

State Agency Health Insurance Administration Manual



Wisconsin Department of Employee Trust Funds
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etf.wi.gov

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

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Department of Employee Trust Funds
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Preface

The *State Agency Health Insurance Administration Manual* (ET-1118) is a reference source intended to aid your administration of and participation in the Wisconsin State Employee Group Health Insurance Program. Its contents are based on state statute, administrative code, and group health contract language and contain instruction 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 after the printing of this manual.

The Department of Employee Trust Funds will make every effort to communicate changes to employers via *Employer Bulletins* and manual updates. This 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, Terms and Conditions for Comprehensive Medical Plan Participation in the *State of Wisconsin Group Health Benefit Program and Uniform Benefits* (ET-1136), and/or case law by ETF.

Consult this manual as a first-step resource when you encounter Group Health Insurance Program-related questions or concerns. If questions remain, contact Employer Communications Center in ETF's Employer Services Section (ESS). ESS provides a single point of contact to resolve issues regarding eligibility, enrollment, coverage and invoicing for ETF benefit programs. A central voice mail system handles calls when all ESS staff member lines are busy. The voice mail system is monitored on a regular basis and all calls are returned within 24 business hours. The ESS telephone numbers are toll-free 1-877-533-5020, 1-608-266-3285 or e-mail at ETFSMBEmployerInsurance@etf.wi.gov.

Your efforts to accurately administer the provisions of the State Group Health Insurance Program are appreciated. If you have comments on this edition or suggestions for the next edition of this manual, please contact toll free at 1-877-533-5020 or 1-608-266-3285.

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101 Applicable Policies, Statutes and Legislation

Wisconsin Statutory Authority: § 40.51

The State of Wisconsin Group Health Insurance Program is authorized by Wis. Stat. § 40.51 and is administered under the authority of the State of Wisconsin Group Insurance Board. The program offers employees and retirees the opportunity to choose between two or more health plans.

Group Insurance Board

The Group Insurance Board (GIB) sets policy and oversees administration of the group health, life, and income continuation insurance programs for eligible state and local employees. The GIB can allow other types of insurers and third-party vendors to provide other insurance plans, if employees pay the entire premium.

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.

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

The goals and objectives of the contract between the GIB and the health plans are to:

- Encourage the growth of alternate health benefit plans that can deliver quality health care benefits efficiently and economically.
- Offer employees a choice between two or more health plans.

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.

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.

The three components of this effort are:

- **Electronic Data Transaction Standards** — Sets uniform methods for conducting electronic transactions.
- **Privacy** — Limits how health information can be used and disclosed.
- **Security** — Requires safeguards for health information maintained in electronic form.

ETF must comply with the following HIPAA regulations:

- When an employee does not apply for health insurance when first eligible, a new opportunity to apply occurs during the annual It's Your Choice Open Enrollment period. Coverage is then effective January 1 of the following year.
- Certain qualifying events such as loss of other group coverage, marriage/establishment of a Chapter 40 domestic partnership, or the birth or adoption of a child, permit an enrollment opportunity without restriction. For more information, contact ETF's *Employer Communication Center* at 1-877-533-5020 (toll free) or 1-608-266-3285.

A Notice of Privacy Practices is posted on ETF's website (etf.wi.gov) and appears in the *It's Your Choice Reference Guide* (ET-2107r).

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, and will be fully implemented by 2018. 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:

- Rights and protections.
- Insurance choices.
- Full coverage for federally required preventive care services.

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

102 Employer Agent Responsibilities

Designate a health insurance representative to:

- Explain eligibility, cost, enrollment procedures and effective dates to employees.
- Provide *It's Your Choice Decision Guide* (ET-2107), either paper or electronically, to all new hires and current subscribers prior to the annual It's Your Choice Open Enrollment period and track when each employee received one.
- Provide information upon initial enrollment, It's Your Choice Open Enrollment,

continuation-conversion provisions, and when applicable, Medicare.

- Secure, audit and maintain health insurance applications, audit and approve online enrollments and arrange payroll deductions.
- Review, reconcile and pay monthly ETF invoices online by the 24th of each month. Refer to Chapter 15.
- Refer employees to the appropriate health plan contacts for claim or benefit questions.
- Refer annuitant health insurance questions to Employer Services Section.
- Refer questions regarding the contract to ETF (Refer to subchapter 106).
- Respond to health plan questions and audits in a timely manner.
- Maintain a supply of current ETF forms, available at etf.wi.gov, and update supply when forms are revised. (refer to Appendix A).

103 Employer Training and Support

Training

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

Technical Support

For technical support with or questions about myETF Benefits System, please call the Help Desk at 1-608-266-9466.

Group Health Plan Questions

Questions about group health plans or benefits should be directed to the Employer Services Section at 1-877-533-5020 (toll-free) or 1-608-266-3285 (local) or ETTFHealthandIns@etf.wi.gov.

104 myETF Benefits System

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

1. myETF Benefits Administrator application for Employers (via Online Network for Employers - ONE).
2. myETF Benefits application for Members (via Online Network for Members - ONM).

The myETF Benefits Administrator Application for Employers allows employers to:

- Initially enroll new employees.
- View and update individual member health insurance eligibility and demographic data.
- Complete mass employee terminations.
- View and update health insurance enrollment data.
- Approve employee submitted changes to health insurance and demographic data.

The administrator (employer) application can be found at the ONE site and is accessed using

the employer's ONE login and password. Access to myETF Benefits is granted via the *Online Network for Employers Security Agreement* (ET-8928).

The myETF Benefits Application for Members allows members and employers to:

- Initially enroll in the health insurance if the employer allows and has set up the employee on myMembers.
- View individual health insurance eligibility and demographic data.
- Update health insurance enrollment data.
- Update demographic information.

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

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

105 ETF Ombudsperson Services

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

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

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

Local (Madison) 608-261-7947
Toll Free 1-877-533-5020 ext. 17947

E-mail 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. Complaints should be made in writing, using the *Insurance Complaint Form* (ET-2405) whenever possible. Additional information regarding ETF ombudsperson services can be found under the "Members" section at etf.wi.gov.

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

106 Employer Services Section Contact Information

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

Madison

Mailing Address	P O Box 7931 Madison WI 53707-7931
Shipping Address	Department of Employee Trust Funds 801 W Badger Road Madison WI 53713-2526
Telephone	1-877-533-5020 (toll free) 1-608-266-3285 (local Madison area)
TTY	1-608-267-0676
Fax	1-608-267-4549
Website	etf.wi.gov
E-mail	ETFHealthandIns@etf.wi.gov

Office Hours

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

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	https://www.navitus.com

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The State of Wisconsin Group Health Insurance Program consists of three types of plans: alternate health plans, Standard Plan, and State Maintenance Plan. Effective January 1, 2015, ETF also offered an alternate High Deductible Health Plan (HDHP).

201 Alternate Health Plans (HMOs, PPOs and HDHPs)

Alternate health plans are health maintenance organizations (HMO), preferred provider organizations (PPO), and high deductible health plans (HDHP) that provide comprehensive benefits at a lower cost than the Standard Plan in exchange for some health care provider limitations.

All alternate health plans participating in the Group Health Insurance Program offer the same level of coverage, called Uniform Benefits, with the exception of dental coverage that may be offered at the discretion of the health plan. If dental coverage is offered, it is Uniform Dental Benefits.

Uniform Benefits 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.

The HDHP mirrors Uniform Benefits except that it contains an up-front deductible and a different out-of-pocket limit. The plan has a \$1,500 single plan, \$3,000 family plan deductible. The deductible does apply to pharmacy. After the deductible, pharmacy benefits again apply to the copays up to an out-of-pocket limit. In a family plan, the entire \$3,000 deductible must be met before the coinsurance coverage begins. The deductible applies to all services except for federally required preventive care. Such care is covered at 100%. For more details, refer to the *It's Your Choice Guides*.

The HDHP is available to most employees and annuitants younger than age 65. Employees who are eligible for the graduate assistant/short term academic staff benefits package and are not in the WRS are not eligible for the HDHP. Subscribers who are enrolled in Medicare or any other disqualifying health plan (for example, a spouse's health insurance plan including a medical flexible spending account or Tricare) are not eligible to enroll in the HDHP.

While coverage levels are the same for alternate health plans, they differ in other ways, namely premium amount, provider network, benefit determinations and administrative requirements. Uniform Benefits and premium amounts change on an annual basis, so the latest *It's Your Choice Decision Guide* (ET-2107) is the most reliable resource for details.

Note: Benefits differ for annuitants and their dependents enrolled in Medicare.

202 Standard Plan

The It's Your Choice (IYC) Access Plan is a comprehensive self-insured Preferred Provider Organization (PPO) that is currently administered by Wisconsin Physicians Service (WPS). Participants enrolled in the Standard Plan can see a provider of their choice without the network restrictions associated with an HMO. In exchange for this freedom to select the provider of their choice, the participants have different benefit levels depending on whether the provider selected is in-network (higher benefit level) or out-of-network (lesser benefit level). Participants can review the Standard PPO Plan (ET-2112) brochure for more details regarding the differences between the benefits under the Standard Plan and the Uniform Benefits offered under the alternate health plans.

203 State Maintenance Plan (SMP)

The State Maintenance Plan (SMP) offers the same Uniform Benefits package as the alternate health plans, but is available only in those counties that do not have a qualified Tier 1 alternate health plan as noted in the current *It's Your Choice Decision Guide*. The SMP is administered by WPS.

204 Three Tier Health Insurance Program

Since the passage of the 2003-2005 biennial budget, the state of Wisconsin has sought to reduce health insurance costs for employees and employers by implementing a 3 Tier system for purchasing health insurance. This was implemented to mitigate the trend of increasing health care costs.

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 employee out-of-pocket cost is lowest for Tier 1 plans and the highest for Tier 3 plans, with Tier 2 falling in the middle.

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

- Tier 1 plans – Low cost.
- Tier 2 plans – Moderate cost.
- Tier 3 plans – High cost.

Please look in the *It's Your Choice Decision Guide* (ET-2107) in the "Health Plan Premium Rates" section, or visit our website if interested in learning more about the 3 Tier model, etf.wi.gov.

205 Contribution Rates

Each year, the monthly amount that state employees are required to pay for health insurance is established by the Office of State Employment Relations (OSER). OSER determines the employee contribution towards premium based on the provisions in Wis. Stat. § 40.05 (4) (ag) and (ah). Effective January 1, 2015, OSER also began to determine the employer contribution for the Health Savings Account that accompanies the HDHP.

206 Pharmacy Benefit Manager (PBM) - Navitus

A pharmacy benefit manager (PBM) is a third party administrator of the prescription drug program and is primarily responsible for processing and paying prescription drug claims. 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 participants enrolled in the Group Health Insurance Program will be covered by a Medicare Part D prescription drug plan (PDP) provided by the PBM. Participants who choose to be enrolled in another Medicare Part D (PDP) other than this prescription drug plan will not have the benefits duplicated.

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.

207 Health Plan Contacts

Health plan addresses and phone numbers are listed on the inside back cover of the *It's Your Choice: Decision Guide* (ET-2107d). In addition, a listing of *Health Plan Contacts* (ET-1728) is available on ETF's website under the *Employer Forms and Brochures* section.

Contact a health plan representative directly with specific questions regarding such topics as referral policies, benefits, filing of claims, and/or provider networks.

208 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 in the *It's Your Choice Reference Guide* (ET-2107r). Questions regarding COB should be directed to the health plans.

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Chapter 3 — Eligibility

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- 302 Dependent Coverage Eligibility**
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- 304 Determining Effective Dates for the Employer Premium Contribution**
- 305 WRS Previous Service Check**

301 Employee, Annuitant and Continuant Eligibility

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

- General state employees: Active state and university employees participating in the Wisconsin Retirement System.
- Elected state officials.
- Members or employees of the legislature.
- Any blind employee of the Beyond Vision (aka WISCRAFT) authorized under Wis. Stat. § 47.03 (1) (b) or § 47.03 (1m) who has completed 1,000 hours of service.
- Any employee on leave of absence who has chosen to continue their insurance.
- Any employee on layoff whose health insurance premiums are being paid from accumulated unused sick leave (Wis. Stat. § 40.05 (4) (bm)).
- The following in the University of Wisconsin System and University of Wisconsin Hospital and Clinics Authority:
 - Any teacher (employment category 40) who is employed by the university for an expected duration of not fewer than six months on at least a one-third full-time appointment.
 - Any teacher who is a participating employee and who is employed by the University of Wisconsin System for an expected duration of not fewer than six months on at least a one-third full-time appointment.
 - Certain visiting faculty members in the University of Wisconsin System.
 - Graduate student assistants (research assistants, fellows, advanced opportunity fellows, scholars, trainees, teaching assistants and project/program assistants) holding a combined one-third (33%) or greater appointment of at least one semester per academic year (nine month) appointments or six months for annual (twelve month) appointments.
 - Employees-in-training (research associates, post-doctoral fellows, post-doctoral trainees, post-graduate trainees 1 through 7, interns (non-physician), research interns, and graduate interns/trainees) holding a combined one-third time (33%) or greater appointment of at least one semester for academic year (nine month) or six months for annual (twelve month) appointments.
 - Short-term academic staff who are employed in positions not covered under the WRS and who are holding a fixed-term terminal, acting/provisional or interim (non

UW-Madison) appointment of 28% or more with an expected duration of at least one semester but less than one academic year if on an academic year (nine month) appointment or have an appointment of 21% or more with an expected duration of at least six months but fewer than twelve months if on an annual (twelve month) appointment.

- Visiting appointees (e.g., visiting professors, visiting scientists, visiting lecturers) may be eligible for the health insurance benefits.
- Any person employed as a graduate assistant and other employees-in-training as designated by the board of directors of the University of Wisconsin Hospitals and Clinics Authority who are employed on at least a one-third full-time appointment with an expected duration of employment of at least six months.
- Annuitants and Continuants (Former Employees/Dependents)
 - Any insured employee who is retired on an immediate annuity or disability annuity, 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).
 - The surviving spouse or domestic partner of an employee or of a retired employee who is covered on the employee's health insurance at the time of death of the employee or retired employee.
 - Insured employees who terminate employment, have attained minimum retirement age (50 for protective services or 55 for all other categories), have 20 years of WRS creditable service and defer their annuity are eligible to continue in the State of Wisconsin Group Health Insurance Program if a timely application is submitted.
 - Any participating state employee who terminates employment after attaining 20 years of WRS creditable service, remains an inactive WRS participant and is ineligible for an immediate annuity (that is, under the minimum retirement age) may enroll in the Group Health Insurance Program at a later date. Enrollment is restricted to the It's Your Choice Open Enrollment period in the fall (typically beginning in October) for coverage effective the following January 1, unless there is a HIPAA qualifying event (refer to subchapter 503 for qualifying events).
 - Any rehired annuitant electing to return to active WRS participation is immediately eligible to apply for health insurance coverage through the employer (any state agency or local employer that participates in the Wisconsin Public Employers Group Health Insurance Program).

302 Dependent Coverage Eligibility

Single coverage covers only the eligible employee. All eligible, listed dependents are covered under a family contract. A subscriber/employee cannot choose to exclude any eligible dependent from family coverage. Eligible dependents for family coverage include:

- Spouse (must be legally recognized in the State of Wisconsin).
- Domestic Partner, if elected.
- Children who include:
 - Natural children.
 - Stepchildren or children of the domestic partner's insured on the contract/policy.
 - 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 covered domestic

partner) 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.

- 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/domestic partner.
- 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: Children may be covered until the end of the month in which they attain age 26. Their spouse and/or dependents are not eligible. Upon the child's loss of eligibility, the child may be eligible for COBRA Continuation.

Note: Pertaining to divorce - if a court orders the subscriber/employee to insure an ex-spouse, the order does not create eligibility for the ex-spouse to remain insured under the subscriber/employee. Ex-spouse eligibility is under COBRA Continuation (refer to Chapter 9). Contact ETF for review of individual situations.

303 Employer Premium Contribution Eligibility

Employees eligible to receive the employer contribution toward the monthly premium payment include:

- A WRS covered employee, having been employed by the state of Wisconsin (local government service does not apply) for a minimum of two months (refer to subchapter 303 to determine prior service). A leave of absence may extend the date an employee becomes eligible for the employer premium contribution. The employee must submit an application to his or her employer within 30 days of the date of hire. Coverage will be effective the first of the month following date of hire (unless hire date is the first of the month, then coverage is effective the first of the month).
- A new employee with at least two months prior service as a state or University of Wisconsin Employee. (except university faculty; see below).
 - A new employee can apply for coverage by submitting a completed application to their employer within 30 days of their date of hire requesting coverage to be effective immediately, first of the month on or after receipt of their application by their employer. If the new employee does not have two months prior state service, the employee will not be eligible for the employer premium contribution and must pay the entire premium.
 - A new employee may also elect coverage to begin when the employer contributes towards the monthly premium. The employee must submit a completed application to their employer prior to becoming eligible for the employer premium contribution. The new employee always becomes eligible for the employer contribution on the first of a month.
 - An employee who is newly eligible for the employer contribution—due to a position change to more than 49%—is eligible for the employer contribution the first of the month following the change. However, the application **must** be received within 30 days of the position change.

- A graduate assistant or employee-in-training at the University of Wisconsin.
- A teacher who is a WRS participating employee and employed by the University of Wisconsin for an expected duration of not fewer than six months with at least a one-third full-time appointment (UW faculty). UW faculty members are immediately eligible for the employer premium contribution and must apply for coverage within 30 days of hire with coverage to be effective the first of the month on or after the employer's receipt of the completed application.
- A member of the Legislature or an elected state official, an employee of the Legislature, a state constitutional officer, a Supreme Court Justice, an Appeals Court Judge, a Circuit Court Judge, the chief clerk or sergeant at arms of the Senate or Assembly, or a district attorney who did not elect under § 978.12 (6) to continue insurance coverage with a county (or who did elect such coverage but terminated that election and elected state coverage within three months of the terminated election). These employees are immediately eligible for the employer premium contribution and must apply for coverage within 30 days of taking office or the event.
- A blind employee of Beyond Vision (aka WISCRAFT) with at least 1,000 hours of service.

A. Employer premium contribution for full- and part-time employees:

The Group Insurance Board, in accordance with Wis. Stat. § 40.51 (6), established the three tier model with employee premium shares based on the three separate premium tiers (The three tier model is explained in Chapter 2.). Wis. Stat. § 40.05 (4) (ag) and (at) provide guidance regarding the state premium contribution. Compensation plans and bargaining agreements, approved by the state Legislature, determine the exact employee and employer share. The employer premium contribution for part-time eligible employees is also subject to compensation plans.

For employees that are hired to work fewer than 1,044 hours per year, the employer premium contribution is limited to half of the total premium (§ 40.05 (4) (ag), Wis. Stat.).

Health insurance plan premiums and employee contributions are published annually in the *It's Your Choice Decision Guide*.

B. Employer premium contribution for limited term employees (LTEs):

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

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

Employees hired to a WRS eligible LTE appointment and the anticipated hours per year are fewer than 1,044 hours, the employee is required to pay half the total premium cost with the employer paying the remaining half. Employees hired to work concurrent WRS eligible LTE appointments and the anticipated hours per year are 1,044 hours or more,

either with the same state agency or different state agencies, they are treated as full-time employees for the determination of the employer premium contribution.

C. Employer premium contribution for graduate assistants:

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

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

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

D. Premium contribution for other represented and non-represented employees:

Some represented employees may have a different employer premium contribution. Consult the applicable collective bargaining contracts. Some non-represented employees may also have a different employer premium contribution. Consult applicable Office of State Employment Relations Publications.

E. Premium contribution for covered state employees on military leave:

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

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

304 Determining Effective Dates for the Employer Premium Contribution

For new employees with no prior WRS service as either a state or a University of Wisconsin employee, the employer premium contribution commences upon accumulating two full months of state employment and submitting a completed health insurance application to their employer

prior to becoming eligible for the employer contribution. Assuming there is no break in service, employees whose employment begins:

- The **first** of a month – Add two months to determine the month in which the employee is eligible to receive the employer contribution.
 - Example 1: Hire date of March 1; health insurance application received March 1 (before becoming eligible for the employer premium contribution), eligible for the employer premium contribution on May 1.
 - This effective date is determined by counting the month of March and April as the two full months of required state service because the employee was hired on the first of the month.

Note: If the health insurance application is received between March 2 - March 31, eligibility for the employer premium commences on June 1.
- The **second through the thirty-first** of a month – Add three months to determine the month in which the employee is eligible to receive the employer contribution.
 - Example 2: Hire date of March 2; health insurance application received on April 2 (before becoming eligible for the employer premium contribution), eligible for the employer premium contribution on June 1.
 - This effective date is determined by counting April and May as the two full months of required state service. March is not counted as a full month since the hire date was not on March 1.

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

- Example: Hire date of August 2; employee who either terminates or goes on a leave of absence beginning on September 2; employee returns to work on October 7; no prior service before August 2.
 - Because there is a break in service, any period worked in a month counts as a full month towards WRS state service. So the months of August, September and October are counted as three full months because there were hours worked in each. The employee is eligible for the employer premium contribution beginning November 1 if a health insurance application was received on or before that date. A leave of absence must also be deemed ended under Wis. Stat. § 40.02 (40) for the employee to be eligible for the employer contribution on November 1.
- **Note:** In this instance, the employee has until November 6 to submit a completed health insurance application (30 days from the date of return to work) for a plan of their choice. For an application received on or before November 1, coverage is effective November 1. The coverage effective date is December 1 for an application received between November 2 and November 6.

Employees with two months WRS prior service as either a state or a University of Wisconsin employee are eligible to apply within 30 calendar days of hire with coverage effective the first of the month on or after the employer's receipt of the application and are immediately eligible for the appropriate employer premium contribution.

305 WRS Previous Service Check

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

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

- Access the *Previous Service Benefit Inquiry* application on ETF's Online Network for Employers (ONE) site at: <http://etfonline.wi.gov/etf/internet/employer/one.html>.

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

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

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

Chapter 4 — Initial Enrollment

- 401 Initial Enrollment and Effective Dates**
- 402 Declining Coverage**
- 403 Enrollment Opportunities for Employees who Previously Declined or Cancelled Coverage**
- 404 Applying for Coverage**
- 405 Insurance Cards**

401 Initial Enrollment and Effective Dates

Immediately upon hire, employers must provide newly eligible employees with the current *It's Your Choice Decision and Reference Guides* (ET-2107d and ET-2107r, respectively) and the *Health Insurance Application/Change Form* (ET-2301). All eligible employees must either enroll online via myETF Benefits or submit a completed application/change form, including those who do not wish to enroll and are choosing to waive/decline coverage (refer to subchapter 402).

Employees can enroll online via myETF Benefits or by downloading and submitting a *Health Insurance Application/Change Form*:

- Within 30 days of the employee's date of hire. Coverage is effective the first of the month on or following receipt of the application by the employing state agency. New WRS employees will be responsible for paying the full premium until employer contributions begin.
- On or before becoming eligible for the employer contribution. Eligibility for employer contribution follows completion of two months of state service under the WRS for permanent/project employees, six months of state service for limited term employees or 1,000 hours of service for Beyond Visison (aka WISCRAFT) employees. Coverage is effective the first of the month on or after the employer's receipt of the application. This does not apply to UW unclassified faculty/academic staff.
- UW unclassified faculty/academic staff: A teacher who is a participating employee and who is employed by the University of Wisconsin for an expected duration of not fewer than six months with at least a one-third full time appointment (UW Faculty). UW Faculty members are eligible for the State premium contribution beginning on the date coverage begins.
- Graduate Assistants: If eligible, may enroll for single or family coverage in any of the available non-high deductible health plans. Their benefits/payroll/personnel office must receive the application within 30 days of the date of first eligible appointment. Health insurance coverage will be effective the first day of the month on or after the employer's receipt of the application. If this is not the grad assistant's first eligible appointment, they may still be eligible for the initial 30-day enrollment period if there was a 30-day employment break between appointments.

