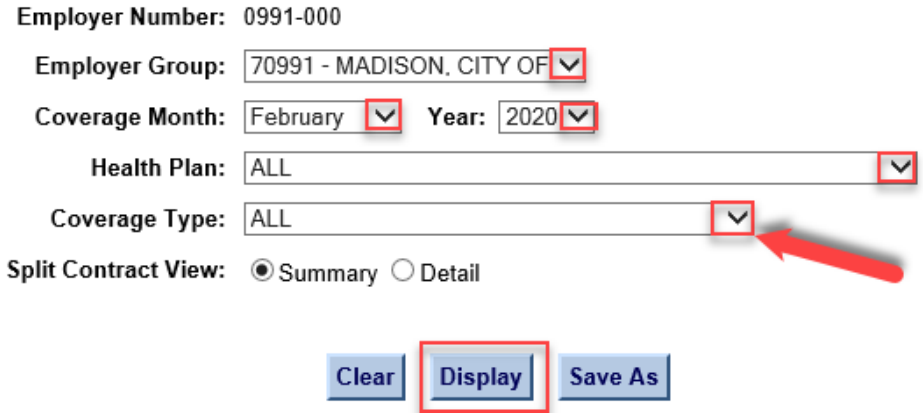
   d. Choose to save the query or exit from Excel. It will not change your query in myETF Benefits.

C-12 Employer Premium Inquiry

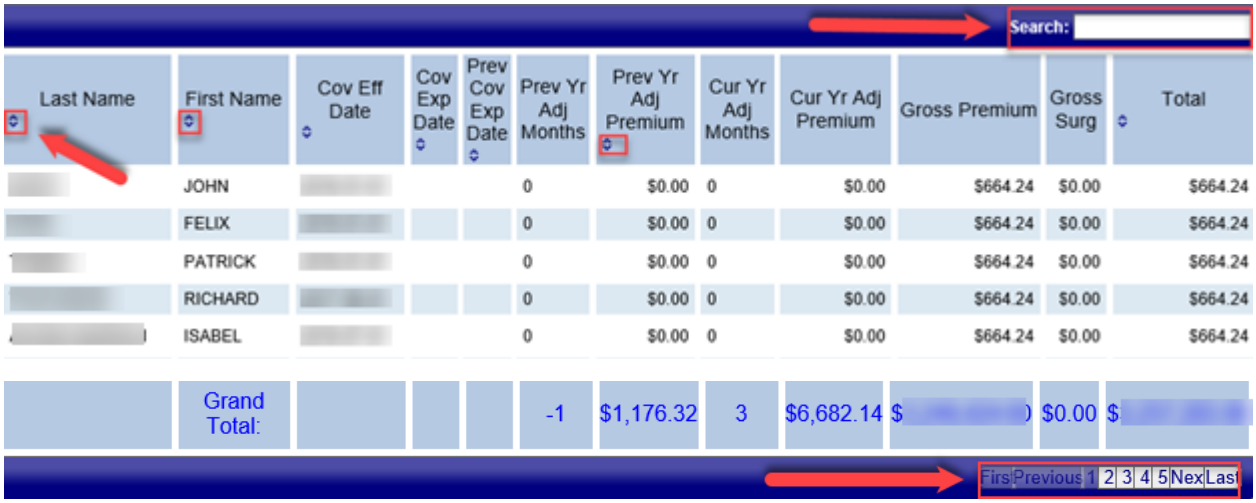
The Employer Premium Inquiry is a function of myETF Benefits where an employer can go to view a list the monthly premium amounts of all their employees (subscribers) enrolled in the group health insurance program and entered in myETF Benefits. This query can either be very broad or broken down by coverage month, a specific health plan, and coverage type.

1. To view the Employer Premium Inquiry, hover over the Health tab and then Inquiry and then Premium Reports. Select Employer Premium Inquiry.

2. Click the dropdown arrows to narrow to your search by month, year, health plan, and coverage type and then click Display.



