

Chapter 5 — Changing Coverage

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

501 Status Changes

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

Status changes include:

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

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

502 Changing Plans Due to a Residential Move

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

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

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

503 Changing from Single to Family Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Who was covered (must list the name of the member who is requesting this special, late enrollment)
 2. Name of Health Insurer
 3. Subscriber number (and name)
 4. Date coverage was terminated
 5. Reason for the cancellation (that is voluntary such as due to non-payment of premium vs. involuntary such as due to job loss)
- **Paternity Acknowledgment:** When an acknowledgment of paternity is filed within 60 days of the birth, and an application is received or online enrollment performed within the 60 day time frame, family coverage is effective on the date of birth. Beyond the 60 day time frame, coverage is effective the first of the month on or after receipt of the application.

Documentation supporting the paternity acknowledgment is required as outlined in

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

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

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

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

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

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

504 Changing from Family to Single Coverage

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

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

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

the *Health Insurance Application/Change Form*.

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

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

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

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

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

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

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

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

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

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

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

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

505 Adding Dependents

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

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

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

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

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

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

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

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

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

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

1. Who was covered (must list the name of the member who is requesting this special, late enrollment)
2. Name of Health Insurer
3. Subscriber number (and name)
4. Date coverage was terminated

5. Reason for the cancellation (that is voluntary such as due to non-payment of premium vs. involuntary such as due to job loss). If loss of employer premium contributions, letter from employer indicating they no longer contribute towards their employee's premium.
- **Paternity Acknowledgment:** If family coverage is already in place, coverage for the dependent(s) will be effective on the date of birth if an acknowledgment of paternity is filed and an application is received or online enrollment performed within 60 days of the birth. If more than 60 days have elapsed, coverage will be effective on the first of the month on or after receipt of the application.

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

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

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

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

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

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

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

The relevant contract and statute provisions follow:

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

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

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

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

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

506 Removing Dependents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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