Note: If currently an active WRS participant, grad assistant positions are **not** eligible for coverage under the graduate assistant program.

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

For initial enrollment, if the new employee's spouse/domestic partner is also an eligible state or participating WPE employee or annuitant, there are several options available.

- If their spouse is already enrolled with single coverage, the new employee may also elect single coverage or elect family coverage in which case the spouse would have to submit an application to cancel their single coverage in order to go onto the new employee's family coverage.
- 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.
- If their domestic partner is already enrolled with either single or family coverage, the new enrollee can elect single coverage, or family coverage if they have additional dependents other than the domestic partner, or the domestic partner can submit an application to cancel their single or family coverage in order to go onto the new enrollee's coverage.

402 Declining (waiving) Coverage

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) indicating coverage is being declined. 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 403), or during the annual It's Your Choice Open Enrollment period for an effective date of January 1 of the following year.

403 Enrollment Opportunities for Employees who Previously Declined or Cancelled Coverage

Employees who have declined coverage during a designated enrollment period can elect coverage either during the next It's Your Choice Open Enrollment period for an effective date of January 1 of the following year or due to a qualifying event.

Under federal law and by contract, the following constitute qualifying events that permit employees who previously declined or cancelled coverage to enroll in any health plan without limitations:

A. Loss of Other Coverage: Employees who declined coverage under the Group Health Insurance Program due to the following circumstances:

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

- Coverage as a citizen of a country with national/universal health-care coverage comparable to the Standard Plan options;

and who lose eligibility for the other coverage or the employer's premium contribution for the other coverage ceases, may take advantage of a 30-day enrollment period, beginning on the date the other health-insurance coverage terminates. This does not include voluntary cancellation of the other coverage. A *Health Insurance Application/Change Form* (ET-2301), or online application via myETF Benefits, 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.

Note: The employee should complete and submit an application 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.

Copies of the required documentation must be submitted to ETF for approval. Coverage is effective on the day following the last day of the other coverage. For example, if coverage ended on May 13th with the other plan, coverage under the state plan would begin on May 14th.

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)

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.

- B. Marriage/Domestic Partnership/Birth/Adoption/Permanent Legal Guardianship/National Medical Support Notice/Paternity:** Employees who declined coverage under the Group Health Insurance Program have an opportunity to enroll in family coverage if they have a new dependent as a result of marriage, domestic partnership, birth, adoption or placement for adoption, placement for permanent legal guardianship (legal ward), a

court ordered National Medical Support Notice, or paternity. If documentation is required and not readily available, the employee should submit the application to the employer before receiving the required documentation to secure the effective date of the enrollment opportunity.

- For marriage or domestic partnership – coverage is effective on the date of marriage or the effective date of the domestic partnership if an application is received within 30 days of that event date.

Note: Wisconsin does not recognize same-sex marriage. If an employee needs to register a same-sex spouse, please have them submit an *Affidavit of Domestic Partnership* (ET-2371).

- For birth, adoption, placement for adoption, granting of permanent legal guardianship, paternity acknowledgement – 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.
- 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.

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

Example: An employee in a WRS-covered position appointed to work fewer than 1,044 hours is eligible for less than half-time employer premium contributions and elects not to participate in health insurance coverage. The employee later receives an appointment, effective October 1, for 1,044 hours or 50% time. (Refer to note regarding number of hours in subchapter 303 B). The employee now has an additional enrollment opportunity due to this increase in hours. The employee can file an application on October 1 for coverage effective on October 1, or the employee can file the application with the employer on or before October 30, (30 days from being hired into the new appointment) for coverage effective on November 1.

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

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.

- D. Escrow Sick Leave:** If an employee who deferred coverage wants to preserve sick leave credits for later use, they must enroll in the Standard Plan 30 days prior to retirement.

404 Applying for Coverage

Verify the employee's eligibility for group health insurance coverage (refer to subchapter 301). Provide the employee with the *It's Your Choice Decision and Reference Guides* and the *Health Insurance Application/Change Form* (ET-2301) and/or show them where to locate both on the ETF website at etf.wi.gov. Inform the employee of the deadline for submitting the application. Employees may also submit their application online via myETF Benefits. Employees should complete the application following the instructions included with the *Health Insurance Application/Change Form*. Each eligible employee must submit an application (paper or online) to the employer even if declining coverage (currently must submit paper form if declining coverage). It is important that there is written documentation indicating the employee declined coverage; employers should retain such documentation. UW staff using ebenefits to decline coverage need not complete this step.

- f. If employees are enrolling using the paper *Health Insurance Application/Change Form*, direct employees to the ETF website at etf.wi.gov.
- g. If employees are enrolling online via myETF Benefits, direct employees to the ETF website at etf.wi.gov and click on the *Members* tab. Under the title *Insurance*, click on the bullet titled *myETF Benefits for Members*. Under the heading *Applications*, first click on *Instructions*. After the employee reviews and/or prints the instructions, then hit the back button. Next, click on *myETF Benefits*. 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.

Note: Instructions for using myETF Benefits can be found in the *It's Your Choice Decision Guide*.

After the employee submits their application (paper or online via myETF Benefits) the employer will review:

- a. 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.
- b. If submitted via *Health Application/Change Form*, the employer must review the completed form before approving the application by completing the Employer Section. **Note: the employee must sign the application. Failure to provide a signature is an incomplete application and will be rejected.**
 - 1. 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).
 - 2. Name of Employer
 - 3. Payroll Representative E-mail
 - 4. Five-digit Group Number – The five digit number assigned to state agencies (e.g., 84535)
 - 5. Employee Type – Enter the appropriate code (refer to Appendix B).

6. Coverage Type Code – Coverage code identifying single or family coverage (refer to Appendix B).
 7. Health Plan Name or Suffix – The full name or two-digit code identifying the health plan.
 8. Employment Status – Is the employee full-time, part-time, or LTE.
 9. Employee Deductions – Are the employee’s health insurance premiums deducted pre-tax or post-tax.
 10. Previous Service – Complete Information – Check the appropriate response for each question.
 11. Date WRS Eligible Employment or Graduate Assistant Appointment Began or Hire Date – The month, day and year the employee began WRS (or grad assistant) employment with the employer. For rehired employees, enter the rehire date.
 12. 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.
 13. Event Date – The date the event took place (e.g., marriage date, birth date, loss of coverage date, etc.).
 14. Prospective Date of Coverage – The month, day and year the coverage should be effective.
 15. Payroll Representative Signature/Phone Number – 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.
- c. Upon completion of the Employer Section, make copies of the application:
1. Employer Copy – retain original for your records.
 2. Employee Copy – return a copy to the employee.
 3. ETF Copy – if requested, submit with copies of any required documentation (e.g., contract in “Waiting for ETF Approval” status).

405 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 206 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 Navitus 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 on the inside back cover of the *It’s Your Choice Decision Guide* (ET-2107d) or online at etf.wi.gov.

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**
- 507 Considerations When Both Spouses Are Employed by the State, the University of WI, or One or Both Are Annuitants**
- 508 Considerations When One Spouse is Employed by a Local Employer in the WPE Group Health Insurance Program or Other Non-State Employer**

501 Status Changes

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 (legally recognized in Wisconsin, refer to subchapter 403 B) 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 *Group 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 application *Group Health Insurance Application/Change Form* by the employer.

If the application to change plans is not received within 30 days following the move, the 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 *Group 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 qualifying 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,
- Has a previously covered 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 *Group Health Insurance Application/Change Form* (ET-2301) to the employer. Several events also allow the employee to change health plans under Internal Revenue Code Section 125.

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 domestic partner affidavit by ETF.

Upon marriage or domestic partnership between parties both employed by the state and/or the University of Wisconsin (or one is an annuitant), 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/domestic partner and any eligible dependents. Family coverage and single coverage cannot be held simultaneously, nor can coverage be maintained under two separate family contracts.

If there are two family plans or a family plan and a single plan, and the employee does not notify you of the marital status change within 30 days, the change to one family plan can only be done prospectively. The employee cannot request a change to single family retroactively.

If two single plans are held and family coverage is selected, the single plan not being converted to family coverage must be cancelled. The cancellation 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 *Group 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 *Group 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:** 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 *Group 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 the *Group 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). Coverage is effective the first of the month on or after receipt of the application **or** the date specified on the NMSN, if one is specified.

If 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.

In addition to the NMSN (serving as required documentation), the employee must also file a *Group Health Insurance Application/Change Form* (ET-2301) to add the children named in the order to coverage.

- **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 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 *Group 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 their premiums are deducted pre-tax and 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 *Group 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.

- **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 of the domestic partner.

Documentation to support the termination of domestic partner may be required as outlined in the *Group 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 an opposite-sex 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.

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, or their last dependent becomes eligible for other coverage. The application to change to single coverage must be submitted within 30 days of the date the dependent(s) enrolled in other coverage. If the application is not received within 30 days, the employee is limited to the annual It's Your Choice Open Enrollment period to remove these dependents.

Documentation to support the eligibility for the other coverage is required as outlined in the *Group 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. Several of these events also allow the employee to change health plans under Internal Revenue Code Section 125.

- **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 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 *Group 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 *Group 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. 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 *Group 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:** 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 *Group 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 not required to provide the coverage through your ETF administered plan and may provide coverage through other means.

Documentation supporting the NMSN is required as outlined in the *Group 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 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.

- **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 *Group 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 final decree of divorce being issued.

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 *Group 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 *Group Health Insurance Application/Change Form* to remove the DP.

If the employee is terminating the domestic partnership due to marrying their opposite-sex DP, they must submit a *Group 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 *Group Health Insurance Application/Change Form*.

- **Death of Dependent:** In the event of a dependent death, a *Group 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 MEBS (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.

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

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

- **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 *Group Health Insurance Application/Change Form*.

507 Considerations When Both Spouses Are Employed by the State, the University of WI, or One or Both Are Annuitants

If an employee's spouse or DP is an eligible state or University of WI employee or an annuitant, one may select family coverage that will cover all eligible tax dependents and any eligible non-tax dependents the employee chooses to cover.

If both an employee and their spouse or domestic partner are enrolled for single coverage, premiums are being deducted on a **pre-tax basis**, and they are not newly married or partnered, family coverage may only be elected effective at the beginning of the calendar year or when the employees have gained a dependent that necessitates family coverage. Annuitant premiums are deducted post-tax.

If premiums are being deducted on a **post-tax basis** and the employee and spouse or domestic partner both have single contracts, one of the single contracts may be changed to a family plan at any time without restriction and the other single contract will be cancelled. Family coverage will be effective the beginning of the month on or after receipt of an electronic or paper application, or a later date specified on the application.

If premiums for family coverage are deducted **pre-tax**, coverage can only be changed to single coverage effective the beginning of the calendar year or when the last dependent becomes ineligible for coverage or becomes eligible for and enrolled in other group coverage.

If premiums are deducted **post-tax**, one family policy can be split into two single plans with the same carrier effective the beginning of the month on or after receipt of an electronic or paper application, or a later date specified on the application from both spouses or domestic partners, provided both work for the state or are annuitants.

Note: A subscriber with family coverage that covers only a DP and/or other non-tax dependents such as a domestic partner's children can change to single coverage at any time because the non-tax dependent's coverage is taxed as imputed income and not subject to the federal regulations governing pre-tax deductions.

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

In addition to the information within subchapter 507, if the employee is insured under their spouse/domestic partner through a participating Wisconsin Public Employer or other non-state employer, and the employee dies, that individual's sick leave credits will not be available for use by the surviving dependents. Under a state family plan, sick leave credits are preserved for the surviving dependents regardless of who should die first.

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Chapter 6 — It's Your Choice Open Enrollment

- 601 It's Your Choice Open Enrollment Eligibility**
- 602 Withdrawing/Rescinding It's Your Choice Enrollment Elections**
- 603 When a Health Plan is not Available at *It's Your Choice***
- 604 Late It's Your Choice Applications**

601 It's Your Choice Open Enrollment Eligibility

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 to the other or one domestic partner to the other, or change from single to family or family-to-single coverage without limitations.

A. It's Your Choice Open Enrollment Period

The Group Insurance 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.

B. Participation in the It's Your Choice Open Enrollment Period

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

1. To enroll, the employee must be eligible for and enrolled in the WRS, or be a currently employed UW graduate assistant. If making a change, the employee must be currently insured in the State Employee Group Health Insurance Program; **and**
2. The employee must enter the change request online into the myETF Benefits system or provide the *Group Health Insurance Application* (ET-2301) to the employer within the designated It's Your Choice Open Enrollment period. Star Employer Agency employees must enter any Its Your Choice changes in the Star system.

C. Distribution of *It's Your Choice Reference and Decision Guide*

The *It's Your Choice Reference and Decision Guides* (ET-2107r and ET-2107d) provides information on important changes, health insurance rates, uniform benefits and plan availability for the plan year. The guides are forwarded to state agencies electronically prior to the It's Your Choice Open Enrollment period for distribution to all eligible employees, insured and uninsured (including those on leave of absence and layoff). There is a limited supply of paper *It's Your Choice Guides* available; employers are encouraged to direct employees to the electronic version found on ETF's website. The *It's Your Choice Guides* must be distributed in a timely manner.

D. 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 *Group Health Insurance Application/Change Forms* during their regular enrollment period. The first application will cover the period from the date of initial coverage through December 31. The second application will change to whatever health plan or coverage type is selected effective January 1, and must have the It's Your Choice box checked as the reason for submitting the application.

E. Employee's employment and/or health coverage ends after submitting an It's Your Choice election.

- If coverage ends on or prior to December 31, list the health plan that coverage is with as of the coverage end date on the *Continuation - Conversion Notice (ET-2311)*.
- List *It's Your Choice* elected health plan on *Continuation - Conversion Notice* if current coverage ends after January 31.

602 Withdrawing/Rescinding *It's Your Choice* Enrollment Elections

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

- Upon receipt of the written request to withdraw/rescind an application, the employer makes two photocopies of the *Group Health Insurance Application (ET-2301)* initially submitted by the employee during It's Your Choice and writes "Rescind" across each copy. Forward one copy of the application along with a copy of the employee's written request to withdraw/rescind the application to ETF. Retain the second copy of the application for the employer's records. ETF will update myETF Benefits by deleting the initial It's Your Choice request and reinstating the employee's coverage that was to end on December 31.
- If the employee entered their It's Your Choice change online and now wishes to withdraw/rescind their requested online change, the employee must notify their employer in writing (letter or e-mail) prior to the January 1 effective date. On receipt of the employee's written request to withdraw/rescind their online change, the employer will make a copy of the employee's letter and forward the copy to ETF while retaining the original copy for the employer's records. ETF will update MEBS by deleting the initial It's Your Choice request and reinstating the employee's coverage that was to end on December 31.
- Please note that 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 803).

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

When a plan is no longer available for the upcoming year, subscribers enrolled in that plan **must** make an It's Your Choice change online **or** submit a *Group Health Insurance Application (ET-2301)* during the It's Your Choice Open Enrollment period to enroll in a new

plan. Subscribers are notified by letter from the departing plan at the onset of It's Your Choice. Information on plans no longer available will also be included in the "Important Changes" section in the *It's Your Choice Decision Guide*.

Note: In some instances, such as a health plan service area merger, applications are not required and subscribers are switched automatically to a new plan. In the event a new application is not required, annual It's Your Choice *Employer Bulletins*, e-mail updates, and the *It's Your Choice Guides* will include instructions.

Subscribers whose plan will no longer be available and who fail to submit an application selecting an available plan during the It's Your Choice Open Enrollment period must apply through the late It's Your Choice application process to select a new health plan to continue coverage. Coverage is effective the first day of the calendar month on or after the date ETF receives the application.

604 Late It's Your Choice Applications

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

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

DIVISION OF INSURANCE SERVICES
EMPLOYEE TRUST FUNDS
P O BOX 7931
MADISON WI 53707-7931

These materials and information can also be scanned and e-mailed using encryption to: etfhealthandins@etf.wi.gov. The subject line should be titled "Late It's Your Choice Application".

7. ETF reviews the materials submitted and issues a letter within 30-60 days to the employee,

copying the employer, that the request was either approved or denied.

605 Late It's Your Choice Review Sample Letter

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

(DATE)

(EMPLOYER NAME AND ADDRESS IF NOT ON THE LETTERHEAD)

Dear (EMPLOYEE NAME):

- Your It's Your Choice health insurance application is being returned to you by our office because it was not received timely. You may request a review of your late application by the Department of Employee Trust Funds through the following process:
- Prepare a written request detailing the circumstances and facts surrounding the reason for your late application and the remedy you are seeking.
- **Submit your written request to our office at the address noted above by January 31.** Do **not** submit your request directly to the Department of Employee Trust Funds.
- We will review your request for completeness and attach any pertinent documentation.
- We will submit your request, your health insurance application, and other documentation to the Department of Employee Trust Funds for review.
- The Department of Employee Trust Funds will review the materials and issue you a letter either approving or denying your request.

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

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Chapter 7 — Leave Of Absence

- 701 Definition of a Leave of Absence**
- 702 Employer Contribution Toward Health Insurance Premium While on an Unpaid Leave of Absence**
- 703 During an Unpaid Leave of Absence (Non Military) - Coverage Does Not Lapse While on a Leave of Absence**
- 704 Coverage During an Unpaid Leave of Absence (Non Military) - Coverage Lapses While on a Leave of Absence**
- 705 Coverage During Military Leave of Absence**
- 706 Coverage During Layoff**
- 707 Coverage During Appeal of Discharge**

701 Definition of a Leave of Absence

Wis. Stat. § 40.02 (4) “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.

A leave of absence (LOA) is not deemed ended or interrupted by reason of resumption of active duty until the employee has resumed active performance of duty for 30 consecutive calendar days for at least 50% of what is considered that employee’s normal work time with that employer. An employee on LOA is subject to the same eligibility and enrollment provisions as an active employee.

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

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

- (a) Only for the initial three months of the leave of absence, except as provided in subd. 3b.
- (b) Unless otherwise provided in the compensation plan under s. 230.12, for the entire leave of absence if the insured employee is receiving temporary disability compensation under s. 102.43.”

Note: Employee also receives the employer contribution toward health insurance premium that was prepaid prior to going out on a LOA in addition to receiving the employer contribution for the initial three months following any prepaid month. For example, an employee goes on a LOA effective September 1. The employer and employee premium has been paid one month in

advance. The employer paid premium will continue for the months of October, November and December.

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

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

- A. Employee returns to active performance of duty and their LOA ends **within the first four months** after beginning a LOA. The following applies to employees returning to active performance of duty:
- No application is required upon resumption of active duty.
 - Employer must track when the employee meets the criteria of a LOA ending under § 40.02 (40).
 - Employer must set the expectation with the employee regarding when a LOA ends and the use of leave time.
 - Employee cannot use leave time to satisfy the criteria ending a LOA under § 40.02 (40)
 - Leave time cannot be used to satisfy the 50% return to work criterion, but this does not prevent an employee from using leave time to supplement their work schedule.
 - Employer deducts employee-required premium contribution from employee's check.

Example:

- Employee goes out on a LOA January 15.
 - Employee eligible for employer contribution toward the health insurance premium for the prepaid coverage month of February plus March, April and May under Wis. Stat. § 40.05 (4) (a) 3.
 - Employee returns to active performance of duty on April 1.
 - LOA ends May 1, upon completing the criteria under Wis. Stat. § 40.02 (40).
 - Employee continues to receive the employer contribution toward the health insurance premium for the coverage month of May.
- B. Employee returns to active performance of duty and the LOA ends **more than four months** after beginning the LOA. The following applies to employees returning to active performance of duty:
- No application is required upon resumption of active duty.
 - Employer must track when the employee meets the criteria of a LOA ending under § 40.02 (40).
 - Employer must set the expectation with the employee regarding when a LOA

ends, the use of leave time, and when they will become eligible for the employer contribution toward the health insurance premium.

- Employee cannot use leave time to satisfy the requirements ending a LOA under § 40.02 (40).
- Leave time cannot be used to satisfy the 50% return to work criterion, but this does not prevent an employee from using leave time to supplement their work schedule.
- The employee becomes eligible for the employer contribution toward the health insurance premium for the coverage month in which the LOA ended.
- Employer deducts or collects the full monthly premium from the employee until the LOA ends. Employee receives a refund of any employer contribution paid by the employee for the month in which the LOA ended.

Example:

- Employee goes out on a LOA October 2.
- Employee eligible for employer contribution toward the health insurance premium for the prepaid coverage month of November plus December, January and February under Wis. Stat. § 40.05 (4) (a) 3.
- Employee pays full premium, no employer contribution, beginning with the coverage month of March.
- Employee returns to active performance of duty on March 20.
- LOA ends April 19; Wis. Stat. § 40.02 (40).
- Employee is eligible for the employer contribution toward the health insurance premium for the coverage month of April, the month the employee's LOA ends.
- Since the total premium has been paid by the employee prior to the coverage month of April, the employee is due a refund of the employer contribution toward the health insurance premium.

C. Additional information regarding employees continuing health insurance coverage during an approved LOA.

- The maximum length of time coverage can be continued for an employee on LOA is 36 months. After 36 months, or upon termination (whichever occurs first), coverage may be continued under continuation coverage (COBRA) regulations. (Refer to Chapter 9 for information about COBRA.)
- Premiums must be paid by the employee in advance, either by deduction from the last payroll check or by direct payment to the employer. Employers must receive premium payments in advance of the coverage month.
- The State contribution toward premium payment continues for the initial three months of the LOA for which premiums have not already been deducted as of the date the LOA begins. This will result in a total of up to four months (after the LOA begins) of employer contribution towards premiums. For the remaining months of the LOA, the employee must pay the entire premium; there is no employer contribution after the initial three months.

- Employees on LOA are included along with active employees on the employer's monthly invoice. Any payments received from employees on LOA should be made payable to the employer and included in the employer's monthly invoice payment to ETF.
- Employers must provide It's Your Choice information to employees on LOA prior to the beginning of the designated It's Your Choice Open Enrollment period.
- An employee on a union-service leave may continue coverage beyond 36 months until termination of the leave or the date that service with the labor organization ceases, whichever occurs first.

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

Insured employees on an unpaid leave of absence (LOA) can choose to allow their health insurance coverage to lapse during their LOA.

- A. Employee allowed their health insurance coverage to lapse while on LOA. The following applies upon returning to active performance of duty:
- Employee must complete and submit an application to the employer within 30 days after resumption of active performance of duty to enroll in coverage.
 - Employee must indicate coverage to be effective "As Soon As Possible" or "When the Employer Contributes toward Premium" on the application.
 - Employee elects "As Soon As Possible" – coverage is effective the first of the month on or following the employer application receive date.
 - Employee becomes eligible for the employer contribution toward the health insurance premium for the coverage month the LOA has ended.
 - Employer will deduct or collect the full monthly premium from the employee until the LOA ends. Employee receives a refund of any employer contribution paid by the employee for the month in which the LOA ended.
 - Employee elects "When the Employer Contributes toward Premium" – coverage is effective the first of the month on or following when the employee becomes eligible for the employer contribution toward the monthly premium.
 - Employer must track when the employee meets the criteria of a LOA ending under § 40.02 (40).
 - Employer must set the expectation with the employee regarding when a LOA ends, the use of leave time, and when they will become eligible for the employer contribution toward the health insurance premium.
 - Employee cannot use leave time to satisfy the criteria ending a LOA under § 40.02 (40).

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

Examples:

- Employee elects coverage to be **effective as soon as possible**:
 - Employee goes out on a LOA June 10.
 - Employee eligible for employer contribution toward the health insurance premium for the prepaid coverage month of July plus August, September and October. Coverage ends/lapses October 31.
 - Employee returns to active performance of duty on February 1.
 - Employee submits an application to enroll in coverage that is received by the employer on February 1. Employee elects coverage to be effective as soon as possible.
 - Coverage is effective February 1.
 - LOA ends March 3; Wis. Stat. § 40.02 (40).
 - Employee must pay the entire premium for the coverage month of February.
 - Employee is eligible for the employer contribution toward the health insurance premium for the coverage month of March, the month the employee's LOA ends.
 - Since the total premium has been paid by the employee prior to the coverage month of March, the employee is due a refund of the employer contribution toward the health insurance premium.