3. A spreadsheet will generate with the information requested.



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

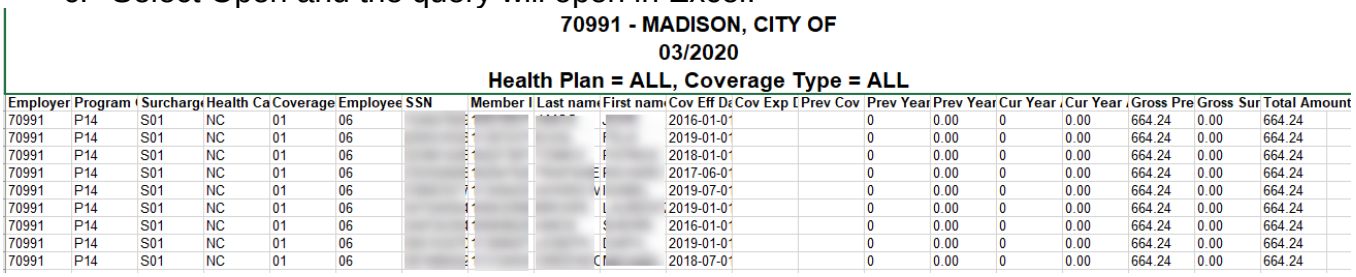
   b. Search for specific information (employee type, Member ID, SSN, last name, etc.) by entering it in the search box
   c. Skip to a page number, next page, or last page.

   d. Sort by a specific column header by clicking the small arrows.

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

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

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



70991 - MADISON, CITY OF
03/2020
Health Plan = ALL, Coverage Type = ALL

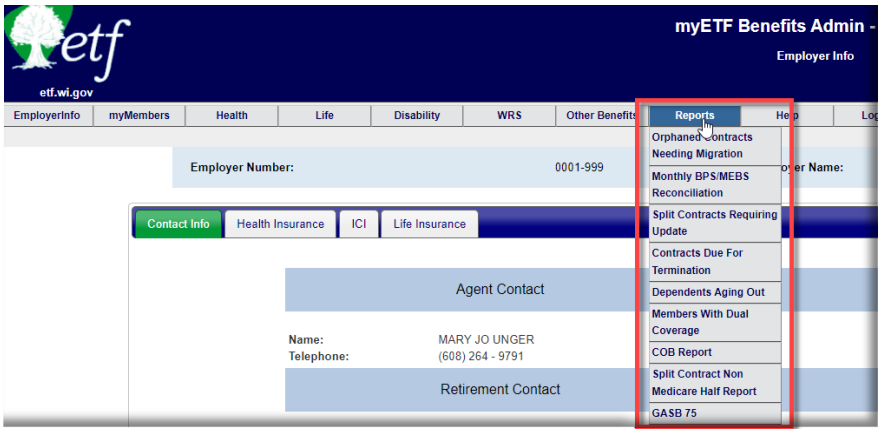
Employer	Program	Surcharg	Health Ca	Coverage	Employee	SSN	Member I	Last nam	First nam	Cov Eff Da	Cov Exp D	Prev Cov	Prev Year	Prev Year	Cur Year	Cur Year	Gross Pre	Gross Sur	Total Amount
70991	P14	S01	NC	01	06					2016-01-01			0	0.00	0	0.00	664.24	0.00	664.24
70991	P14	S01	NC	01	06					2019-01-01			0	0.00	0	0.00	664.24	0.00	664.24
70991	P14	S01	NC	01	06					2018-01-01			0	0.00	0	0.00	664.24	0.00	664.24
70991	P14	S01	NC	01	06					2017-06-01			0	0.00	0	0.00	664.24	0.00	664.24
70991	P14	S01	NC	01	06					2019-07-01			0	0.00	0	0.00	664.24	0.00	664.24
70991	P14	S01	NC	01	06					2019-01-01			0	0.00	0	0.00	664.24	0.00	664.24
70991	P14	S01	NC	01	06					2016-01-01			0	0.00	0	0.00	664.24	0.00	664.24
70991	P14	S01	NC	01	06					2019-01-01			0	0.00	0	0.00	664.24	0.00	664.24
70991	P14	S01	NC	01	06					2018-07-01			0	0.00	0	0.00	664.24	0.00	664.24

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

C-13. Running Reports

Sometimes an employer may want to run reports from MEBS to collect data from a specific time period, for a specific health plan, or some other characteristic. Some of the common methods follow:

1. Reports Drop-Down:
   a. Hover your mouse over the “Reports” drop-down and select the report you want to view



2. Health Drop-Down:
   a. Hover your mouse over the “Health” drop-down
   b. Hover your mouse over the “Inquiry” drop-down
   c. Hover your mouse over the “Enrollment Reports” drop-down
   d. Select the report you want to run (“Dependent Inquiry” shown)