- Employee elects coverage to be **effective when the employer contributes** toward premium:
 - Employee goes out on a LOA June 10.
 - Employee eligible for employer contribution toward the health insurance premium for the prepaid coverage month of July plus August, September and October. Coverage ends/lapses October 31.
 - Employee returns to active performance of duty on February 1.
 - Employee submits an application to enroll in coverage that is received by the employer on February 1. Employee elects coverage to be effective when the employer contributes toward premium.
 - LOA ends March 3; Wis. Stat. § 40.02 (40).
 - Employee becomes eligible for the employer contribution toward premium on March 3.
 - Coverage is effective April 1, first of the month on or after becoming eligible for the employer contribution toward premium.
 - Employee is only required to pay the required employee share of the monthly premium for the coverage month of April going forward.

- Additional information regarding employees whose health insurance coverage lapsed during an approved LOA:
 - The employee may change level of coverage if a status change (e.g., marriage, birth, etc.) occurred during the LOA. (Refer to Chapter 4, subchapter 403 for information about other enrollment opportunities.) Employees may change health plans if the change results from a move to a different county during the LOA.
 - An employee who allows coverage to lapse and returns from a LOA that encompassed

the entire previous It's Your Choice Open Enrollment period will be allowed an It's Your Choice enrollment opportunity provided an application is filed with the employer within 30 days of the employee's return to active performance of duty.

- The coverage effective date for employees returning from military leave or Family Medical Leave of Absence (FMLA) is the date the employee returns to work provided an application is filed with the employer within 30 days of the employee's return to work. A full month's premium is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire premium for that month is waived.

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

- FMLA spans the end of one calendar year and continues into the next year (twelve weeks of one year ending December 31st and twelve weeks beginning January 1st of the next year): The effective date is the date the employee returns to work, as long as it is not beyond the allowable twelve weeks for the current calendar year.
Note: FMLA is based on a calendar year and cannot exceed a twelve-week period in any given calendar year.
- An employee on FMLA exceeds the twelve-week calendar year limit and elects to continue the leave using leave without pay: The effective date of the employee's reinstatement in the Group Health Insurance Program is the first of the month on or after the employer's receipt of the employee's health insurance application after completing 30 consecutive calendar days for an accumulation of hours of at least 50% of their appointed employment.

705 Coverage During Military Leave

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

Employees not remaining on payroll while on military leave must make employee-paid premium share contributions directly to the employer. Wis. Stat. § 230.315, created by Act 162, lists three criteria to be met by a state employee activated to serve on military duty in order to receive pay differential, accrue sick leave and paid annual leave, and receive other employee benefits as though no interruption of service occurred:

1. Be activated to serve on military duty or in the U.S. Public Health Service, other than for training purposes, on or after January, 1, 2003; and
2. Serve as a member of the Wisconsin National Guard, a reserve component of U. S. armed forces, or recalled to active military duty from inactive reserve status; and
3. Receive a military leave of absence under Wis. Stat. § 230.32 (3) (a) or 230.35 (3), under a collective bargaining agreement, under rules promulgated by the Office of State Employment Relations, or be eligible for reemployment under the provisions of Wis. Stat. § 45.50.

The employee or designated representative may elect within 60 days after being activated to receive benefits resulting from this legislation by completing the *Health Insurance Election for Military Service Personnel* (ET-2350). The employer must receive this form within 60 days after the employee is activated.

Employees who prefer to rely solely on military provided health care and family health insurance may elect to cancel state coverage. Upon release from active duty, return to employment and within 30 days of the loss of the military coverage—loss of coverage is defined as an “event”—the employee may reinstate their state health insurance coverage (same health plan and same coverage level) without prejudice by filing a *Group Health Insurance Application* (ET-2301). The coverage effective date is the day following the last day of the military coverage. Employees who are not eligible for the employer premium share when called to active duty, but who become eligible while on military leave, have 30 days from the date of their return to employment to file a health insurance application.

706 Coverage During Layoff

Coverage may be continued during layoff with the following conditions:

- The state contribution is available for the first three months of layoff for which premiums have not already been deducted. After that, the employee is responsible for the entire premium.
- Employee may continue coverage for up to five years using converted sick leave to pay premiums until the sick leave credits are exhausted followed by 36 months under continuation provisions. In the event that sick leave conversion credits are used, the full amount of the required employee premiums is deducted from the credits until the credits are exhausted, the employee is re-employed, or five years elapse from the date of the layoff. The use of sick leave during layoff is the record-keeping responsibility of the employer. The employee is reported to ETF the same as any other employee on layoff who is continuing their coverage. (For more information on sick leave, refer to Chapter 12 - Accumulated Sick Leave Conversion Credits.)
- Premiums must be paid in advance, either by deduction from the last paycheck or by direct payment to the employer. Payments must be received by the employer prior to the period of coverage.
- Employees on layoff are reported along with your active employees and employees on LOA. Any payments received from employees on layoff should be made payable to the employer and included in your monthly remittance to ETF.
- If an employee is on layoff during an entire It's Your Choice Open Enrollment period, the employee must be given an It's Your Choice opportunity. It's Your Choice information should be sent to those employees who are on layoff prior to the beginning of the designated It's Your Choice Open Enrollment period.

The following apply to employees on layoff status who allow health insurance coverage to lapse and choose to reinstate coverage upon return to work:

- The employee must submit a *Group Health Insurance Application* (ET-2301) and is limited to the same health plan and level of coverage as before the layoff. The application must

be received within 30 days of the employee's return to work. Coverage is effective the first of the month following the employer's receipt of the completed *Group Health Insurance Application*. After 30 days, enrollment is limited to the It's Your Choice Open Enrollment period or if there is another qualifying event that occurs.

- The employee may change level of coverage only if a special enrollment opportunity (e.g., marriage, birth, etc.) occurs during the layoff. (Refer to Chapter 4, subchapter 403 for information about special enrollment opportunities.)
- Employees moving to a different health plan service area during a layoff may change health plans.
- An employee who returns from a layoff that encompassed the entire previous It's Your Choice Open Enrollment period will be allowed an open enrollment opportunity provided an application is filed with the employer within 30 days of the employee's return to work.

707 Coverage During Appeal of Discharge

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:

- The employer must receive the first premium payment within 30 days of discharge.
- Future premium payments must be made through the employer and must be received in advance of the coverage month.
- The employee must pay both the employee and employer share of premium due each month until the appeal is resolved.

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

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

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

If the discharge is for reasons other than gross misconduct, the employee is eligible to continue health insurance for the balance of 18 months from the original termination date (the balance of the continuation period). If the discharge is for gross misconduct, the employee is eligible for conversion coverage and should contact the health plan for information on benefits, rates and policy provisions. (Refer to Chapter 9 for information about continuation and conversion.) A *Continuation-Conversion Notice* (ET-2311) must be provided to the employee using the original discharge date.

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CHAPTER 8 —Cancellation and Termination of Coverage

801 Ending Coverage

802 Changing From Active to Annuitant Coverage

803 Voluntary Cancellation of Coverage

801 Ending Coverage

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

Active coverage may be ended for an employee based upon an employee's request to complete a spouse-to-spouse transfer, death of the subscriber, disability approval (non-ICI), retirement, termination of employment or employee's request to cancel coverage. The ending of an employee's coverage will be reported on the Monthly Employer Invoice. (Refer to Chapter 15 regarding instructions and information on the Monthly Employer Invoice.)

Reason	Coverage End Date	Comments
Cancel Coverage	Refer to subchapter 803	Employee is voluntarily ending coverage. Refer to subchapter 803 regarding Internal Revenue Code (IRC) Section 125 pre-tax and post-tax requirements. If employee does not pay required premiums while out on a leave of absence (LOA), this is a cancellation, voluntarily ending coverage.
Termination of Employment	End of the calendar month in which the employee terminates employment.	Employee's coverage is an involuntary loss of coverage. If employee is terminating employment because they are retiring, going on an unpaid LOA or on permanent layoff, but is not starting an immediate annuity, refer to Chapter 12 regarding reporting sick leave.
Cancel Spouse-To-Spouse Employment	Refer to subchapter 803	Employee voluntarily ending coverage. Cannot complete a cancellation mid-year without an allowable status change under the plan language (contract) or HIPAA qualifying event if premiums are deducted pre-tax.

Reason	Coverage End Date	Comments
Disability Approval (Non-ICI)	Coverage is continued as an annuitant without lapse upon approval of a disability benefit.	This is an employer entry in 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 802. Also refer to Chapter 12 for reporting sick leave.
Retirement	Coverage is continued as an annuitant without lapse upon retirement if an employee retires with an immediate annuity.	Requires an employer entry in myETF Benefits. No application is required from employee. Enter the number of available sick leave hours and pay rate for the member terminating coverage. ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs. Refer to subchapter 802. Also refer to Chapter 12 for reporting sick leave.
Death of Subscriber with Single Coverage	End of the calendar month in which the death occurred.	Refund any premiums paid in advance for coverage beyond the end of the month in which death occurred.
Death of Subscriber with Family Coverage	Coverage under the employee's contract continues through the last day of the month for which the premium was deducted.	Do not refund any premiums unless authorized by ETF. Refer to Chapter 12 for reporting sick leave. Refund may be due if coverage was paid for the next month.

802 Changing from Active to Annuitant Coverage

Retiring insured employees are eligible to continue health coverage under any of the following conditions: (Refer to Chapter 10)

- Employee receives an immediate annuity upon retirement (monthly or lump sum benefit), WRS disability, or Long-Term Disability Insurance benefit.
- Employee terminates after age 55 (50 for protective category employees) with at least 20 years of creditable WRS service, but does not take an immediate retirement annuity.

When an employee retires, the employer must end their coverage in myETF Benefits. They must also complete the required entry in the Accumulated Sick Leave system (AcSL) in myETF Benefits (Refer to Chapter 12).

803 Voluntary Cancellation of Coverage

When an employee wishes to cancel coverage for any of the reasons listed in subchapter 801, they cannot complete their request mid-year without an eligible family status change that is allowed under the plan language (contract) or a HIPAA qualifying event if the employee premium is being deducted on a pre-tax basis under Internal Revenue Code (IRC) Section 125.

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

Event	Eligibility Requirements	Coverage End Dates	Comments
Move from Service Area	<i>Health Insurance Application</i> (ET-2301) or myETF Benefits request must be submitted within 30 days of the move from the service area date.	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 cancellation request is always the end of a month. Retroactive cancellations are not allowed.
Pre-Tax Employee Terminating Employment	<i>Health Insurance Application</i> 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 cancellation request is always the end of a month. Retroactive cancellations are not allowed.

Event	Eligibility Requirements	Coverage End Dates	Comments
<p>Pre-Tax Employee Going on an Unpaid LOA</p>	<p><i>Health Insurance Application</i> 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.</p>	<p>End of the month following receipt of the application/myETF Benefits request or the event date, whichever is later.</p>	<p>An employee who continued coverage during a LOA is eligible to receive the employer share of the monthly premium for the one coverage month premiums were pre-paid plus three additional months. Once the employee is paying the employer share of the premium or the entire premium post-tax, coverage can be canceled at the end of any month following receipt of an application/request. Coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.</p>

Event	Eligibility Requirements	Coverage End Dates	Comments
<p>Pre-Tax Family Status Change</p>	<p>An allowed family status change under the plan language (contract) or a HIPAA qualifying event must occur.</p> <p><i>Group Health Insurance Application/Change Form</i> or myETF Benefits request must be submitted within 30 days of the IRC Section 125 status change, the event.</p>	<p>End of the month following receipt of an application/myETF Benefits request or the event date, whichever is later.</p>	<p>Refer to Chapter 5 for status changes allowed under the plan language (contract) and HIPAA qualifying events.</p> <p>Documentation may be required.</p> <p>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.</p> <p>Coverage end date for a cancellation request is always the end of a month.</p> <p>Retroactive cancellations are not allowed.</p>

Event	Eligibility Requirements	Coverage End Dates	Comments
Pre-Tax Employee Premium Contribution Has Increased Significantly	<i>Health Insurance Application</i> 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 cancellation request is always the end of a month. Retroactive cancellations are not allowed.
Pre-Tax Employee (and all dependents, if applicable) Became Eligible for and Enrolled in Other Group Coverage	<i>Health Insurance Application</i> or myETF Benefits request must be submitted within 30 days of the date the other coverage became 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, enrollment acknowledgment. Coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.
Pre-Tax Annual It's Your Choice Open Enrollment Period	<i>Health Insurance Application</i> or myETF Benefits request must be submitted during the It's Your Choice Open Enrollment Period.	Coverage end date is December 31.	Based on plan language (contract), coverage can be cancelled 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
<p>Premiums Deducted Post Tax</p>	<p><i>Health Insurance Application</i> or myETF Benefits request must be submitted.</p>	<p>Coverage end date is the end of the month following the application received date or the myETF Benefits request date. 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.</p>	<p>An application can be submitted requesting a future cancellation date other than the end of the month following receipt of the application. Coverage can be canceled mid-year. Coverage end date for a cancellation request is always the end of a month. Retroactive cancellations are not allowed.</p>

**Department of Employee Trust Funds
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Chapter 9 – COBRA, Continuation and Conversion

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901 Overview of COBRA, Continuation and Conversion

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), participants and their eligible dependents covered under the State Group Health Insurance Program have options available to them for the continuation or conversion of health insurance coverage in the event eligibility for group coverage ends. COBRA requires that the State Group Health Insurance Program offer subscribers (employees/members) and their covered dependents (qualified beneficiaries) temporary extension of identical coverage at the group rate for a maximum of 18 months (36 months under certain circumstances) following specific events, referred to as “qualifying events” (refer to subchapter 902). The following provides an overview of Continuation and Conversion.

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 Wisconsin Group Insurance Board (GIB) to reinforce and broaden continuation rights under certain circumstances (e.g., to include domestic partners).

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.

Conversion:

Conversion coverage is available to participants who have been covered under the State Group

Health Insurance Program under terms negotiated with the health plan. Participants may elect to convert to 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.

902 Persons Eligible for Continuation (Qualified Beneficiaries)

Under federal and state laws, when group health insurance coverage would otherwise end because of a life event known as a “qualifying event,” employees and their covered dependents become “qualified beneficiaries” and must be offered continuation coverage (refer to subchapter 905 for employer responsibilities).

- A. Employees must be offered continuation coverage in the event coverage is lost due to either of the following events:
- Termination of employment (for reasons other than gross misconduct), including retirement. The exception is when an employee retires and elects to take an immediate annuity and to continue health insurance. (Refer to Chapters 10, 11, and 12).
 - Completion of the maximum prepayment periods of 36 months while on a leave of absence or layoff. (Refer to Chapter 7).
- B. The spouse/domestic partner of an employee with family coverage in the State Group Health Insurance Program becomes a qualified beneficiary as a result of any of the following qualifying events:
- Death of spouse/domestic partner (employee). (Refer to Chapter 14 on Employee Death.)
 - Divorce. Coverage as a dependent spouse continues until the later of:
 - The end of the month in which the employer provides notification of continuation rights (*Continuation - Conversion Notice* [ET-2311]). (Refer to subchapter 903.)
 - or**
 - The end of the month in which the divorce is entered/final.
 - Termination of domestic partnership. Coverage as a domestic partner ends at the end of the month after the partnership is terminated.
 - Spouse/domestic partner (employee) loses coverage for reasons listed above under section A.
- C. Each eligible dependent child of an employee with family coverage in the State Group Health Insurance Program becomes a qualified beneficiary as a result of any of the following qualifying events:
- Death of parent/stepparent or parent/stepparent’s domestic partner (employee; refer to Chapter 14 on Employee Death).
 - Dependent eligibility status ceases under the State Group Health Insurance Program

(Refer to the chart in subchapter 906 for examples).

- Parents become divorced resulting in loss of eligibility.
 - Parent/step-parent and their domestic partner end a domestic partnership resulting in loss of eligibility.
 - Parent (employee) loses coverage for reasons listed above in A.
- D. An eligible dependent of a minor dependent of an employee with family coverage in the State Group Health Insurance Program becomes a qualified beneficiary when losing eligibility as a result of the minor dependent turning age 18. Coverage for the dependent of a minor dependent terminates at the end of the month in which the dependent child turns 18.
- E. An eligible disabled dependent, over age 26, of an employee with family coverage in the State Group Health Insurance Program becomes a qualified beneficiary upon loss of disabled status. Coverage terminates at the end of the month in which it is determined the disabled status ceases.

Note: When a voluntary change in coverage from a family plan to a single plan is done in anticipation of a divorce, the spouse and dependent children are eligible for continuation coverage when the divorce is final. The effective date for continuation coverage in this case is the date of the entry of the judgment of divorce. This is usually when the judge signs the divorce papers and the Clerk of Courts date-stamps them. In all other cases, voluntary cancellation does not create a continuation enrollment opportunity.

903 Employee Responsibilities

Employees and/or the qualified beneficiaries (refer to subchapter 902) are responsible for informing the employer of a qualifying event in which an employee and/or dependent loses eligibility for coverage under the State Group Health Insurance Program.

Under Federal COBRA law, if the employer is not notified within 60 days of the:

- event that caused the loss of coverage, or
- end of the period of coverage,

whichever is later, the right to continuation coverage is lost. Under state continuation law, separate requirements may allow notification after the 60-day period in limited divorce circumstances.

In the event of a divorce, if an employee does not notify their employer of their divorce, coverage for the ex-spouse and any stepchildren continues if the family premium continues to be paid. The ex-spouse must then be given the right to continue coverage even if notice is given beyond 60 days following the divorce. Should the employee fail to advise the employer of divorce within 60 days of the event, the employer must provide notice to stepchildren that they are ineligible to continue coverage as a qualified beneficiary of the employee as soon as possible. Coverage terminates the end of the month in which the employer provides the notice of the right to continue coverage (*Continuation - Conversion Notice* (ET-2311)) to the ex-spouse and any stepchildren or children of minor stepchildren. In this situation, employers must check with ETF on the length of continuation coverage that is available.

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

Note on terminations of domestic partnerships: Former DPs are also eligible to elect a single contract or a family contract with eligible dependents also losing coverage. Dependents of DPs are treated like stepchildren (or their dependents' children if that dependent is a minor) in the same way as indicated in the paragraph above. Coverage of former DPs (and dependents) will only extend through the end of the month the partnership terminates; the employer notification date will not affect the end date of coverage. DPs lose continuation rights if notice of termination is not received within 60 days.

904 Qualified Beneficiary Responsibilities

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

- Submitting the *Continuation - Conversion Notice* (ET-2311) and the *Group Health Insurance Application* (ET-2301) to ETF. Both forms (an employee need only submit a *Continuation - Conversion Notice* unless requesting a change in coverage) must be sent to ETF (that is, postmarked) no later than 60 days from the termination of their coverage or within 60 days of the date they were notified by their employer, whichever is later. If qualified beneficiaries do not elect continuation coverage within the 60-day period, they lose eligibility to enroll under continuation.
- Paying premium to the health plan when billed by the health plan.
- 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.
- Subscribers and their insured dependents continuing coverage must enroll in Medicare Parts A and B when initially eligible. A copy of the Medicare card must be submitted to ETF. COBRA coverage ends when the subscriber or dependents enroll in Medicare Parts A and B. If Part B becomes effective after the continuation begins, the continuation period ends at the end of the month prior to when Medicare Parts A and B become effective.

905 Employer Responsibilities

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

- *Continuation - Conversion Notice* (ET-2311), with the employer sections completed.
- *Group Health Insurance Application* (ET-2301). This form is needed to enroll in continuation or conversion. The employee does not need to complete the application if continuing the coverage already in effect. The employee must still complete and return the *Continuation - Conversion Notice*.

Note: A continuation notice must be provided within the five-day period even when it is determined the qualified beneficiary is not entitled to continuation coverage, for example, notice of the qualifying event was not provided to the employer within the required time period. (Refer to subchapter 906 for information on providing notice.)

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

- If electing continuation coverage, the completed *Continuation - Conversion Notice* and *Group Health Insurance Application* forms must be sent to ETF (i.e., postmarked) no later than 60 days after the date of the notice or 60 days after coverage ends, whichever is later.
- If electing continuation coverage, the health plan will bill the continuant(s) directly.
- If electing continuation coverage and the continuants are moving or will move to a different county for more than three months, they are eligible to change to another health plan without restrictions, provided the application is received within 30 days after the move. The application must be returned to the employer if the change would be effective before the termination of coverage paid through the employer; otherwise, the application must be returned to ETF.

Note: When entering a coverage end date in myETF Benefits for the employee's coverage or the end date for any specific dependent on the employee's contract through 'Remove Dependent', enter an end date that is the end of the month following the event. There is an exception to this when removing the subscriber's spouse due to divorce (refer to subchapter 903).

906 Notice Requirement Illustration Chart

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

Event	Occurs	Coverage Continues Until	Employee or Beneficiary Must Notify Employer By	Employer Must Provide Continuation Notice By	To Elect Continuation, Application Must Be Submitted To ETF By
Child (or stepchild, DP's dependent) turns 26 and is not disabled.	3/15	3/31	05/30	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.
Dependent of Minor Eligibility Ends as Dependent turns 18	03/15	03/31	05/30	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.

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 notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.
Divorce Decree is Entered	03/15	End of the month in which continuation notice is given	05/30 If continuation notice is given late, check with ETF.	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.
Domestic Partnership is terminated	03/15	03/31	05/30 If continuation notice is given late, check with ETF.	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.
Employee Terminates Employment	03/15	03/31	05/30	5 days after receipt of notice	The later of 60 days after coverage terminates or 60 days after employer issues ET-2311.

907 Continuation Coverage Information

The benefits and limitations of coverage under continuation are identical to those provided to active employees. Participants enrolled in continuation coverage (continuants) must select the health plan already in effect at the time of termination of active coverage. Should the qualified beneficiary not reside in the same county as the subscriber, the qualified beneficiary may elect a health plan in their county of residence when enrolling in continuation coverage, even if the subscribers health plan is available in the qualified beneficiary's county. Continuants are allowed to change health plans during the annual It's Your Choice Open Enrollment period or following a residential move out of the county.

Continuation coverage may be in effect for up to 18 (sometimes 36) months. However, continuation coverage may be terminated early and cannot be reinstated for any of the following reasons:

- The premium for continuation coverage is not paid when due.
- The subscriber becomes covered under another group health plan; a subscriber who refuses health insurance offered by another employer will not be affected.
- A spouse is divorced from a covered employee and subsequently remarries and is covered through the new spouse's group health plan.
- Qualified beneficiary voluntarily cancels continuation coverage.

Continuants may elect to convert to individual coverage (conversion at non-group rates) upon reaching the maximum continuation coverage period. Continuants are responsible for knowing when group continuation coverage ends and must contact their health plan directly to make application for conversion coverage as provided by the health plan.

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Chapter 10 — Retirement, Disability or Long-term Disability Insurance

1001 Coverage – Requirements to Continue

1002 Coverage for Former State Employees Whose Coverage Lapsed

1003 Premium Payment

1001 Coverage – Requirements to Continue

Coverage under the State Group Health Insurance Program may be continued when an employee is eligible for a retirement benefit or applies for a Wisconsin Retirement System disability or Long-Term Disability Insurance (LTDI) benefit upon termination of employment. In addition, subscribers and their insured dependents who are continuing coverage must enroll in Medicare Parts A and B when first eligible. This is required by state statute, as the State Group Health Insurance Program is designed to integrate with, rather than duplicate, Medicare benefits. The group health insurance coverage will be converted to a plan that is integrated with Medicare effective on the first of the month in which the member is required to be enrolled in Medicare. The amount of the monthly premium will be reduced accordingly. Retrospective adjustments to premiums are limited to the shortest retroactive enrollment limit set by Medicare (90 days), in accordance with the Group Health Insurance Program contract.

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

Retirement Benefit

Group health insurance coverage will automatically be continued if the employee retires on an *immediate annuity*. 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. (Refer to Chapter 12 regarding the Accumulated Sick Leave Conversion Credit program.)

Health insurance coverage automatically continues for state employees upon retirement. If the retiring employee does not wish to continue health insurance coverage after retirement and wants to cancel coverage, ***ETF must receive that notification in writing with the member's signature PRIOR to their active employee coverage ending.*** If the retiring employee wishes to escrow/bank their unused sick leave credits upon retirement, they must contact ETF for information and a *Sick Leave Escrow Application* (ET-4305).

Disability or LTDI Benefit

Insured employees applying for a WRS disability or LTDI benefits must pre-pay premiums through their employers until their WRS disability or LTDI benefit is approved by ETF, or else coverage will lapse.

Employees who are on an unpaid leave of absence immediately prior to termination, and whose coverage has lapsed due to non-payment of premiums, can reinstate coverage if an immediate WRS disability or LTDI benefit is taken. Once the WRS disability or LTDI benefit is approved, ETF will send the employee a letter and a *Group Health Insurance Application* (ET-2301) offering lifetime coverage under the State Group Health Insurance Program. The *Group Health Insurance Application* must be received by the deadline provided in the letter (30 days from the date of the letter). ETF will notify the employer when a disability or LTDI benefit is approved. The employer will then need to terminate the employee from active coverage. (Refer to Chapter 8.)

Termination with 20 Years of WRS Service; Not Taking Immediate Annuity

Group coverage can be continued when terminating after age 55 (50 for protective category employees) when the employee has at least 20 years of WRS creditable service, even if an immediate retirement annuity is not taken. The employee completes and submits a *Continuation – Conversion Notice* (ET-2311) to ETF at the time of the employee's termination. (Refer to Chapter 9.)

Termination before Minimum Retirement Age with 20 Years of Service

Insured state employees leaving state service before reaching minimum retirement age (therefore, not eligible for an immediate annuity) with at least 20 years of WRS creditable service who do not close their WRS account may continue coverage under the State Group Health Insurance Plan indefinitely. These employees are required to pay the full premiums. They cannot use sick leave credits to pay premiums or apply to escrow their sick leave credits until they later apply for their retirement annuity. At the time of termination the employer certifies the retiring employee's sick leave, but it is "suspended" or held until it is escrowed upon application for retirement (refer to Chapter 12). The employee must complete a *Continuation-Conversion Notice* and a *Group Health Insurance Application* if they wish to continue coverage until they formally retire.

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

1002 Coverage for Former State Employees Whose Coverage Lapsed

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

- Currently receiving a monthly annuity or took a lump sum annuity payment from the WRS.
- Terminated state employment before reaching their minimum retirement age of 55 (50 for protective category employees) with at least 20 years of WRS creditable service.

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

1003 Premium Payment

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

- **Sick leave credits** - From sick leave credits until exhausted, Wis. Stat. § 40.05 (4) (b). Sick leave credits may be escrowed at the time of retirement if the employee is covered under comparable non-state health coverage. The employee should contact ETF for information and a *Sick Leave Escrow Application* (ET-4305).
- **Annuity Deduction** - Premiums are paid from a monthly retirement or disability annuity if the annuity is sufficient to cover the entire premium.
- **Direct Pay** - When the annuity is not sufficient to cover the entire premium, the health plan will directly bill the annuitant, and the annuitant will pay premiums directly to the health plan.
- **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).

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Chapter 11 — Rehired Annuitants

1101 Eligibility

1102 Coverage

1103 Disability Annuitants

1101 Eligibility

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

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

In the event a rehired annuitant elects to return to active WRS coverage or is statutorily required to return to active WRS coverage, the annuity is suspended effective the first of the month following ETF's receipt of the *Rehired Annuitant Form* (for annuitants electing coverage) or the first of the month following the rehired date (for annuitants with WRS termination dates on or after July 2, 2013) until the employee again retires and reapplies for an annuity. Under either scenario, annuitants returning to active WRS participation are immediately eligible to apply for health insurance coverage through the state agency. Any remaining accumulated sick leave conversion credits are suspended until the employee subsequently retires again. Additional sick leave accrued from state employment after the employee again participates in the WRS is added to their existing sick leave balance when retiring again. **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.

A rehired annuitant returning to active WRS participation is only eligible for health insurance coverage through the active employer. There is no option to continue the group health insurance coverage they held as a WRS annuitant. An annuitant rehired by a WRS participating employer not offering health insurance to its employees will lose group health insurance coverage as an annuitant. In other words, regardless of whether an employer participates in the Group Health Insurance Program or not, an annuitant returning to active WRS coverage is no longer eligible for annuitant health coverage. Eligibility for annuitant health insurance is retained only when a rehired annuitant does not elect to return to active WRS participation or the position is not expected to require two-thirds of full-time hours (880 hours for teachers, 1,200 hours for all others) and last at least one year, i.e., their WRS annuity is not suspended due to returning to work.

1102 Coverage

Upon receipt of the *Rehired Annuitant Form* (ET-2319), ETF will determine both the WRS participation begin date and the WRS annuity suspension date, then will notify both the annuitant and employer. For an employee who was insured as an annuitant, health insurance coverage through the active employer becomes effective the day after the coverage as an annuitant lapses.

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

As premiums paid through the annuity are deducted one month in advance, insurance is paid for one month beyond the annuity suspension date. Premiums paid through the annuitant's accumulated sick leave conversion account are also paid one month beyond the annuity suspension date. ETF will assist the employer in determining the date the rehired annuitant should be added to active coverage on the monthly additions report. A *Group Health Insurance Application* (ET-2301) electing coverage must be received by the employer within 30 days following the WRS participation begin date. When the employee retires again, refer to Chapter 12 for instructions on continuation of health insurance coverage, as the former annuitant is now considered an active employee.

A rehired annuitant electing to return, or statutorily required to return, to active WRS participation, but not electing to enroll in health insurance through the active employer ceases to be eligible for annuitant health coverage. However, ETF's continuation provisions allow an employee to continue coverage for a maximum of 36 months by paying the entire premium. ETF will notify the rehired annuitant of the right to continue prior coverage under COBRA law. Continuation coverage does not make the employee eligible to return to the prior annuitant group coverage when they again terminate employment and retire.

1103 Disability Annuitants

A WRS participant receiving a disability annuity 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, a WRS re-employed disability annuitant who has not reached normal retirement age (65, or age 53-54 for protective category employees [53 for those with 25 or more years of creditable service; 54 for those with fewer than 25 years]) will have the disability annuity suspended if the individual earns more than a set "earnings limit" during a calendar year of employment. 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 is able to 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 *Group Health Insurance* Application (ET-2301). 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.

Chapter 12 — Accumulated Sick Leave Conversion Credits (ASLCC)

1201 Accumulated Sick Leave Conversion Credit Program

1202 Eligibility

1203 Unpaid Leave/Temporary Layoff

1204 Permanent Layoff

1205 Permanent Layoff Sick Leave Conversion Reference Chart

1206 Accumulated Sick Leave and Chapter 40 Terminations

1207 Certifying Credits through the Online Accumulated Sick Leave System (AcSL)

1208 Generating a Sick Leave Credit Estimate through the Online Accumulated Sick Leave System (AcSL)

1209 Escrow of Sick Leave Credits

1210 Payment

1211 Annual Statement of Account

1201 Accumulated Sick Leave Conversion Credit Program

In accordance with Wis. Stat. § 40.95, eligible employees can convert accumulated sick leave hours to a dollar-based credit to pay premiums for coverage under the State Group Health Insurance Program (if an applicable compensation plan or collective bargaining agreement provides for sick leave conversion). Accumulated sick leave is converted to credits only for the payment of state group health insurance premiums. The sick leave credits are computed as $\text{Hours} \times \text{Highest Basic Pay Rate} = \text{Sick Leave Credits}$.

1202 Eligibility

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

1. A terminated, **vested** employee enrolled in the State Group Health Insurance Program at time of termination who:
 - retires with an immediate monthly annuity or retirement lump sum benefit that has an effective date within 30 days of termination; or
 - terminates employment at age 55 or older (50 for protective category employees) and has 20 years of creditable WRS service; or
 - qualifies for a WRS 40.65 duty disability, 40.63 regular disability, or Long-Term Disability Insurance (LTDI) benefit.
2. An eligible surviving spouse, domestic partner and/or dependents. Eligibility for a survivor to use these sick leave credits may be dependent upon whether the employee was

covered by a state group health insurance family policy on the date of death. Refer to the *Sick Leave Conversion Credit Program* (ET-4132) brochure for more information.

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

3. A vested employee who, at the time of termination, was a(n):
 - State constitutional officer.
 - Member or officer of the Legislature.
 - State agency head or administrative official appointed by the governor with senate confirmation.
 - Head of certain legislative service agencies.
 - Employee with 20 years of WRS creditable service, who terminated before their minimum retirement age and did not elect a WRS separation benefit.

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

4. Employee on unpaid leave (Refer to subchapter 1203.)
5. An employee on permanent layoff (Refer to subchapter 1204.)

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

1203 Unpaid Leave / Temporary Layoff

A. Unpaid Leave of Absence:

Length of Coverage Availability	Payment of Premiums	Employee-Required Contributions	Employer-Required Contributions
<p>An additional 3 months of employer contribution toward premium. Thereafter, employee may continue for up to 36 months under COBRA continuation provisions, by paying the full premium after the employer contribution ends.</p>	<p>Paid in advance by deduction from last payroll check or by personal check; then 30 days prior to the end of the period for which premiums were previously paid.</p> <p>Any employee share must be paid in advance by deduction from the employee's last check or by personal check.</p>	<p>After the 3 additional months of employer contribution toward premium upon leave or temporary layoff, employees still on leave can continue coverage by paying the entire share of premium to their employer in advance.</p>	<p>First 3 months (in addition to any prepaid months at time of termination) after employee is on leave.</p>

B. Temporary Layoff:

Length of Coverage Availability	Payment of Premiums	Employee-Required Contributions	Employer-Required Contributions
<p>An additional 3 months of employer contribution toward premium. Thereafter, employee may continue for up to 36 months under COBRA continuation provisions, by paying the full premium after the employer contribution ends.</p> <p>Can remain on coverage up to 5 years if using sick leave credits.</p> <p>COBRA coverage after the employer contribution ends, sick leave credits are exhausted or employee is still using credits after 5 years have elapsed.</p>	<p>Paid in advance by deduction from last payroll check or by personal check; then 30 days prior to the end of the period for which premiums were previously paid.</p> <p>Any employee share must be paid in advance by deduction from the employee's last check or by personal check.</p>	<p>After the 3 additional months of employer contribution toward premium upon temporary layoff, employees still on leave can continue coverage by paying the entire share of premium to their employer in advance.</p> <p>During temporary layoff only, accumulated unused sick leave may be converted by the employer to a dollar amount to pay premiums. Premiums are deducted until:</p> <ul style="list-style-type: none"> ~ the sick leave credits are exhausted, or ~ the 1st of the month following the employee's acceptance of other employment offering a comparable health insurance plan or policy, or ~ five years have elapsed from the date of layoff, whichever occurs first. 	<p>First 3 months (in addition to any prepaid months at time of termination) after employee is laid off.</p>

1204 Permanent Layoff

For group health insurance purposes, a state employee whose employment is terminated due to permanent layoff is to be treated as if terminated for retirement purposes or on a leave of absence per Wis. Stat. § 40.02 (40) and § 40.05 (4) (bm), meaning that upon termination due to permanent layoff, health insurance coverage may be continued. In addition, all employees terminated due to permanent layoff are entitled to an additional three months of state contribution toward the health insurance premium. This is in addition to the premiums that have already been remitted in advance through normal payroll deduction.

- A. Conversion of Accumulated Sick Leave [Wis. Stat. § 40.05 (4) (b)] - This provision applies to a state employee terminated due to permanent layoff (or a state employee otherwise terminated, e.g., for retirement purposes) who:
1. Begins an immediate monthly annuity; or
 2. Receives a lump sum annuity; or
 3. Has 20 years of creditable service and **is eligible** to retire on an immediate annuity but delays application.

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

- Accumulated unused sick leave is converted at the employee's **highest basic rate of pay** while employed by the state. Accumulated and supplemental sick leave is certified by the employer through the online Accumulated Sick Leave system (AcSL). Upon receipt of the employer's certification of the converted sick leave, ETF will establish a sick leave account to be used for payment of health insurance premiums.
- Sick leave may be used to fund the employee's premium contribution effective the first of the month following the date the layoff begins, if there is an employee contribution due, for the three additional months of employer paid premium as provided in Wis. Stat. § 40.05 (4) (a) 3. After the three additional months of state contribution toward premiums, the employer will certify the remaining unused sick leave balance to ETF, and the full amount of the premium will then be deducted by ETF from the sick leave credits until the credits are exhausted.
- Under Wis. Stat. § 40.05 (4) (b), the employee may elect to delay using converted sick leave credits if the employee is covered under a comparable health insurance plan. Comparable health insurance means a plan or policy that provides hospital and medical benefits substantially equivalent to those of the Standard Health Insurance Plan established under Wis. Stat. § 40.52 (1).

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

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

1. Has attained 20 years of creditable service,
2. Remains a participant (does not take a separation benefit from the WRS), and
3. Is not eligible for an immediate annuity due to not being minimum retirement age, i.e., age 55 (age 50 for protective occupations).

Once eligible to apply for a monthly retirement annuity or lump sum retirement annuity, these state employees are eligible to convert accumulated sick leave under the provisions of the ASLCC program and, if eligible, the SHICC program, effective the date on which the department receives the employee's retirement application as follows:

- Accumulated unused sick leave is converted at the employee's **highest basic rate of pay** while employed by the state. Accumulated and Supplemental sick leave is certified by the employer through the online Accumulated Sick Leave system (AcSL). Upon receipt of the employer's certification of the converted sick leave, ETF will establish a sick leave account to be used for payment of health insurance premiums.
- At the request of the employee, the employer must convert accumulated sick leave to fund the employee's premium contribution, if any, effective the first of the month following the date the layoff begins under the provisions of Wis. Stat. § 40.05 (4) (a) 3. After the three additional months of state contribution toward premiums, the employer will certify the remaining unused sick leave balance to ETF through the online Accumulated Sick Leave system (AcSL), unless the employee requests the employer continue converting accumulated sick leave under Wis. Stat. § 40.05 (4) (bm) [refer to C below].
- An employee covered under a comparable health plan with sick leave preserved under Wis. Stat. § 40.05 (4) (bc), may elect, at the time they are eligible for an annuity and submit a retirement application, to delay using the converted sick leave credits per Wis. Stat. § 40.05 (4) (b). Comparable health insurance means a plan or policy that provides hospital and medical benefits that are substantially equivalent to the Standard Health Insurance Plan established under Wis. Stat. § 40.52 (1).

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

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

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

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

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

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

- Upon request, between the date on which the employee receives notice of layoff and the actual layoff date, accumulated unused sick leave may be converted by the employing

agency at the employee's **highest basic rate of pay** while employed by the state, for payment of health insurance premiums.

- Sick leave may be used to fund the employee's premium contribution effective the first of the month following the date the layoff begins. After the three additional months of state contribution toward the premiums, the employee is responsible for the full employee and employer premium, although sick leave credits may be converted by the employer to pay the entire cost.
- An employee using sick leave credits under this provision that returns to state employment and is eligible for reinstatement will have any unused sick leave hours reinstated.
- The full amount of the required premium shall be deducted from the credits until the first of the following occurs:
 1. The credits are exhausted;
 2. The employee accepts other employment with a comparable health insurance policy or plan (even if the employee declines the coverage). This coverage ends the first of the month following the date of other employment; or
 3. Five years elapse from the layoff date.

Health insurance continuation coverage (in compliance with COBRA) using the *Continuation - Conversion Notice* (ET-2311) must be offered when the available sick leave premium contribution ends. (Refer to Chapter 9.)

1205 Permanent Layoff Sick Leave Conversion Reference Chart

This chart provides information regarding sick leave conversion at the time of an employee's permanent layoff (based upon employee status at the time of termination).

Employee status at time of permanent layoff.	Statutory Reference	State Health Contribution	ASLCC Program	SHICC Program	Administrative Responsibility
1. Begins immediate annuity or annuity lump sum. [\$40.25 (1)]	\$40.05(4)(a)3 \$40.05(4)(b)	Up to one month prepaid plus additional 3 months.	Sick leave converted upon layoff. Employee can choose to use sick leave to pay the employee premium contribution during the three additional months of employer paid premium, effective the 1st of the month following the date the layoff begins. Remaining sick leave will be certified to ETF and used once the employer's obligation under §40.05(4)(a)3 has been met unless Escrowed according to § 40.05 (4)(b).	Available after ASLCC is exhausted if the employee has 15 or more full years of adjusted continuous state service. Other OSER regulations apply.	<ul style="list-style-type: none"> Employing agency pays premiums for 3 months after layoff (not including prepaid months) as though an active employee. Employing agency certifies the employee's remaining accumulated sick leave through the on-line Accumulated Sick Leave system (AcSL). <i>(Instructions located in subchapter 1207.)</i> ETF deducts full amount of premium until sick leave credits are exhausted.
2. Eligible for an immediate annuity with less than 20 years of WRS creditable service, but defers application.	\$40.05(4)(a)3 \$40.05(4)(bm)	<ul style="list-style-type: none"> Up to 1 month prepaid plus additional 3 months. If requested, employing agency converts sick leave for health insurance until: Credits are exhausted; 1st of month following employee's acceptance of other employment with a comparable health insurance plan or policy; or 5 years have elapsed; whichever occurs first. 	Any remaining sick leave after §40.05(4)(bm) use for the employee premium contribution for the first three months, effective the first of the month following the date the layoff begins, is lost unless employee reinstates into state service within five years.	Available after ASLCC is exhausted if the employee has 15 years or more of adjusted continuous state service. Other OSER regulations apply. Any remaining credits after §40.05 (4) (bm) use are lost.	<ul style="list-style-type: none"> Employing agency pays premiums for three months after layoff as though employee is an active employee. Employing agency converts sick leave and submits health insurance premiums to ETF as though an active employee. Employing agency responsible for administration, funding and monitoring sick leave balance.

Employee status at time of permanent layoff.	Statutory Reference	State Health Contribution	ASLCC Program	SHICC Program	Administrative Responsibility
<p>3. Eligible for an immediate annuity with 20 or more years of WRS creditable service, but defers application.</p>	<p>§40.05(4)(a)3 §40.05(4)(b)</p>	<p>Up to one month prepaid plus additional three months.</p>	<p>Sick leave converted upon layoff. Employee can choose to use sick leave to pay the employee premium contribution during the three additional months of employer paid premium, effective the first of the month following the date the layoff begins. Remaining sick leave will be certified to ETF and used once the employer's obligation under §40.05 (4) (a) 3 has been met unless escrowed according to §40.05 (4) (b).</p>	<p>Available after ASLCC is exhausted if the employee has 15 years of adjusted continuous state service. Other OSER regulations apply.</p>	<ul style="list-style-type: none"> Employing agency pays premiums for three months after layoff (not including prepaid months) as though an active employee. Employing agency certifies the employee's remaining accumulated sick leave through the online Accumulated Sick Leave system (AcSL). (<i>Instructions located in subchapter 1207.</i>) ETF deducts full amount of premium until sick leave credits are exhausted.
<p>4. Not eligible for immediate annuity with fewer than 20 years of creditable service.</p>	<p>§40.05(4)(a)3 §40.05(4)(bm)</p>	<ul style="list-style-type: none"> Up to one month prepaid plus additional three months. If requested, employing agency converts sick leave for health insurance until: Credits are exhausted; First of month following employee's acceptance of other employment with a comparable health insurance plan or policy; or Five years have elapsed, whichever occurs first. 	<p>Any remaining sick leave after §40.05 (4) (bm) use is lost unless employee reinstates into state service within five years.</p>	<p>Available after ASLCC is exhausted if the employee has 15 years of adjusted continuous state service. Other OSER regulations apply. Any remaining credits after §40.05(4)(bm) use are lost.</p>	<ul style="list-style-type: none"> Employing agency pays premiums for 3 months after layoff (not including prepaid months) as though an active employee. Employing agency converts sick leave and submits health insurance premiums to ETF as though an active employee. Employing agency responsible for administration, funding and monitoring sick leave balance.

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Employee status at time of permanent layoff.	Statutory Reference	State Health Contribution	ASLCC Program	SHICC Program	Administrative Responsibility
<p>5. Ineligible for an immediate annuity with 20 or more years of WRS creditable service.</p>	<p>§40.05(4)(a)3 §40.05(4)(bm) §40.05(4)(bc)</p>	<ul style="list-style-type: none"> • Up to one month prepaid plus additional three months. • If requested, employing agency converts sick leave for health insurance until: <ul style="list-style-type: none"> * credits are exhausted; * first of month following employee's acceptance of other employable health insurance plan or policy; or * five years have elapsed; whichever occurs first. 	<p>Sick leave converted upon layoff. Employee can choose to use sick leave to pay the employee premium contribution during the three additional months of employer paid premium, effective the 1st of the month following the date the layoff begins.</p> <p>After the three additional months of employer contribution:</p> <ol style="list-style-type: none"> 1. Employing agency certifies any remaining sick leave through the online Accumulated Sick Leave system (AcSL) to be preserved by ETF until the employee applies for a retirement benefit; or 2. Employee requests to continue using converted sick leave to pay for premiums through the employer until credits are exhausted, the 1st of the month following employee's acceptance of other employment with a comparable health insurance plan or policy; or five years have elapsed; whichever occurs first. Employing agency then certifies any remaining sick leave through the online Accumulated Sick Leave system (AcSL) to be preserved by ETF until the employee applies for a retirement benefit. 	<p>Available after ASLCC is exhausted if the employee has 15 years of adjusted continuous state service. Other OSER regulations apply.</p>	<ul style="list-style-type: none"> • Employing agency pays premiums for 3 months after layoff (not including prepaid months). Employee can choose to use converted sick leave to pay any employee share of premiums. • Employer reports employee to ETF as though an active employee. <p>Then:</p> <ul style="list-style-type: none"> • Employing agency certifies any remaining sick leave through the online Accumulated Sick Leave system (AcSL) to be preserved by ETF for conversion upon receipt of retirement application. <i>(Instructions located in sub-Chapter 1207.)</i> • Employing agency responsible for administration, funding and monitoring sick leave balance during any period when the employee is using these credits to pay the premiums while still covered as an active employee.

1206 Accumulated Sick Leave and Chapter 40 Terminations

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

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

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

The table below provides examples of § 40.63 situations, including action for health insurance affected by policy changes:

Type of Employee/ Disability Type	Employee's Situation upon Approval of Disability	Type of Termination	Action BEFORE § 40.63 Benefit Approval	WRS Death Benefit
A. State § 40.63	Sick leave balance remains (earnings not all paid). Health insurance coverage continued during LOA.	Sever employee/ employer relationship or exhaust sick leave balance before § 40.63 can be approved. (If sick leave is exhausted, go to C.)	Employer reports termination or employee exhausts sick leave balance (extending last day paid). Employee continues health insurance as an annuitant with deductions from sick leave conversion account.	Annuitant

Type of Employee/ Disability Type	Employee's Situation upon Approval of Disability	Type of Termination	Action BEFORE § 40.63 Benefit Approval	WRS Death Benefit
B. State § 40.63	Sick leave balance remains (earnings not all paid). Health insurance coverage lapsed during LOA.	Sever employee/ employer relationship or exhaust sick leave balance before § 40.63 can be approved. (If sick leave is exhausted, go to D.)	Employer reports termination OR employee exhausts sick leave balance (extending last day paid). Health insurance reinstated as annuitant if enrollment received within 30 days of approval notice. Employee continues health insurance as an annuitant with deductions from sick leave conversion account.	Annuitant
C. State § 40.63	No sick leave balance remains (earnings all paid). Health insurance coverage continued during LOA.	Employer's Option: Chapter 40 termination or sever the employee/ employer relationship.	Employer reports termination. Employee continues health insurance as an annuitant through annuity deduction or direct pay.	Annuitant

Type of Employee/ Disability Type	Employee's Situation upon Approval of Disability	Type of Termination	Action BEFORE § 40.63 Benefit Approval	WRS Death Benefit
D. State § 40.63	No sick leave balance remains (earnings all paid). Health insurance coverage lapsed during LOA.	Employer's Option: Chapter 40 termination or sever the employee/ employer relationship.	Employer reports termination. Health insurance reinstated as annuitant if enrollment received within 30 days of approval notice. Employee continues health insurance as an annuitant through annuity deduction or direct pay.	Annuitant
E. State § 40.63	No sick leave balance remains (earnings all paid). No health insurance as active employee.	Employer's Option: Chapter 40 termination or sever the employee/ employer relationship.	Employer reports termination. No enrollment opportunity allowed; coverage not in effect prior to the LOA.	Annuitant

The table below provides examples of LTDI situations, including action for health insurance affected by policy changes:

Type of Employee/ Disability Type	Situation during leave of absence upon approval of disability	Type of Termination	Action BEFORE LTDI Approval	WRS Death Benefit
A. State LTDI	Sick leave balance remains (earnings not all paid). Health insurance coverage continued during LOA.	Sever employee/ employer relationship or exhaust sick leave balance before LTDI can be approved. (If sick leave exhausted, go to C.)	Employer reports termination or employee exhausts sick leave balance (extending last day paid). Employee continues health insurance with deductions from sick leave conversion account.	Inactive employee contribution balances.
B. State LTDI	Sick leave balance remains (earnings not all paid). Health insurance coverage lapsed during LOA.	Sever employee/ employer relationship or exhaust sick leave balance before LTDI can be approved. (If sick leave exhausted, go to D.)	Employer reports termination or employee exhausts sick leave balance (extending last day paid). Health insurance reinstated if enrollment received within 30 days of approval notice. Employee continues health insurance as an annuitant with deductions from sick leave.	Inactive employee contribution balances.
C. State LTDI	No sick leave balance remains (earnings all paid). Health insurance coverage continued during LOA.	Leave of absence. Termination allowed, not required.	Employer reports LOA or termination. Employee continues health insurance during LOA by payment of employee/ employer premiums to employer.	Active employee minimum of twice the employee required contributions.

Type of Employee/ Disability Type	Situation during leave of absence upon approval of disability	Type of Termination	Action BEFORE LTDI Approval	WRS Death Benefit
D. State LTDI	No sick leave balance remains (earnings all paid). Health insurance coverage lapsed during LOA.	LOA. Termination allowed, not required.	Employer reports LOA or termination. Health insurance reinstated if enrollment received within 30 days of approval notice. Employee continues health insurance during LOA by payment of employee/employer premiums to employer.	Active employee: minimum of twice the employee required contributions.
E. State LTDI	No sick leave balance remains (earnings all paid). No health Insurance coverage as active employee.	LOA. Termination allowed, not required.	Employer reports LOA or termination. No enrollment opportunity allowed; coverage not in effect prior to the LOA.	Active employee: minimum of twice the employee required contributions.

1207 Certifying Credits through the Online Accumulated Sick Leave System (AcSL)

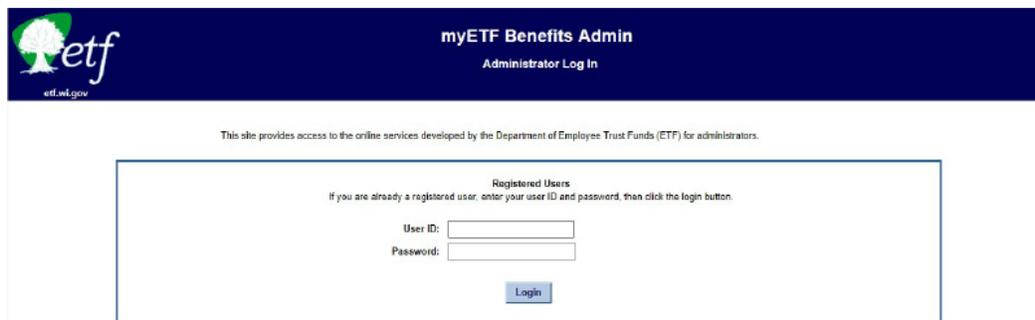
An employer must certify accumulated and supplemental sick leave credits through the AcSL system within 30 days after an employee’s termination. Certify credits for each employee terminating from state service who:

1. is age 55 or older (age 50 if protective occupation);
2. is applying for a disability benefit or LTDI;
3. died;
4. is a *public official* (qualifies for delayed sick leave usage under 1991 Wisconsin Act 39 [Public Official]); or
5. is terminating after 20 years of service but is not eligible for an immediate annuity (qualifies for delayed sick leave usage under 2003 Wisconsin Act 33).

Access

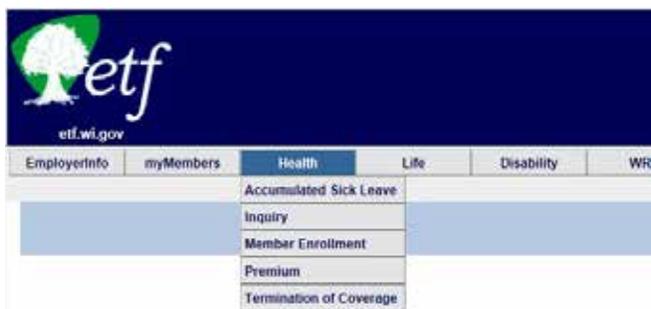
Employers can access AcSL through the myETF Benefits for Administrators menu.

1. Log in to myETF Benefits with your User ID and Password.



The screenshot shows the 'myETF Benefits Admin' Administrator Log In page. At the top left is the 'etf' logo with 'etf.wi.gov' below it. The page title is 'myETF Benefits Admin' and 'Administrator Log In'. A message states: 'This site provides access to the online services developed by the Department of Employee Trust Funds (ETF) for administrators.' Below this is a 'Registered Users' section with the instruction: 'If you are already a registered user, enter your user ID and password, then click the login button.' There are two input fields: 'User ID:' and 'Password:'. A 'Login' button is positioned below the password field.

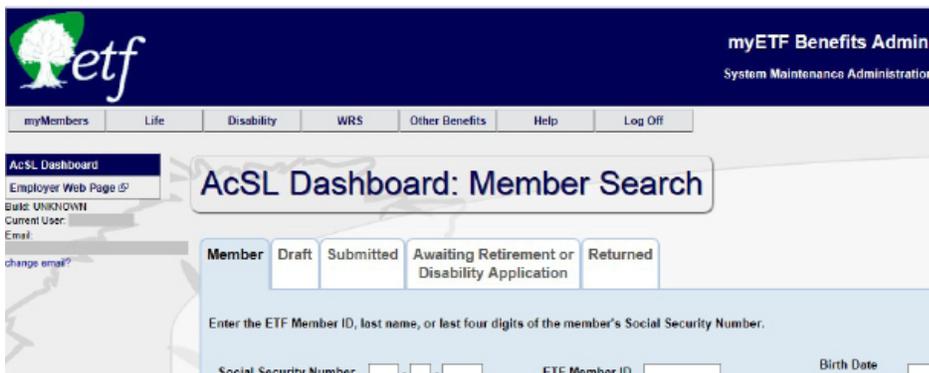
2. Under the 'Health' tab, choose the option "Accumulated Sick Leave".



The screenshot shows the 'Health' tab selected in the myETF Benefits Admin interface. The 'etf' logo and 'etf.wi.gov' are visible at the top left. A navigation bar includes 'EmployerInfo', 'myMembers', 'Health', 'Life', 'Disability', and 'WRS'. The 'Health' menu is open, showing options: 'Accumulated Sick Leave', 'Inquiry', 'Member Enrollment', 'Premium', and 'Termination of Coverage'.

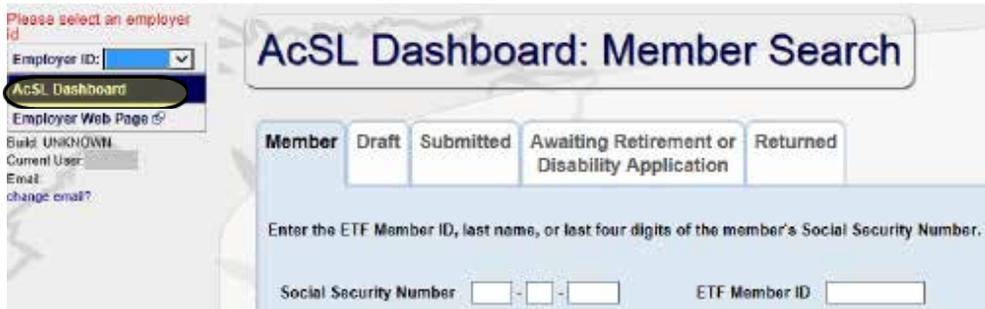
Menu

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



The screenshot shows the 'AcSL Dashboard: Member Search' page. At the top left is the 'etf' logo and 'etf.wi.gov'. The page title is 'myETF Benefits Admin' and 'System Maintenance Administration'. A navigation bar includes 'myMembers', 'Life', 'Disability', 'WRS', 'Other Benefits', 'Help', and 'Log Off'. The 'AcSL Dashboard' menu is open on the left, showing 'Employer Web Page' and 'AcSL Dashboard'. The main content area has a heading 'AcSL Dashboard: Member Search' and a search prompt: 'Enter the ETF Member ID, last name, or last four digits of the member's Social Security Number.' There are input fields for 'Social Security Number', 'ETF Member ID', and 'Birth Date'. A 'Member' dropdown menu is set to 'Draft', with other options being 'Submitted', 'Awaiting Retirement or Disability Application', and 'Returned'. A 'change email?' link is visible on the left side.

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

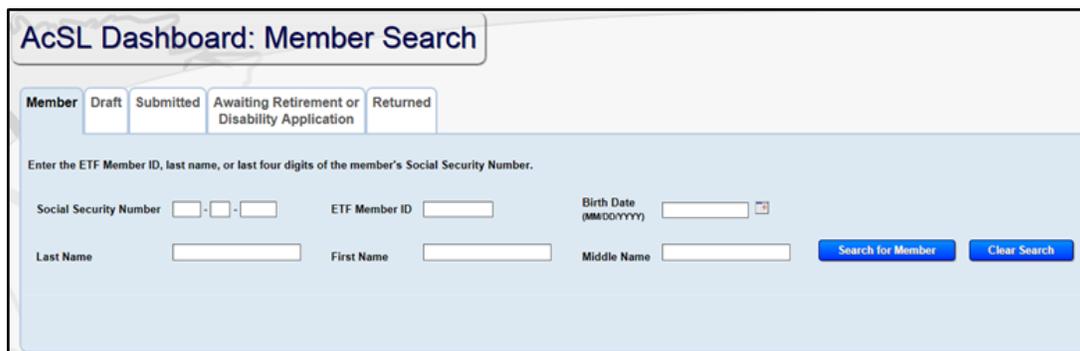


3. As you begin the process of entering a sick leave certification, additional menu options appear. Select any of the available menu options at any time to navigate to that screen.



Member Search

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



3. Verify the employee and click on 'View Member Information'.

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

Last Name	First Name	Middle Name	Social Security Number	ETF Member ID	DOB	City	State	Action
Doe	John	J	9999	99999999	01/01/1851	Madison	WI	View Member Information
Doe	Jane	J	8888	11111111	01/01/1111	Stoughton	WI	View Member Information

Sick Leave Certification Entry

1. Click 'Start New Certification'.

The screenshot shows a 'Member Information Overview' page with several sections:

- Employee Information:** Fields for Member Name, Social Security Number, ETF Member ID, Birth Date, Date of Death, Address, and Gender.
- Health Plans where (Subscriber):** Fields for Current Employer Name (UNIVERSITY OF WISCONSIN SYSTEM (00212)), Health Plan Career (STANDARD PLAN 01), Coverage Type (SINGLE), Group Number (8346), Coverage Begin Date (7/12/2004), and Coverage End Date.
- Employment History:** Table with columns for Employer Number, Employer Name, Begin Date, and Termination Date. It lists two entries for the University of Wisconsin System.
- Health Plans where (Dependent):** A section indicating the member is not currently a dependent on any other subscriber's health plan.
- Sick Leave Certifications:** A section with a 'Start New Certification' button and a 'Generate Estimate' button. Below it, it states 'This member has no certifications'.
- Sick Leave Accounts:** A section with a 'Sick Leave Accounts' button and a note 'This member has no accounts'.
- Review Pending Transaction(s):** A section stating 'No pending transactions at this time'.

2. Fill in the termination date and choose the reason for termination from the drop-down menu.

- The termination date must be formatted as mm/dd/yyyy. The termination date can neither be blank nor in the future or you will receive an error message.
- The termination reason cannot be blank.

The screenshot shows a three-step process for entering termination information:

- Step 1: Enter Termination Information:** This step is highlighted in yellow. It contains a message 'This certification has not yet been saved.' and two main sections:
 - Employee Information:** Fields for Member Name, Social Security Number (masked as XXX-XX-), ETF Member ID, Birth Date, Date of Death, Address, and Gender.
 - Termination Information:** Fields for Termination Date (mm/dd/yyyy) set to 05/15/2014, and Reason for Termination (a dropdown menu set to Retirement Eligible). A 'Next' button is located below these fields.
- Step 2: Verify Health Plan**
- Step 3: Calculate Accumulated Leave Credits**

3. Click "Next".

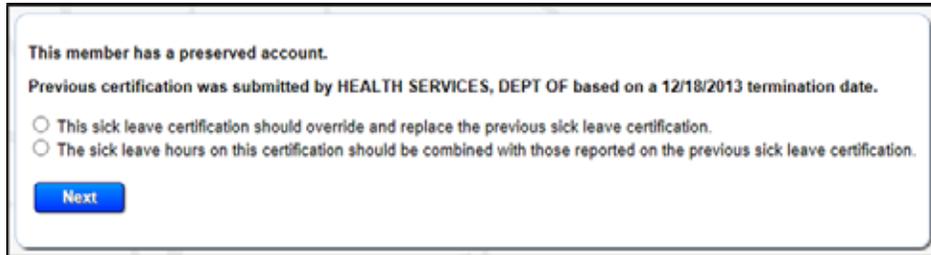
Note: If the termination reason is "Retirement" or "Death" the member **must** have active health insurance coverage under the State Group Health Insurance Program in order for the

sick leave credits to be certified.

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



- b. If you believe this message is in error, please contact ETF for assistance.
- c. If a **preserved** sick leave account is on file, you will receive the following message:



- i. What is a “preserved” sick leave account?
- If an employee terminates employment with at least 20 years of creditable WRS service, they qualify to have their sick leave preserved.
 - If an employee is either a state constitutional officer, a member or an officer of the legislature, or the head of a state department or agency who was appointed by the governor with senate confirmation, they qualify to have their sick leave preserved after termination.
4. You **must choose one** of the following:
- a. “This sick leave certification should override and replace the previous sick leave certification.”
- i. “**Override and replace**” should be used for situations where the employee returns to state employment within a valid reinstatement period and had their remaining sick leave balance from the previous period of employment added to the starting leave balance for the current period of state employment.
- b. “The sick leave hours on this certification should be combined with those reported on the previous sick leave certification.”
- i. “**Combined**” should be used for situations where an employee returned to state employment outside of a valid reinstatement period and wasn’t eligible to receive their remaining sick leave balance from the previous period of state employment.
5. Then click ‘*Next*’ to proceed.

Entering Sick Leave Hours for Submission

1. Click 'Enter Sick Leave Hours to Submit' at the bottom of the screen.



2. Enter all of the necessary employee information.

- **For UW Employers Only** – Employers certifying sick leave on behalf of UW employees are required to answer the following question:

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

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

Termination Information	
Select employer from list	EMPLOYEE TRUST FUNDS, DEPT OF
Termination Date (MM/DD/YYYY)	05/13/2014
Reason for Termination ?	Retirement Eligible

Accumulated Leave (ASLCC) Information	
Unused Sick Leave Hours	0.00
Other Creditable Leave Hours	0.00
Highest Basic Hourly Pay Rate as State Employee	0.000
ASLCC Total	\$0.00

Supplemental Sick Leave (SHICC) Information	
Note: Do not complete this section if the employee is in a position (e.g., Crafts) that is not eligible for SHICC credits.	
Seniority Date/Adjusted Continuous Service Date (MM/DD/YYYY) Note: Do not use the WRS Service Date.	
Bargaining Unit	
Years of Service in General/Executive Category WITHIN THE FIRST 24 YEARS	0
Years of Service in Protective Category WITHIN THE FIRST 24 YEARS	0
Years of Service in Excess of 24 Years	0
Full Years of Service/Seniority	0
SHICC Eligible Hours	0.00
SHICC, 500 Hour Restoration	0.00
SHICC Total	\$0.00

Grand Total	
Certification Total	\$0.00

Field Name	Instructions
Unused Sick Leave Hours	Required field.
Other Creditable Leave Hours	Optional field. Must reflect the number of hours of sabbatical or unused vacation that eligible employees elect to convert.
Highest Basic Hourly Pay Rate as State Employee	Required field.
Seniority Date	Required field. Date must be formatted as MM/DD/YYYY.
Bargaining Unit	Optional field.
Years of Service in General/ Executive Category within the First 24 Years	The combined total of the value entered in this field and the “Years of Service in Protective Category” field must equal the lesser of 24 years or the value in “Full Years of Service”.
Years of Service in Protective Category within the First 24 Years	The combined total of the value(s) entered in this field and the “Years of Service in General/Executive Category” field must equal the lesser of 24 years or the value in “Full Years of Service”.
“Full Years of Service/Seniority”	Automatically calculates based on the term date and seniority date that were entered.
SHICC Eligible Hours	Enter the total sick leave hours eligible for SHICC.
SHICC, 500 Hour Restoration	This field will accept only values of “0” or “500”.

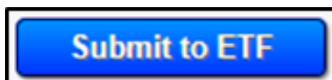
- The certification contains a field for ‘*Employer Notes*’ to be used for your reference, to share info with ETF, etc. These notes will stay with the certification in AcSL but will *not* appear on the printed certification.

Employer Notes

- If you need to save the certification for completion at a later date, click ‘*Save Draft*’.



- If you have finished the certification, click ‘*Submit to ETF*’.



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



Employees on Layoff and Sick Leave Certification

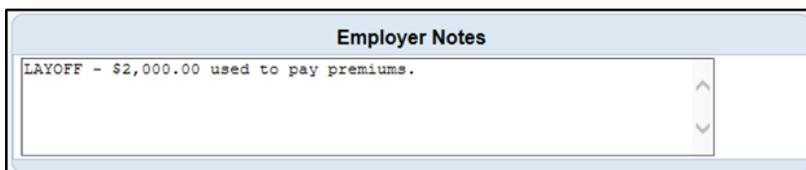
For employees who are on layoff and are eligible to use their sick leave credits through their employer to pay for health insurance premiums:

- a. The employing agency is responsible for administration, funding and monitoring sick leave balances. Therefore, the employing agency must manually track how much sick leave is used to pay premiums.
- b. You can generate the dollar amount of sick leave available for the employee by using the '*Generate Estimate*' function in AcSL. Estimates are only available to view immediately after it is generated and cannot be saved in AcSL. You may save it as a PDF to your own computer.



- or -

- c. You can key it as an actual certification and save it as a draft (refer to instructions provided previously in this section on how to save a certification as a draft).
Note: *Do not submit this to ETF. The employing agency is responsible for administration of these balances.*
- d. If eligible, the employing agency certifies any remaining sick leave through AcSL to be preserved by ETF for conversion upon receipt of retirement application.
- e. The employing agency will follow the same instructions provided previously in this section on how to submit a sick leave certification. There are, however, two special things to note when submitting a sick leave certification for layoff situations:
 - Enter the full amount of Accumulated Sick Leave and SHICC the employee had **at the time of layoff**.
 - In the “Employer Notes” field, please indicate “LAYOFF”, as well as how many of the sick leave credits have been used through the employer to pay for premiums.
- f. ETF will adjust the sick leave balance based on the information you provide.



ETF Review and Acceptance/Rejection of Certification

1. Once you submit the certification, ETF will review it and then either **approve** the certification and set up a sick leave account or **reject** the certification and return it to you, the employer.
 - a. While in *Draft* status, you can change the certification values as often as needed before submitting to ETF.

- b. Once you 'Submit to ETF' the values are *frozen*. If you determine that something needs to change, you will need to amend the certification.
- c. In some situations, ETF may reject the sick leave certification and return it to the employer (e.g., employee is not vested or employee did not take an immediate annuity, etc.).

Printing a Certification

1. Once a certification has been submitted, print a copy. Choose "View Certification" from the Member Info Overview page and select the "View Printable Certification" button. A PDF of the certification that you can print for your records.



Example of PDF:

	STATE OF WISCONSIN Department of Employee Trust Funds Robert J. Conlin SECRETARY	801 W Badger Rd PO Box 7931 Madison WI 53707-7931 1-877-633-6020 (toll free) Fax (608) 267-4649 TTY (608) 267-0676 http://etf.wi.gov																																												
	SICK LEAVE CREDIT CERTIFICATION Submitted -01/08/2014																																													
<table border="1" style="width: 100%;"> <tr> <th colspan="2">Employee Information</th> <th colspan="2">Health Plan at Date of Termination</th> </tr> <tr> <td>Member Name</td> <td></td> <td>Health Plan Carrier</td> <td>UNITY UW HEALTH</td> </tr> <tr> <td>Member SSN</td> <td>XXX-XX-</td> <td>Coverage Type</td> <td>FAMILY</td> </tr> <tr> <td>Member ID</td> <td></td> <td>Group Number</td> <td>83445</td> </tr> <tr> <td>Birth Date</td> <td></td> <td>Coverage Begin Date</td> <td>01/01/2009</td> </tr> <tr> <td>Address</td> <td></td> <td>Coverage End Date</td> <td></td> </tr> <tr> <td>Gender</td> <td>MALE</td> <td>Plan Subscriber</td> <td></td> </tr> <tr> <td>Termination Date</td> <td>05/31/2013</td> <td></td> <td></td> </tr> <tr> <td>Termination Reason</td> <td>Retirement Eligible</td> <td></td> <td></td> </tr> </table>			Employee Information		Health Plan at Date of Termination		Member Name		Health Plan Carrier	UNITY UW HEALTH	Member SSN	XXX-XX-	Coverage Type	FAMILY	Member ID		Group Number	83445	Birth Date		Coverage Begin Date	01/01/2009	Address		Coverage End Date		Gender	MALE	Plan Subscriber		Termination Date	05/31/2013			Termination Reason	Retirement Eligible										
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SHICC, 500 Hour Restoration	0.00																																													
SHICC Total	\$ 25,000.00																																													
<table border="1" style="width: 100%;"> <tr> <th colspan="2">Grand Total</th> </tr> <tr> <td>Certification Total</td> <td>\$ 50,000.00</td> </tr> </table>			Grand Total		Certification Total	\$ 50,000.00																																								
Grand Total																																														
Certification Total	\$ 50,000.00																																													

Generated on 05/13/2014 ET-4563 (REV 11/2012)

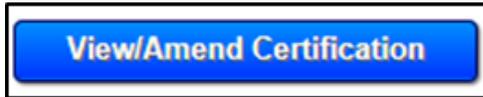
Amended Certification vs. New Certification

- **Creating a New Certification:** If there are additional sick leave hours to report (i.e. an employee who retired and had his/her hours reported to ETF returns to work as a rehired annuitant, becomes a participating WRS employee, and then retires again. The sick leave earned during that 2nd period of employment should be reported on a NEW certification.)
- **Amending:** If you determine that **any** value (term date, term reason, ASLCC hours or pay rate, SHICC seniority date, etc.) originally keyed was incorrect and needs to be changed.

Amending a Certification

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

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



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



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



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

This certification has been saved as a draft.

This is an AMENDED certification.

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

Termination Information

Employer ID	UNIVERSITY OF WISCONSIN SYSTEM (0001131)
Termination Date (MMDDYYYY)	07/08/2013
Reason for Termination	Retirement Eligible

Accumulated Leave (ASLCC) Information

Unused Sick Leave Hours	3.05
Other Creditable Leave Hours	0.00
Highest Basic Hourly Pay Rate as State Employee	40.457
ASLCC Total	\$123.39

Supplemental Sick Leave (SHICC) Information

Note: Do not complete this section if the employee is in a position (e.g., Crafts) that is not eligible for SHICC credits.

Seniority Date/Adjusted Continuous Service Date (MMDDYYYY) Note: Do not use the WRS Service Date.	
Bargaining Unit	
Years of Service in General/Executive Category WITHIN THE FIRST 24 YEARS	0
Years of Service in Protective Category WITHIN THE FIRST 24 YEARS	0
Years of Service in Excess of 24 Years	0
Full Years of Service/Seniority	0
SHICC Eligible Hours	0.00
SHICC, 500 Hour Restoration	0.00
SHICC Total	\$0.00

Grand Total

Certification Total	\$123.39
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b. Any field the employer has entered on the certification can be amended.

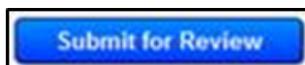
- If you need to save the amended certification for completion at a later date, click 'Save Draft'.



- Once you have finished amending the certification, click 'Submit to ETF'.



Note: If you have restricted access, you will not see the 'Submit to ETF' button. You must click on 'Submit for Review' to send the certification to your central payroll office for approval.



Dashboard Tabs

Member Tab:

- There are multiple tabs on the AcSL Dashboard page. The first is labeled ‘*Member Search*’, where you search for your employees.



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

“Draft”:

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

Member Search	Draft	Submitted	Awaiting Retirement or Disability Application	Returned			
Social Security Number	ETF Member ID	Member Name	Updated Reason	Created On	Updated By	Notes	Action
92	1042			09/03/2013	P.		Edit/Delete Certification
47	1101			01/08/2014	mat		Edit/Delete Certification
31	10231			01/08/2014	me		Edit/Delete Certification
59	10086			12/23/2013	ma		Edit/Delete Certification
20				12/05/2013	P.		Edit/Delete Certification

“Submitted”:

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

Member Search	Draft	Submitted	Awaiting Retirement or Disability Application	Returned			
Social Security Number	ETF Member ID	Member Name	Updated Reason	Created On	Updated By	Notes	Action
47	1041			01/08/2014	Bu		View Certification
27	100			12/23/2013	ma		View Certification
59	1008			01/29/2014	ma		View Certification
81	1021			01/30/2014	C.		View Certification
63	1032			02/04/2014	C.		View Certification

“Awaiting Retirement or Disability Application”:

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

Member Search	Draft	Submitted	Awaiting Retirement or	Returned					
Social Security Number	ETF Member ID	Member Name	Updated Reason	Created On	Updated By	Notes	Action		
23	1027		AWAITING RET/DIS APP	12/04/2013	GR		View Certification		

“Returned”:

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

Member Search	Draft	Submitted	Awaiting Retirement or Disability Application	Returned					
Social Security Number	ETF Member ID	Member Name	Updated Reason	Created On	Updated By	Notes	Action		
00	1104			06/12/2013	CU		Edit/Delete Certification		
37	1027			09/26/2013	But		Edit/Delete Certification		
78	1041			11/21/2013	CA		Edit/Delete Certification		
42	1107			11/27/2013	JUF		Edit/Delete Certification		

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

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

1208 Generating a Sick Leave Credit Estimate through the Online Accumulated Sick Leave System (AcSL)

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

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

Member Information Overview :

Employee Information	
Member Name	
Social Security Number	XXX-XX-
ETF Member ID	
Birth Date	
Date of Death	
Address	No address on file
Gender	FEMALE

Employment History			
Employer Number	Employer Name	Begin Date	Termination Date
0001131	UNIVERSITY OF WISCONSIN SYSTEM	08/31/1998	

Sick Leave Certifications

2. Enter in the projected future termination date, and reason for termination.
3. Click 'Next'. AcSL will display current health insurance information.
4. Click on the 'Enter Estimated Sick Leave Hours' button.

Step 1: Enter Termination Information Step 2: Verify Health Plan Step 3: Calculate Accumulated Leave Credits

This is an ESTIMATE only.

Employee Information		Termination Information	
Member Name		Termination Date (MM/DD/YYYY)	06/30/2015
Social Security Number	XXX-XX-	Reason for Termination	Retirement Eligible
ETF Member ID			
Birth Date			
Date of Death			
Address	No address on file		
Gender	FEMALE		

Health Plans where _____ is a Subscriber as of termination date
is not a subscriber on any state health plan contract.

Health Plans where _____ is a Dependent as of termination date
Not a dependent on any other subscriber's health plan.

- a. **For UW Employers only** – Employers generating estimates on behalf of UW employees are required to answer the following question:

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

5. Enter the employee's ASLCC and SHICC information.
 - a. Refer to subchapter 1207 for instructions on the sick leave certification's input fields.
6. Click the 'Print Copy for Member' button. A PDF of the sick leave credit estimate will be generated.

This is an ESTIMATE only.

Employee must be covered by the state group health insurance program on the retirement date to be eligible for these credits.

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

Termination Information

Employer ID UNIVERSITY OF WISCONSIN SYSTEM (0001131)
 Termination Date (MMDDYYYY) 06/30/2015
 Reason for Termination Retirement Eligible

Accumulated Leave (ASLCC) Information

Unused Sick Leave Hours	1270.00
Other Creditable Leave Hours	0.00
Highest Basic Hourly Pay Rate as State Employee	25.000
ASLCC Total	\$31,750.00

Supplemental Sick Leave (SHICC) Information

Note: Do not complete this section if the employee is in a position (e.g., Crafts) that is not eligible for SHICC credits.

Seniority Date/Adjusted Continuous Service Date (MMDDYYYY) 01/01/1981
Note: Do not use the WRS Service Date.
 Bargaining Unit
 Years of Service in General/Executive Category WITHIN THE FIRST 24 YEARS 24
 Years of Service in Protective Category WITHIN THE FIRST 24 YEARS 0
 Years of Service in Excess of 24 Years 10
 Full Years of Service/Seniority 34
 SHICC Eligible Hours 1270.00
 SHICC, 500 Hour Restoration 500.00
SHICC Total \$44,250.00

Grand Total

Certification Total	\$76,000.00
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[Print Copy for Member](#)

Note: Sick leave estimates cannot be saved in the AcSL system. You can save a copy of the PDF to your computer.

Example:

		STATE OF WISCONSIN Department of Employee Trust Funds Robert J. Condon SECRETARY		601 W. Badger Rd. PO Box 7920 Madison WI 53707-7920 1-877-622-6222 (Toll Free) Fax (608) 267-4249 TTY (608) 267-0476 http://etf.wis.gov	
SICK LEAVE CREDIT CERTIFICATION ESTIMATE -05/14/2014 This is an ESTIMATE only. Employee must be covered by the state group health insurance program on the retirement date to be eligible for these credits.					
Employee Information Member Name Member SSN XXX-XX- Member ID Birth Date Gender FEMALE Termination Date 05/02/2015 Termination Reason Retirement Eligible			Health Plan at Date of Termination Health Plan Carrier Coverage Type Group Number Coverage Begin Date Coverage End Date Plan Subscriber		
Accumulated Leave (ANLCC) Information Unused Sick Leave Hours 1,270.00 Other Creditable Hours 0.00 Highest Basic Hourly Pay Rate \$ 25.00 ANLCC Total \$ 31,750.00			Employer Information Employer Name UNIVERSITY OF WISCONSIN SYSTEM Submitted by ETF on behalf of the employer Submitted date 05/14/2016		
Supplemental Sick Leave (SHCC) Information Seniority Date 01/01/1981 Academic Year Employee? No Bargaining Unit Years of Service in General/Executive Category (within the first 24 years) 24 Years of Service in Protective Category (within the first 24 years) 0 Years of Service in Excess of 24 years 10 Full Years of Service/Seniority 34.00 SHCC Eligible Hours 1,270.00 SHCC, 500 Hour Restoration 500.00 SHCC Total \$ 44,250.00			There are no previous versions of this certificate.		
Grand Total Certification Total \$ 76,000.00					
Generated on 05/14/2014		ET-4563 (REV 11/2012)			

1209 Escrow of Sick Leave Credits

Eligible state employees or their surviving dependents insured under the State Group Health Insurance Program at the time of termination may elect to escrow (bank) their accumulated sick leave credits. The employee can elect to escrow the sick leave for an indefinite period if continuously covered by comparable non-state health insurance coverage. Comparable non-state health insurance coverage means a plan with hospital and medical benefits substantially equivalent to the state’s Standard Plan.

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

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

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

1210 Payment

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

1211 Annual Statement of Account

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

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

Chapter 13 - Medicare

1301 Overview of Medicare

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.

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. Either the employer or the employee can enter the information into myETF Benefits. If the employer enters it, please have the employee provide a *Health Insurance Application* (ET-2301).

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

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

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

Premium Rates:

Active employees (non-annuitants) are not required to enroll in Medicare Part B when first eligible and do not receive the Medicare reduced premium rate in the event that they do enroll in Medicare. The coverage types of Medicare Single, Medicare Family - 1 and Medicare Family - 2 are not listed for active employees because they are not eligible for the Medicare reduced rates, as the Group Health Insurance Program pays primary on claims for these employees.

Employees aged 65 and older are automatically enrolled in Medicare Part A coverage. Upon retirement they and/or their Medicare eligible dependents must immediately enroll in Medicare Part B. At that time, their annuitant premiums will be reduced and Medicare will become the primary payer for their claims. If they do not enroll in Part B, they will be responsible for paying the portion of the claims Medicare would have paid if they had Part B. For example, Medicare

pays 80% for Part B services like allowable durable medical equipment and our program pays the remaining 20%. Without Part B coverage, the annuitant would pay the 80% portion of the claim.

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.

Annuitants:

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

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

Chapter 14 — Employee Death

1401 How to Report an Employee Death

1402 Surviving Spouse/Domestic Partner and Dependents

1403 Surviving Spouse/Domestic Partner who is also an Employee Eligible for Coverage

1401 Report an Employee Death to ETF Immediately

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

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

1402 Surviving Spouse and Dependents

In the event an employee or annuitant with family health coverage dies, the surviving spouse/domestic partner and/or eligible dependents will continue coverage. The surviving spouse/domestic partner may continue coverage indefinitely; dependent children (as defined under the State Group Health Insurance Program) may continue coverage as long as they remain eligible under the program. There will be no employer contribution towards the monthly premium.

If the surviving spouse/domestic partner and dependents **do not** wish to continue coverage, ETF must receive a signed written request. Should the surviving spouse/domestic partner (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 and use of sick leave credits to pay health insurance premiums. Premiums are due no later than the first of the month following the last month through which the decedent's premiums are paid. Premiums will be deducted from accumulated sick leave conversion credits or any WRS annuity the dependent may be receiving. If there is no sick leave or annuity, or the annuity is insufficient to allow for the deduction of the premium, the survivor must pay the premium directly to the health plan.

Survivors may not add persons to the policy who were not covered at the time of death, unless the individual was previously insured under the contract of the deceased employee and regains eligibility.

If an employee is covered under a spouse's/domestic partner's insurance plan outside of the State Group Health Insurance Program (through a private employer or a participating local employer) and the state employee dies, the surviving spouse/domestic partner does not have

access to the deceased state employee's accumulated sick leave.

Note: The employer must promptly certify accumulated and supplemental sick leave credits through the Accumulated Sick Leave System (AcSL) upon the death of an employee (refer to Chapter 12.)

1403 Surviving Spouse who is also a State Employee Eligible for Coverage

When an employee with family coverage dies, and the surviving spouse/domestic partner 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.
 - If the surviving spouse/domestic partner and/or dependent(s) are already covered under the State Group Health Insurance Program, the decedent's sick leave credits will automatically be banked for use.
 - Once the decedent's sick leave credits are banked, the surviving spouse/domestic partner and/or dependent(s) may use the banked sick leave credits when one of the following occurs:
 - An involuntary loss of health insurance coverage (e.g., terminating employment).
 - A retirement; in order to use the deceased employee's inactivated sick leave credits, the spouse/domestic partner must meet the eligibility requirements upon retirement as stated in Chapter 10, subchapter 1001.
2. Enroll as the surviving spouse/domestic partner and retain coverage indefinitely as indicated in subchapter 1402. Premiums will be paid through accumulated sick leave conversion credits, WRS annuity, or directly by the surviving spouse/domestic partner to the health plan.

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

Chapter 15 — Invoicing

1501 Viewing Your Invoice

1502 Reconciling Your Invoice

1503 Accepting and Paying Your Invoice (Wismart and Automated Clearing House (ACH))

1504 Late Interest Charge

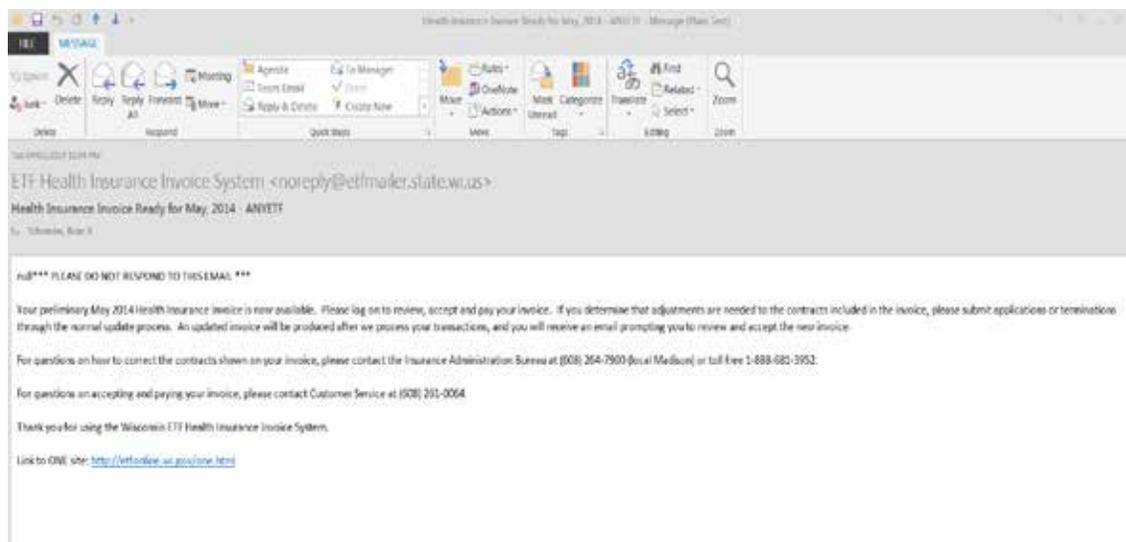
1505 Who to Contact for Assistance

1501 Viewing Your Invoice

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).

A. Invoice Generation

During the evening on the first day of every month, the myETF Benefits system initially generates an invoice for health insurance premiums for all state employers. An e-mail is sent to all employer's authorized agent and insurance contacts to alert them that an invoice is available for their review. An example of such an e-mail is below:



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

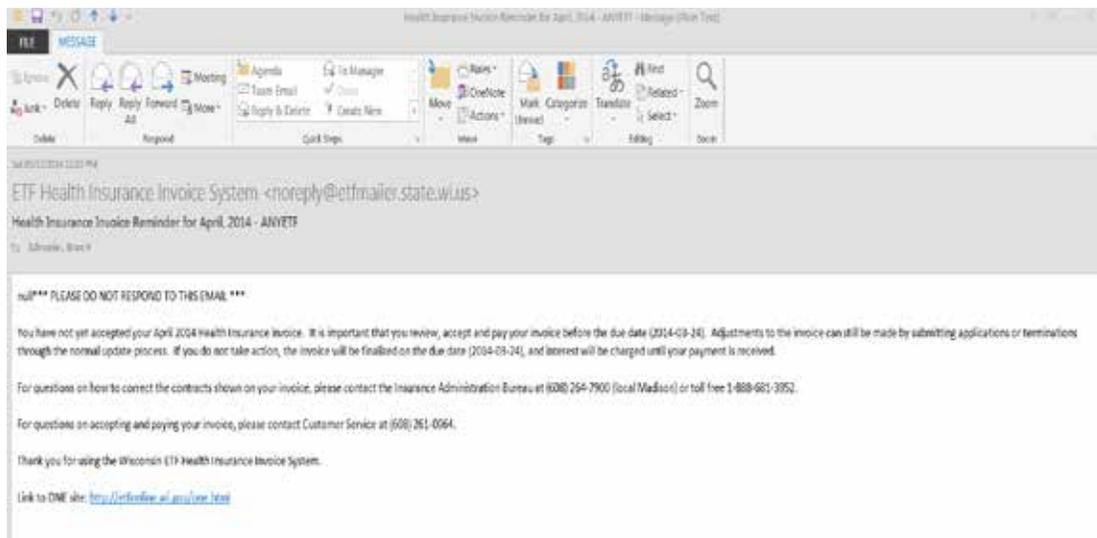
B. Invoice Regeneration and E-mail Notices

Each day, health insurance enrollments, terminations, changes in coverage level, or changes in health plans may be entered into myETF Benefits by the employee, the employer, or ETF. Whenever this is done, the invoice will regenerate to reflect what has been entered into the system. myETF Benefits will again send an e-mail to the authorized agent and insurance contacts to inform them the employer's invoice has again been created. An example of this e-mail is in Section A above. The system will go through this process each day that entries are made that change the previous days invoiced amount until the invoice is accepted by the employer. If no new entries are made that impact the previous day's invoice amount, the system will not regenerate the invoice and no additional e-mails will be sent.

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

C. Deadlines for Accepting Monthly Invoices

Once an invoice is generated by the myETF Benefits system, an authorized employer representative can accept that invoice at any time. This is done by accessing the myETF Benefits system and going to the *Health* drop-down and selecting *Premium, Employer Invoice*. If the invoice has not been accepted, on the 15th of every month the myETF Benefits system will send an e-mail to the person authorized to accept the invoice to remind them that the employer invoice has not been accepted. An example of such an e-mail is below.



The latest date an employer must accept the invoice is the 24th of each month. If the employer invoice is not accepted by 5:45 p.m. on the 24th of each month, any unaccepted employer invoice will automatically be accepted by the myETF Benefits system. See Section 1503 for more information on accepting and paying the monthly invoice and due dates.

D. Viewing the Employer Monthly Invoice

To access the monthly employer invoice, authorized users log into the myETF Benefits

system. Once logged in, the first screen displayed to the user will be the myEmployer Info screen.

1. The user should then click on the 'Health' tab. From the drop-down, move the mouse to the 'Premium' button. Hover over the 'Premium' button to display the 'Employer Invoice' and 'Member Invoice' buttons. Hover your mouse over 'Employer Invoice' and click on that button. myETF Benefits will take the user to the next screen—*Employer E-mail Check*.



2. On this screen, the agent or authorized user can use this screen to view and update their individual e-mail contact information by clicking on the *employer e-mail address update* link. If the user is not updating their e-mail contact information, click the 'Continue' button to move to the Health Insurance Invoice Summary screen.



3. The *Health Insurance Invoice Summary* screen provides the user with the ability to search for the invoice by coverage month and year. Users can review the current coverage month's invoice or previous invoices. This screen also provides employers with the invoice amount, invoice number, invoice date (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 is required to make an entry in once it is determined how much of the invoice amount is the employee share.

At the bottom of the Health Insurance Invoice Summary are the 'Invoice Detail', 'Contract Activity' and 'Accept' buttons. The 'Invoice Detail' and 'Contract Activity' applications are used in reconciling the invoice and are discussed in subchapter 1502. The 'Accept' button is used once the invoice has been reconciled and the employer is ready to accept the invoice and pay the invoice amount. Refer to subchapter 1503 for more information and instructions on accepting and paying your invoice.



1502 Reconciling Your Invoice

To ensure employers are accurately paying the premiums due for their employee’s health insurance coverage, the invoice amount and invoice activity must be reconciled each month against the employer’s payroll system. To reconcile the monthly invoice, employers have available to them the “Invoice Detail” and “Contract Activity” applications. In addition, employers have access to two reports to utilize in their reconciliation effort, the “Enrollment Report” and “Premium Report”.

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.



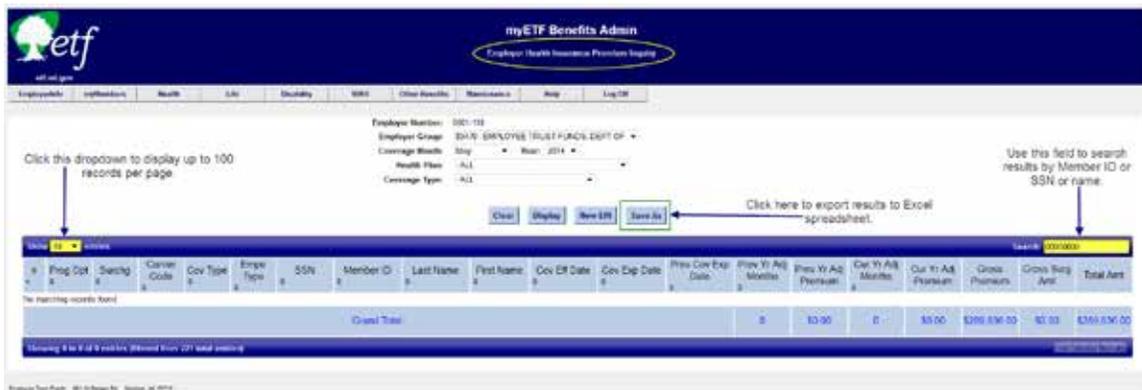
1. When the 'Premium Inquiry' application opens, you will get the following screen. The user must set the search filters for coverage month and year, health plan and coverage type.

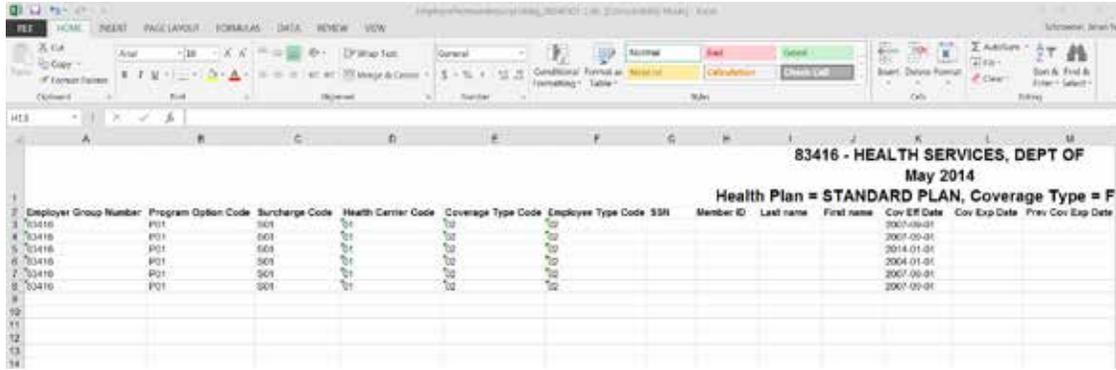


The following illustrates the results once the search filters are set and the user clicks 'Display'. The results being displayed will provide the specific details of the employees for whom you are being billed or refunds are being generated on that coverage month's invoice by health plan and coverage type with the specific premium amount. A separate line will display for an adjustment that is refunding premiums to the employer for any month(s) in the current year or previous year and a separate line will display any adjustment that is charging premiums to the employer for any month(s) in the current year or previous year.

The user can click on 'Clear' and set new filters from the drop-downs, then click 'Display'. The user can also go directly to the drop-downs, select new filters, then click 'Display' again without clearing the screen.

The 'Save As' button provides the user the ability to take the information being displayed and move it to an Excel spreadsheet. Using the Excel spreadsheet allows the user to sort however they wish and run it against their payroll system in their reconciliation effort.





In addition to the functionality of creating an Excel spreadsheet, employers have the ability to sort the data retrieved by each specific column without creating an Excel spreadsheet. This is accomplished by clicking on the arrow symbol (highlighted) just under each column name.

n	Prog Opt	Surchg Code	Carrier Code	Cov Type	Empe Type	SSN	Member ID	Last Name	First Name	Cov Eff Date	Cov Exp Date	Prev Cov Exp Date	Prev Yr Adj Months	Prev Yr Adj Premium	Cur Yr Adj Months	Cur Yr Adj Premium	Gross Premium	Gross Surg Amt	Total Amt
---	----------	-------------	--------------	----------	-----------	-----	-----------	-----------	------------	--------------	--------------	-------------------	--------------------	---------------------	-------------------	--------------------	---------------	----------------	-----------

2. Invoice Detail

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



The information displayed is the total number of contracts being billed on the invoice. The information is broken down by health plan, employee type and coverage level. The application totals the contracts into one group total and assesses the Employee Reimbursement Accounts Administrative Fee that is added to the total invoice amount. This application does not provide specific employee information for whom the employer is being billed.

Health Plan	Employee Type	Coverage Type	Number of contracts by carrier/coverage type	Premium amount	Total premiums for coverage type and number of contracts	Prior month adjustments by carrier/coverage type	Premiums total by carrier/coverage type
12 2014 HEALTH PLAN	STATE EMPLOYEE - REGULAR	REGULAR	1	1,044.76	1,044.76	0.00	1,044.76
12 2014 HEALTH PLAN	Health Plan Fee	None	1	0.00	0.00	0.00	0.00
12 2014 HEALTH PLAN	STATE EMPLOYEE - REGULAR	REGULAR	1	818.10	818.10	0.00	818.10
12 2014 HEALTH PLAN	Health Plan Fee	None	1	0.00	0.00	0.00	0.00
12 2014 HEALTH PLAN	STATE EMPLOYEE - REGULAR	REGULAR	1	807.20	807.20	0.00	807.20
12 2014 HEALTH PLAN	Health Plan Fee	None	1	0.00	0.00	0.00	0.00
12 2014 HEALTH PLAN	STATE EMPLOYEE - REGULAR	REGULAR	1	1,001.40	1,001.40	0.00	1,001.40
12 2014 HEALTH PLAN	Health Plan Fee	None	1	0.00	0.00	0.00	0.00
Total Total			4	4,862.46	4,862.46	0.00	4,862.46

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.

Invoice and Payment Summary
For 9001-110 - EMPLOYEES TRUST FUNDS DEPT OF

Insurance Contact is JOANNE KRAUSE 508-256-7307. If not correct, please call (508) 261-0064.

Search by Coverage: Month: June Year: 2014

Summary for June 2014

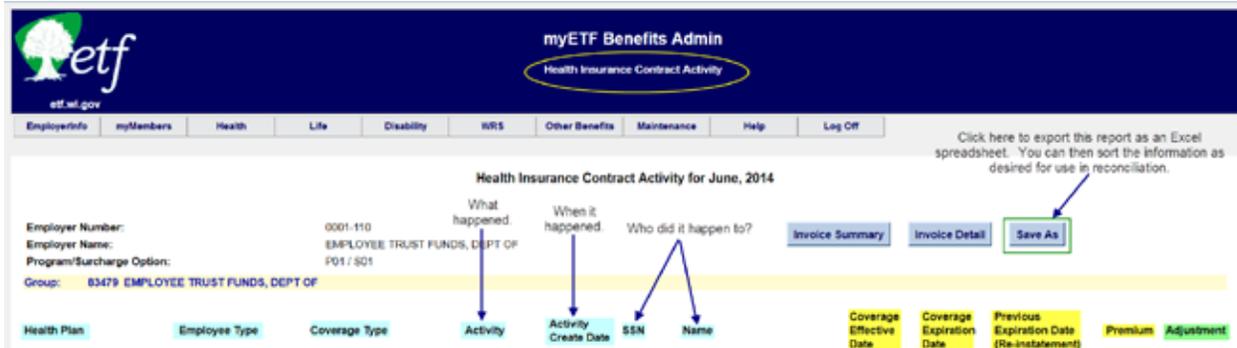
Invoice Amount: 0.00
Invoice Number:
Invoice Date:
Accept Date:
Approved By:
Employee Name:
Initial Payment Label:
Interest Amount: 0.00

June 2014 Premium Due: 0.00

Buttons: Invoice Detail, **Contract Activity**, Approve

Click here to access the Contract Activity screen. This will display the adds, terms, and coverage level changes (as adds and terms) that occurred during the invoice period. This does NOT show all individuals who are on the employers invoice, only those with changes.

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.



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

Wismart

Automated Clearing House (ACH)

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 e-mail acknowledging the acceptance of the invoice. Once an invoice has been accepted, no further changes can be made to it.

If an invoice has not been accepted by the due date, the system will automatically accept it on the employer’s behalf that night. The employer will receive an e-mail letting them know that the system has accepted the invoice and they need to submit a payment.

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

Paying the Invoice:

ETF uses myETF Benefits as the system of record. The *invoice premium due* field is the amount owed to ETF. The invoice reflects what ETF will remit to the health plans on behalf of the employers.

State employers are set up to pay either by Wismart Payment Voucher (PV) or Automated Clearing House (ACH).

Wismart PV:

The employer will need to log in to Wismart and approve the applicable PV(s). Once the PV(s) has been accepted in Wismart, ETF will see it on their report the following day. Payments submitted in Wismart are manually keyed into the Health Insurance Payments System by ETF staff at the end of each month. At this time the current invoice balance will be reflected in myETF Benefits. Any outstanding balances should be resolved on the next payment.

If you have any issues with Wismart you should contact the Wismart help desk at 1-608-264-6600.

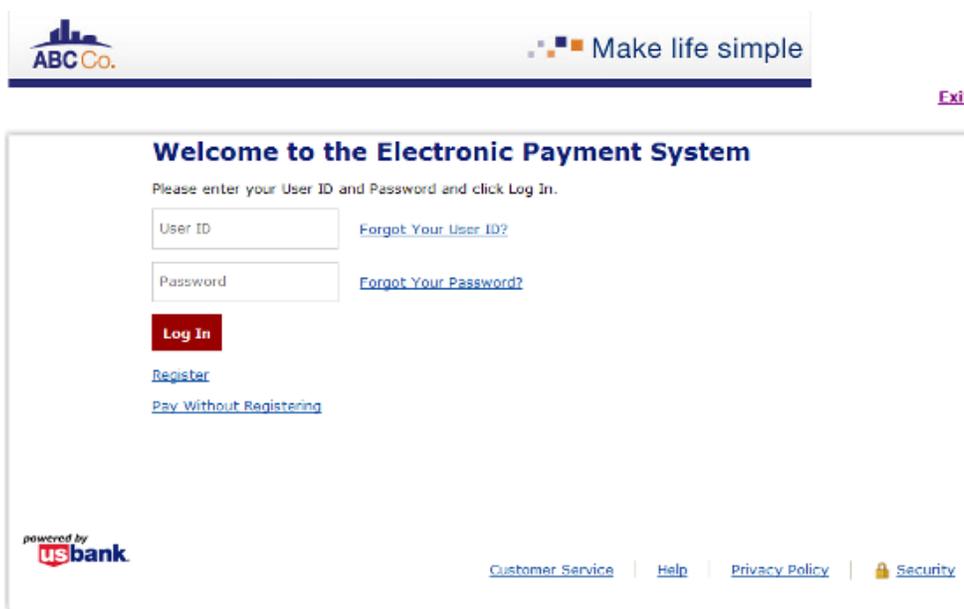
Automated Clearing House (ACH):

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

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

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

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



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

ABC Co. Make life simple Exit

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

Make a Payment

My Payment

Payment for Your Organization

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

Payment Information

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

Payment Method

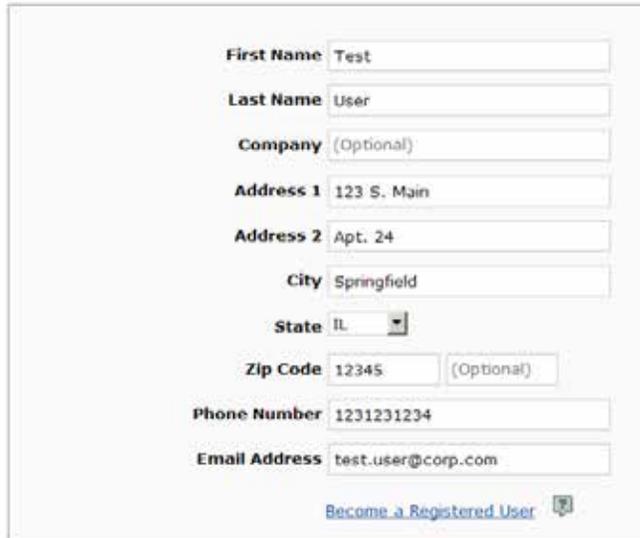
Saved Payment Methods Select [Use a new payment account](#)
Email Address test.user@corp.com

Continue Cancel

This will have 3 sections.

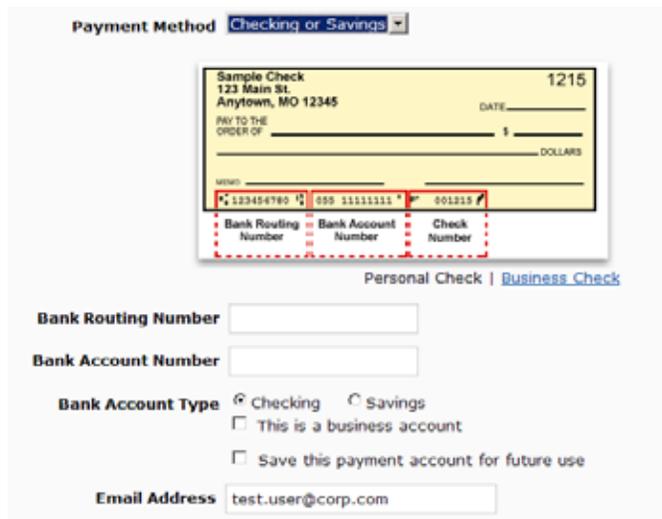
1. My Payment – This will show the Amount Due and Due Date
2. Payment Information – This is where users will select their payment terms
 - a. Frequency – Select One Time.
 - b. Payment Date – Select either Pay Now or Pay on a future date.
 - i. Selecting Pay on a future date allows the user to select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

Contact Information



A form titled "Contact Information" with the following fields: First Name (Test), Last Name (User), Company (Optional), Address 1 (123 S. Main), Address 2 (Apt. 24), City (Springfield), State (IL), Zip Code (12345) (Optional), Phone Number (1231231234), and Email Address (test.user@corp.com). A link "Become a Registered User" is at the bottom right.

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.



A form titled "Payment Method" with a dropdown menu set to "Checking or Savings". It features a "Sample Check" image with fields for Bank Routing Number (123456789), Bank Account Number (987 11111111), and Check Number (001213). Below the image are input fields for "Bank Routing Number", "Bank Account Number", and "Bank Account Type" (radio buttons for "Checking" and "Savings", with checkboxes for "This is a business account" and "Save this payment account for future use"). An "Email Address" field contains "test.user@corp.com".

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

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

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

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

Review Payment

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

Payment Details

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

Payment Method

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

Billing Address

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

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

powered by 

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

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

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

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

Confirmation

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

Confirmation Number **KATABC00001543**

Payment Details

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

Payment Method

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

Billing Address

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

powered by 

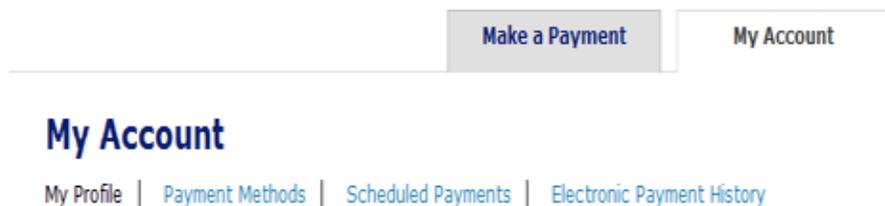
[Customer Service](#) | [Help](#) | [Privacy Policy](#) | [Security](#)

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

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

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

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



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

1504 Late Interest Charge

Payment is due the 24th of every month, with exceptions being weekends and US Bank holidays. If a payment is received after the due date then a late payment interest charge will be applied to the employer's invoice based on the following calculation:

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

The interest charge will be assessed after the payment has been submitted and should be paid as soon as possible. For employers paying by Wismart PV, the late interest charge can be paid as an additional PV or an amount added to the following month's PV. Employer's 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.

My Account

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

My Contact Information

First Name	Test
Last Name	User
Company	(Optional)
Address 1	123 S. Main
Address 2	Apt. 24
City	Springfield
State	IL
Zip Code	12345 (Optional)
Phone Number	(123)123-1234
Email Address	test.user@corp.com

Login Details

User ID	krtest1
Password	**** Change my Password
Security Question	What was the name of your childhood best friend?
Answer	Sue
Security Question	What is your favorite sports team?
Answer	Spartans
Security Question	What is your mother's maiden name?
Answer	Lynn

[Save](#) [Cancel](#)

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.

My Account

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

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

Nickname	Method	Type	Number	Actions
Test Visa	Credit	Visa	*1111	Edit Delete

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

My Account

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

Electronic Payment History

Show entries

Search Filter:

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

Showing 1 to 5 of 5 entries

[First](#) [Previous](#) [1](#) [Next](#) [Last](#)

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.

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

Appendix A — Forms and Brochures

Document name	Form number	Link
WRS Administration Manual	ET-1127	http://etf.wi.gov/publications/et1127.pdf
Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits (Health Insurance contract)	ET-1136	Contact ETF for a copy.
It's Your Choice Decision Guide	ET-2107d	http://etf.wi.gov/publications/iyc14/et2107d.pdf
It's Your Choice Reference Guide	ET-2107r	http://etf.wi.gov/publications/iyc14/et2107r.pdf
State Standard Plan	ET-2112	http://etf.wi.gov/publications/et2112.pdf
Group Health Insurance Application	ET-2301	http://etf.wi.gov/publications/et2301.pdf
COBRA Continuation Conversion Notice	ET-2311	http://etf.wi.gov/publications/et2311.docx
Rehired Annuitant Form	ET-2319	http://etf.wi.gov/publications/et2319.pdf
Converting Your Group Life Insurance to Pay for Health Insurance or Long Term Care Insurance Premiums	ET-2325	http://etf.wi.gov/publications/et2325.pdf
Affidavit of Domestic Partnership	ET-2371	http://etf.wi.gov/publications/et2371.pdf
Affidavit of Termination of Domestic Partnership	ET-2372	http://etf.wi.gov/publications/et2372.pdf
Group Health Insurance	ET-4112	http://etf.wi.gov/publications/et4112.pdf
Sick Leave Conversion Credit Brochure	ET-4132	http://etf.wi.gov/publications/et4132.pdf
Sick Leave Escrow Application	ET-4305	http://etf.wi.gov/publications/et4305.pdf
Medicare Eligibility Statement	ET-4307	http://etf.wi.gov/publications/et4307.pdf

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

Appendix B — Codes

1. **Employee Type Codes**
2. **Coverage Type Codes**
3. **Individual Relationship Codes**
4. **Health Plan Codes**
5. **High Deductible Health Plan (HDHP) Codes**

1. Employee Type Codes

Code	Employee Coverage	Description
01	State-elected	Legislators, state constitutional officers, circuit, supreme court, or appeals judges, chief clerk or Sergeant-at-Arms of the Senate or Assembly
02	Regular State	State Employee
03	UW Classified	UW other than faculty.
04	UW Unclassified	UW Faculty
05	Beyond Vision (aka WISCRAFT)	For use by Beyond Visison (aka WISCRAFT) only - for blind employees with over 1,000 hours.
07	State Annuitant	Retired employee who is eligible for health insurance.
08	State Surviving Spouse/Dependent	Used for survivors of currently insured subscriber who dies while carrying family health insurance coverage.
10	State Continuant	ETF Use Only - Continuant
11	State Participant – 1991 WI Act 152	Terminated State Employee with at least 20 years of creditable service.
12	Graduate Assistant	Graduate Assistants, employees in training, short-term academic staff, fellows, and scholars.
13	Continuant- Graduate Assistant	ETF Use Only - Graduate Assistant Continuant.
17	LTE	Limited term employees.

2. Coverage Type Codes

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

3. Individual Relationship Codes

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

4. Health Plan Codes

Code	Health Plan Name
01	STANDARD PLAN
05	SMP
11	ANTHEM BLUE PREFERRED SOUTHEAST
14	ANTHEM BLUE PREFERRED NORTHEAST
15	DEAN HEALTH INSURANCE
17	DEAN HEALTH INSURANCE PREVEA360
21	HUMANA EASTERN
22	HUMANA WESTERN
30	GHC OF EAU CLAIRE
35	GHC OF SOUTH CENTRAL WISCONSIN
37	GUNDERSEN HEALTH PLAN
40	UNITY HEALTH INSURANCE COMMUNITY
47	ARISE HEALTH PLAN NORTHERN
48	ARISE HEALTH PLAN SOUTHEAST (eff. 01/01/2015)
55	HEALTH TRADITION HEALTH PLAN
63	MEDICAL ASSOCIATES HEALTH PLAN
64	MERCYCARE HEALTH PLANS
70	NETWORK HEALTH
71	SECURITY HEALTH PLAN
74	PHYSICIANS PLUS
84	WPS METRO CHOICE SOUTHEAST (withdrawn 12/31/2014)
85	HEALTHPARTNERS HEALTH PLAN
86	WEA TRUST EAST
87	WEA TRUST NORTHWEST CHIPPEWA VALLEY
88	WPS METRO CHOICE NORTHWEST (withdrawn 12/31/2014)
89	WEA TRUST SOUTH CENTRAL
90	WEA TRUST NORTHWEST MAYO CLINIC HEALTH SYSTEM (eff. 01/01/2015)
92	UNITY HEALTH INSURANCE UW HEALTH
94	UNITEDHEALTHCARE OF WISCONSIN

5. High Deductible Plan (HDHP) Codes - (effective January 1, 2015)

Code	Health Plan Name
H6	HDHP - STANDARD PLAN
H7	HDHP - SMP
HA	HDHP - ANTHEM BLUE PREFERRED SOUTHEAST
HB	HDHP - ANTHEM BLUE PREFERRED NORTHEAST
HC	HDHP - DEAN HEALTH INSURANCE
HD	HDHP - DEAN HEALTH INSURANCE PREVEA360
HE	HDHP - HUMANA EASTERN
HF	HDHP - HUMANA WESTERN
HG	HDHP - GHC OF EAU CLAIRE
HH	HDHP - GHC OF SOUTH CENTRAL WISCONSIN
HI	HDHP - GUNDERSEN HEALTH PLAN
HJ	HDHP - UNITY HEALTH INSURANCE COMMUNITY
HK	HDHP - ARISE HEALTH PLAN NORTHERN
HL	HDHP - ARISE HEALTH PLAN SOUTHEAST
HM	HDHP - HDHP - HEALTH TRADITION HEALTH PLAN
HN	HDHP - MEDICAL ASSOCIATES HEALTH PLAN
HO	HDHP - MERCYCARE HEALTH PLANS
HP	HDHP - NETWORK HEALTH
HQ	HDHP - SECURITY HEALTH PLAN
HR	HDHP - PHYSICIANS PLUS
HS	HDHP - HEALTHPARTNERS HEALTH PLAN
HT	HDHP - WEA TRUST EAST
HU	HDHP - WEA TRUST NORTHWEST CHIPPEWA VALLEY
HV	HDHP - WEA TRUST SOUTHCENTRAL
HW	HDHP - WEA TRUST NORTHWEST MAYO CLINIC HEALTH SYSTEM
HX	HDHP - UNITY HEALTH INSURANCE UW HEALTH
HY	HDHP - UNITEDHEALTHCARE OF WISCONSIN

**Department of Employee Trust Funds
State Agency Health Insurance Administration Manual**

Appendix C — myETF Benefits

C-1 How to Log Into myETF Benefits

C-2 Add Coverage

C-3 Add Dependent

C-4 Remove Dependent

C-5 Change Health Plans

C-6 Termination of Coverage

C-7 Pending Transactions

C-8 Enrollment Inquiry

C-9 Dependent Inquiry

C-10 Address Inquiry

C-1. How to Log into myETF Benefits

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

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

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

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





4. Enter your User ID and Password.



5. Enter your employer number and click the 'Verify' button.

myETF Benefits Admin
Employer Info

Employer Info myMembers Health Life Disability WRS Other Benefits Help Log Off

Employer Specific Function - Employer Number Required

Use this screen to specify the employer whose data you would like to access. You must provide the employer's seven digit employer number. You must have the authority to access this information.

Please enter the seven digit Employer Number and click Verify

Employer Number:

Verify

Employee Trust Funds 821 W Edger Rd Madison, WI 53713

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

myETF Benefits Admin
myEmployerInfo

Employer Number: XXXX-XXX Employer Name: EMPLOYER

Contact Info Health Insurance Life Insurance

Agent Contact Insurance Contact

Name: AGENT NAME Telephone: 0000-XXX-XXXX

Name: AGENT NAME Telephone: 0000-XXX-XXXX

Retirement Contact Address Information

Name: AGENT NAME Telephone: 0000-XXX-XXXX

Address: AGENT ADDRESS CITY, ST, ZIP CODE

Agent Email: An agent email available More Clear

myMembers Requests New EIN Employee Locations

Employee Trust Funds 821 W Edger Rd Madison, WI 53713

C-2. Add Coverage

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

ETF Use Only		State of Wisconsin Department of Employee Trust Funds (ETF) Health Insurance Application/Change Form						Employer Notes		
1. APPLICANT INFORMATION			ETF Member ID			SSN <u>XXX-XX-XXXX</u>				
Applicant Name – First <u>FIRST</u>	M.I. <u>M</u>	Last <u>LAST</u>	Previous Name		DOB MM/DD/CCYY	Gender <u>M</u>	Physician/Clinic <u>PRAIRIE CLINIC</u>			
Home Mailing Address—Street and No. <u>1234 STREET LANE</u>			City <u>CITY</u>	State <u>ST</u>	Zip Code <u>ZIPCODE</u>	<input type="checkbox"/> Check here if updating address phone, email, or marital status.				
Primary Telephone Number: (608) 555-1111			Country (if not USA)		Applicant E-mail:					
MARITAL OR DOMESTIC PARTNERSHIP STATUS: <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership (DP) <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Date: <u>MM/DD/CCYY</u>										
Spouse/DP: SSN <u>XXX-XX-XXXX</u>			Name <u>FIRST NAME/LAST NAME</u>							
Previous Name <u>MAIDEN NAME</u>			Physician/Clinic <u>PRAIRIE CLINIC</u>							
DOB: <u>MM/DD/CCYY</u>			Gender: <u>F</u>			Tax Dep <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
ELIGIBILITY STATUS: <input checked="" type="checkbox"/> Employee <input type="checkbox"/> Graduate Assistant <input type="checkbox"/> Survivor <input type="checkbox"/> Continuant (COBRA) <input type="checkbox"/> Annuitant/Retiree				NEW HIRE — I WANT MY COVERAGE TO BE EFFECTIVE: <input checked="" type="checkbox"/> As soon as possible (Employee will pay entire monthly premium until eligible for contribution) <input type="checkbox"/> When employer contributes to premium						
Coverage Desired <input type="checkbox"/> Single <input checked="" type="checkbox"/> Family			Health Plan Selected: <u>Unity - Community</u>							
2. REASON FOR APPLICATION Reasons marked with an * require supporting documentation. See page 4 of this application for specific documentation requirements.										
A. Decline Coverage (Check one box below and go to Section 6 to sign and date your application.) <input type="checkbox"/> I do not wish to enroll at this time. <input type="checkbox"/> I do not wish to enroll at this time as I currently have other insurance coverage.										
B. Enrollment (Check a Reason and an Event below and indicate the date of event. Update Dependent Information below as appropriate) Note: Deletion of a Dependent due to loss of eligibility provides a COBRA enrollment opportunity. Notice must be provided to Employer within 60 days of event.										
Reason: <input checked="" type="checkbox"/> Add Coverage (Add Cvg) <input type="checkbox"/> Add Dependent (Add Dep) <input type="checkbox"/> Remove Dependent (Rem Dep)										
Event:										
<input checked="" type="checkbox"/> New Hire (Add Cvg)			<input type="checkbox"/> State Annuitant/Retiree Re-enroll Effective Date _____ (Add Cvg)							
<input type="checkbox"/> Spouse/DP to Spouse/DP Transfer (Add Cvg)			<input type="checkbox"/> Eligible Dependent Not Included on Initial Enrollment (Excludes DP and Adult Dependents)							
<input type="checkbox"/> Transfer from One Employer to Another Employer (Add Cvg)			<input type="checkbox"/> Loss of other Coverage/Employer Contributions* (Add Cvg, Add Dep)							
Name of Previous Employer _____			<input type="checkbox"/> Divorce*/DP Terminated* (Rem Dep)							
<input type="checkbox"/> Marriage/DP* (Add Cvg, Add Dep)			<input type="checkbox"/> Death of Dependent (Rem Dep)							
<input type="checkbox"/> Birth (Add Cvg, Add Dep)			<input type="checkbox"/> Disabled Dependent: Disability Ends or Dependent Marries or Support less than 50% (Rem Dep)							
<input type="checkbox"/> Adoption* (Add Cvg, Add Dep)			<input type="checkbox"/> Grandchild's Parent Turns 18 (Rem Dep)							
<input type="checkbox"/> National Medical Support Notice* (Add Dep)			<input type="checkbox"/> Adult Dependent Eligible for other coverage (Rem Dep)							
<input type="checkbox"/> Paternity Acknowledgment* (Add Dep)			<input type="checkbox"/> Annual It's Your Choice (Jan. 1) (Add Cvg, Add Dep, Rem Dep)							
<input type="checkbox"/> Legal Ward/Guardianship* (Add Dep)			<input type="checkbox"/> COBRA (Add Cvg)							
<input type="checkbox"/> Legal Ward/Guardianship Ends* (Rem Dep)			<input type="checkbox"/> Other: _____							
<input type="checkbox"/> Disabled, Age 26 or Older* (Add Dep)			Event Date: <u>09/19/2013</u> (required)							
<input type="checkbox"/> LTE New Hire - State Only (Add Cvg)										
DEPENDENT INFORMATION (excludes spouse/DP) — Complete all requested information.										
Social Security Number	First Name	M.I.	Last	Previous	Birth Date (mm/dd/ccyy)	Gender (M/F)	Rel. Code	Tax Dep? (Y/N)	Disabled? (Y/N)	Enter Physician/Clinic or Provide Dependent address for COBRA, if removing dependent.
<u>XXX-XX-XXXX</u>	<u>CHILD</u>	<u>M</u>	<u>LAST</u>		<u>MM/DD/CCYY</u>	<u>F</u>	<u>19</u>	<u>Y</u>	<u>N</u>	<u>PRAIRIE CLINIC</u>



Applicant Name XXXXXXXX		ETF Member ID	SSN XXXXXXXXXX
2. REASON FOR APPLICATION (continued) Reasons marked with an * require supporting documentation. See page 4 of this application for specific documentation requirements.			
C. Change Health Plan (Check one box below, Indicate Current Health plan, Provide date of event, Update Section 1 or 2 if applicable) <input type="checkbox"/> Move from Service Area <input type="checkbox"/> Eligible Section 125 Status Change (see Instructions, Section 2(4))* <input type="checkbox"/> Annual It's Your Choice (Jan. 1) Current Health Plan: _____ Event Date: _____			
D. Spouse/DP/Dependent Personal Data Update/Correction <input type="checkbox"/> Update Name/SSN/DOB (Complete Section 1 or 2) Previous Name _____ Previous DOB _____ Previous SSN _____			
E. Cancel Coverage: <input type="checkbox"/> I wish to cancel coverage: Event Date _____ (Check a post-tax or pre-tax box below.) My Premiums are Deducted: <input type="checkbox"/> Post-tax, Coverage may be cancelled at any time <input type="checkbox"/> Pre-tax (If pre-tax check a box below.) <input type="checkbox"/> I am terminating employment. <input type="checkbox"/> My employee premium contribution has increased significantly.* <input type="checkbox"/> I am going on unpaid leave of absence. <input type="checkbox"/> I (and all dependents if applicable) became eligible for and enrolled in other group coverage.* <input type="checkbox"/> Cancel current family coverage to perform a spouse to spouse transfer. <input type="checkbox"/> Eligible Section 125 Status Change* (see Instructions, Section 2(4))* <input type="checkbox"/> Annual It's Your Choice Enrollment (Jan. 1). Event: _____ Note: If pre-tax, coverage may only be cancelled due to a qualifying event or during the annual It's Your Choice period.			
F. Family to Single Coverage: If your employee premium share is taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage. My employee-required premium contribution is deducted (Check one box below, indicate event date, and update Section 1): <input type="checkbox"/> Pre-tax and my employee premium contribution has increased significantly <input type="checkbox"/> Pre-tax and my last dependent has become ineligible for this coverage. <input type="checkbox"/> Pre-tax and all dependents became eligible for and enrolled in other group coverage.* <input type="checkbox"/> Pre-tax, eligible Section 125 Status Change (see Instructions, Section 2(4))* Event: _____ <input type="checkbox"/> Pre-tax, change to single during annual It's Your Choice (Jan. 1). Event Date: _____ <input type="checkbox"/> Post-tax, midyear changes to coverage level can be made at any time.			
3. ADDITIONAL INFORMATION Are any of the dependents listed under Dependent Information your or your spouse/DP's grandchild? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of parent _____			
4. MEDICARE INFORMATION/UPDATE MEDICARE INFORMATION Are you or any insured dependent covered under Medicare? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If yes, list names of insured and Medicare dates. Name: _____ Dates: Part A _____ Part B _____ HIC # _____ Name: _____ Dates: Part A _____ Part B _____ HIC # _____			
5. OTHER HEALTH INSURANCE COVERAGE/UPDATE OTHER HEALTH INSURANCE (If yes, complete requested information) Other coverage? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Name of Company _____ Policy #: _____ Group #: _____ Name(s) of Insured: _____			
6. SIGNATURE (Read the TERMS AND CONDITIONS on page 7 and sign the application.) By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and I have read and agree to the TERMS AND CONDITIONS . A copy of this application is to be considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. §943.395. Additional documentation may be required by ETF at any time to verify eligibility.			
SIGN HERE & Return to Employer 		Signature Date Signed (mm/dd/yy) 09/23/13	
7. EMPLOYER COMPLETES (Coding instructions are in the Employer Health Insurance Administration Manual)			
Employer Number 69-036-XXXX-XXX		Name of Employer NAME OF EMPLOYER	
Payroll Representative E-mail			
Group Number XXXX	Employee Type 02	Coverage Type Code 02	Health Plan Name or Suffix UNITY COMMUNITY/40
EMPLOYMENT STATUS: <input checked="" type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> LTE		Employee Deductions: <input checked="" type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax	
Previous Service - Complete Information 1. Are you a WRS participating employer? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If Yes, answer questions 2, 3, and 4. 2. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. Previous service check completed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 4. Source of previous service check: <input checked="" type="checkbox"/> Online Network for Employers (ONE) <input type="checkbox"/> ETF		Date WRS Eligible Employment or Graduate Assistant Appointment Began or Hire Date 09/19/13	Employer Received Date 09/23/13
Payroll Representative Signature/Phone Number (XXX) XXX-XXXX Agent Name		Event Date 09/19/13	Prospective Date of Coverage 10/01/13

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

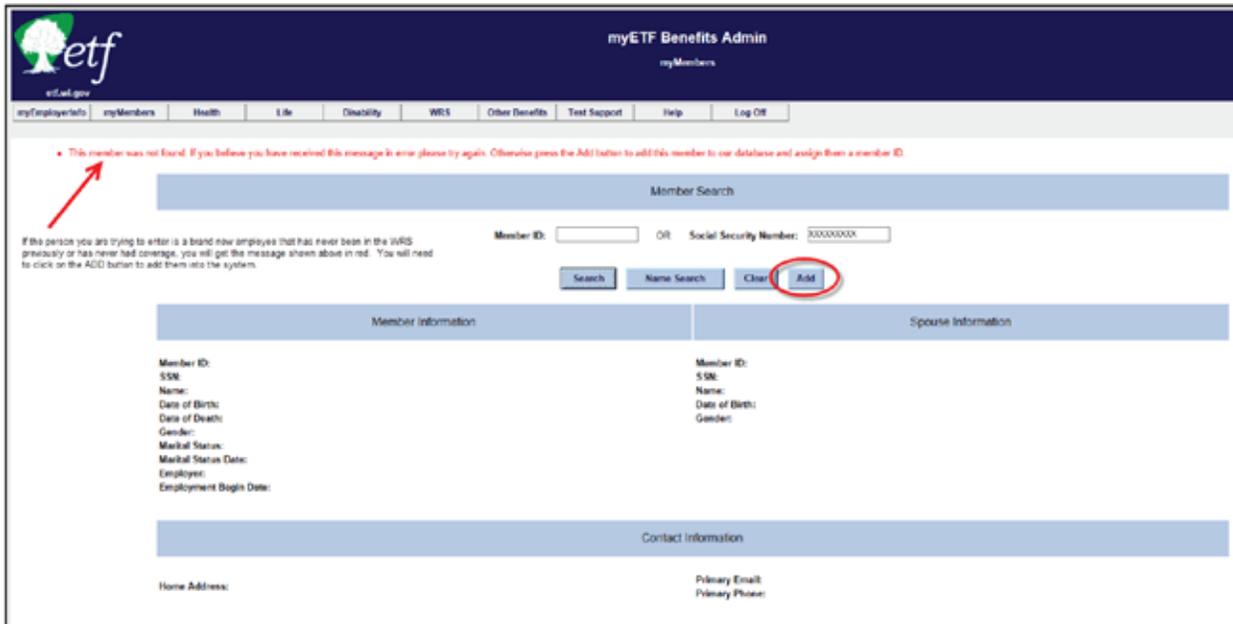
The screenshot shows the 'myETF Benefits Admin' interface. At the top, there is a navigation bar with the 'myMembers' tab highlighted by a red circle. Below the navigation bar, there are fields for 'Employer Number' (XXXX-XXX) and 'Employer Name' (EMPLOYER). The main content area is divided into sections for 'Agent Contact', 'Insurance Contact', 'Retirement Contact', and 'Address Information'. Each section contains fields for Name, Telephone, and Agent Name. A 'Search' button is visible at the bottom right of the main content area.

The screenshot shows the 'myETF Benefits Admin' interface. The 'myMembers' tab is selected in a dropdown menu, indicated by a red arrow. The main content area shows the 'myMembers Requests' section with fields for 'Employer Number' (XXXX-XXX) and 'Employer Name' (EMPLOYER).

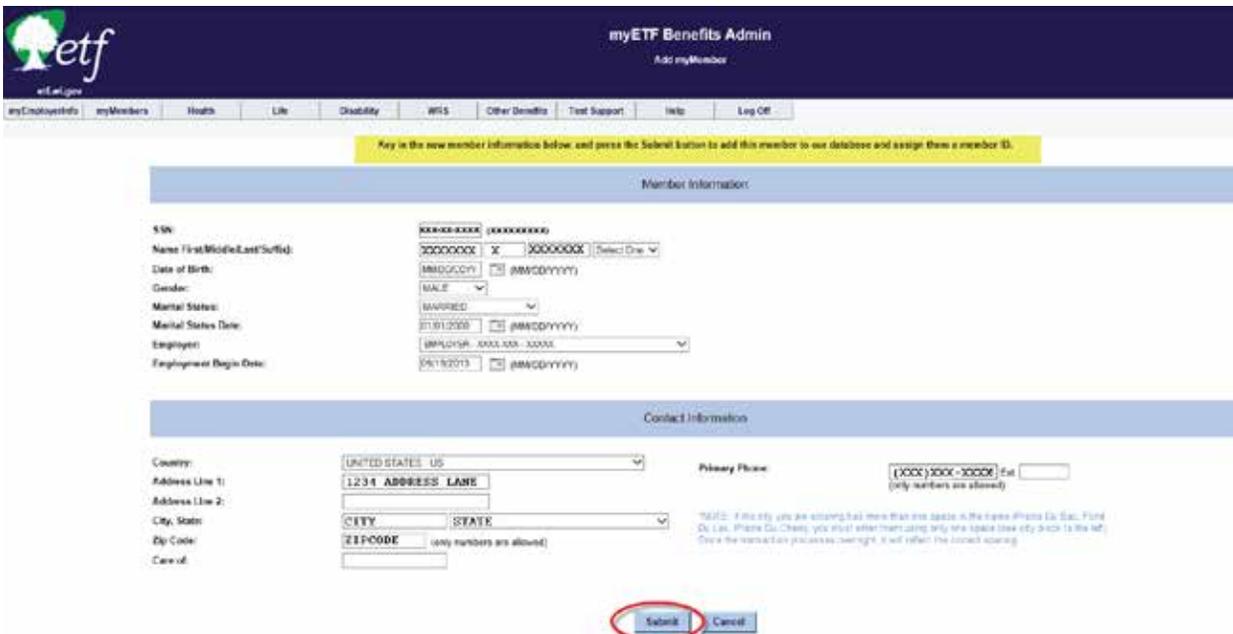
2. Enter the employee's ETF Member ID or SSN into the appropriate box and click the 'Search' button or click 'Enter' (if it is a brand new employee with no prior WRS service, there will not be an ETF Member ID).

The screenshot shows the 'myETF Benefits Admin' interface. The 'Member Search' form is displayed. The 'Member ID' field is highlighted with a red circle, and the 'Search' button is also highlighted with a red circle. The form includes fields for 'Member ID' and 'Social Security Number' (XXXXXXX). Below the search form, there are sections for 'Member Information' and 'Spouse Information', each with fields for Name, SSN, Date of Birth, Date of Death, Gender, Married Status, Married Status Date, Employer, and Employment Begin Date. A 'Contact Information' section is also visible at the bottom.

- a. If the employee’s basic demographic information pops up, scroll to the bottom of the page and click the ‘Edit’ button.
- b. If the employee can not be found, click the ‘Add’ button near the top of the screen.



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



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

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

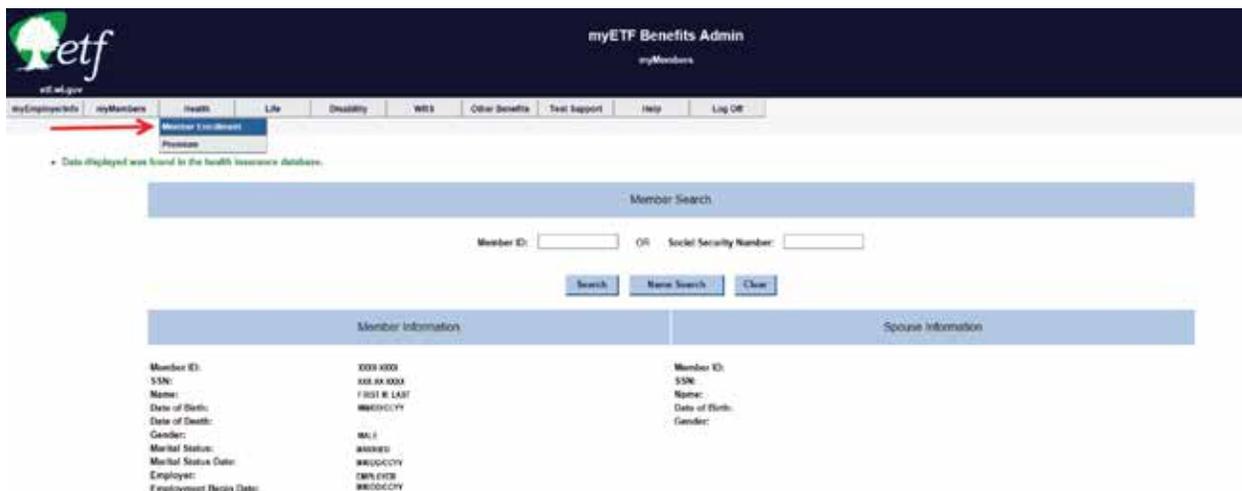
5. Once you are on the review page, review the data (any changes/additions will appear in red).
 - a. If all corrections/additions are correct, click the 'Confirm' button.
 - b. If additional changes are needed, click the 'Cancel' button and return to the previous screen and follow the procedures under Number 3.



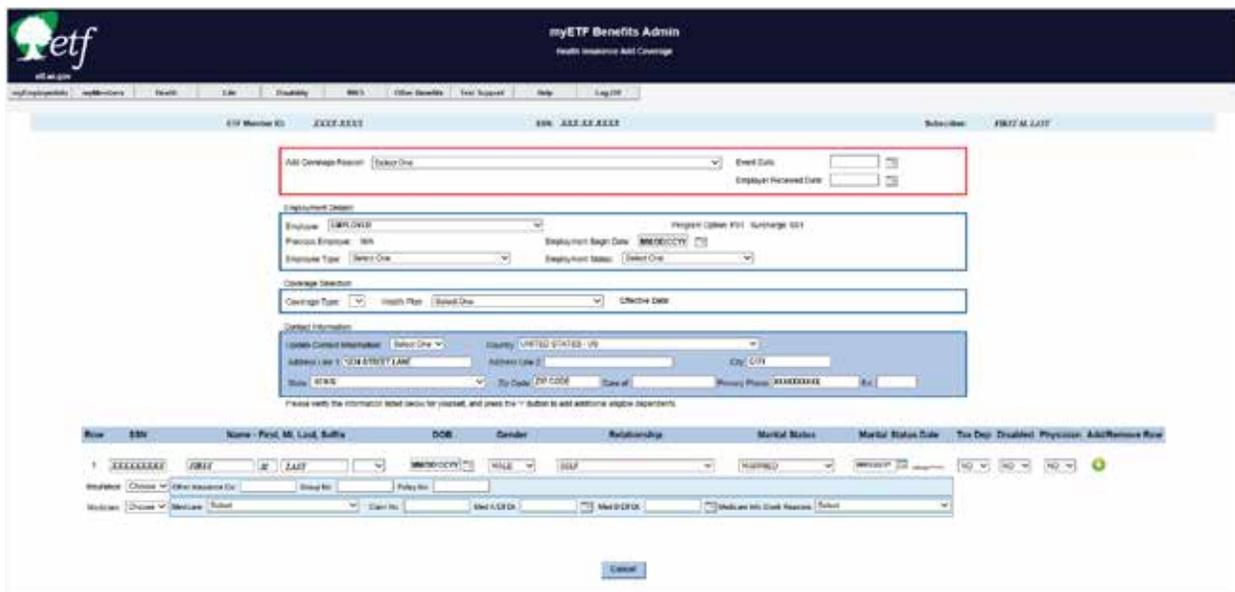
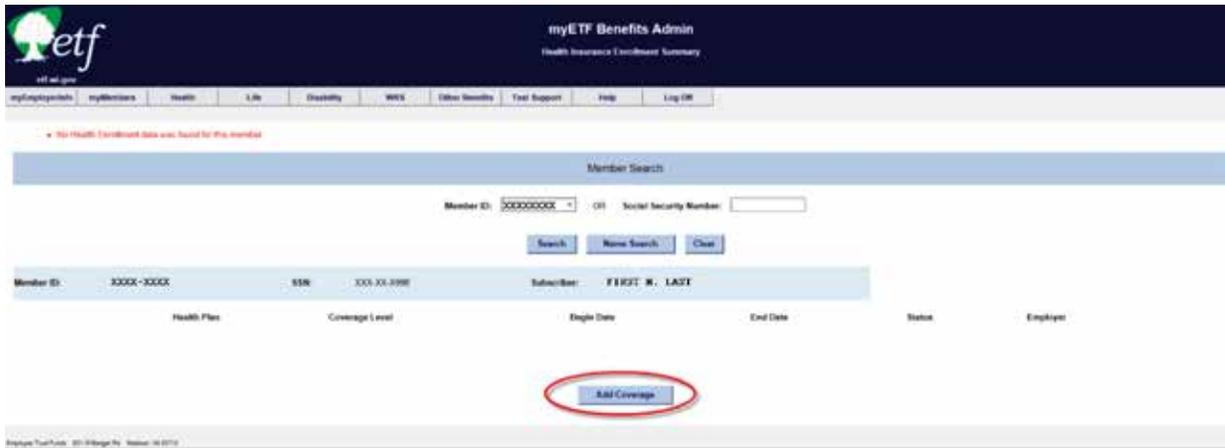
Note: This is the confirmation page when adding a new member into myETF Benefits. The confirmation screen will look different if you are only updating information; that confirmation screen will show a summary of changes made and will have a print button in the upper right corner as well as a Return to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

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

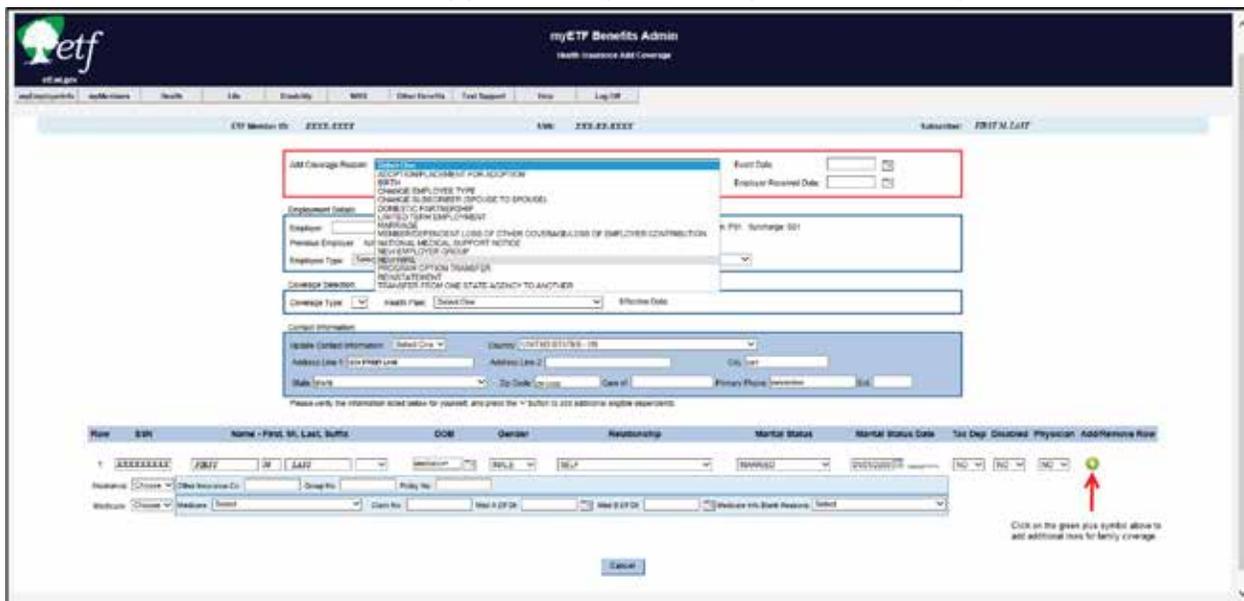
6. At the top of the screen, highlight the Health Tab and select Member Enrollment from the drop-down.



7. Click the 'Add Coverage' button at the bottom of the screen.



8. Select the reason for the application. (For Example – New Hire).



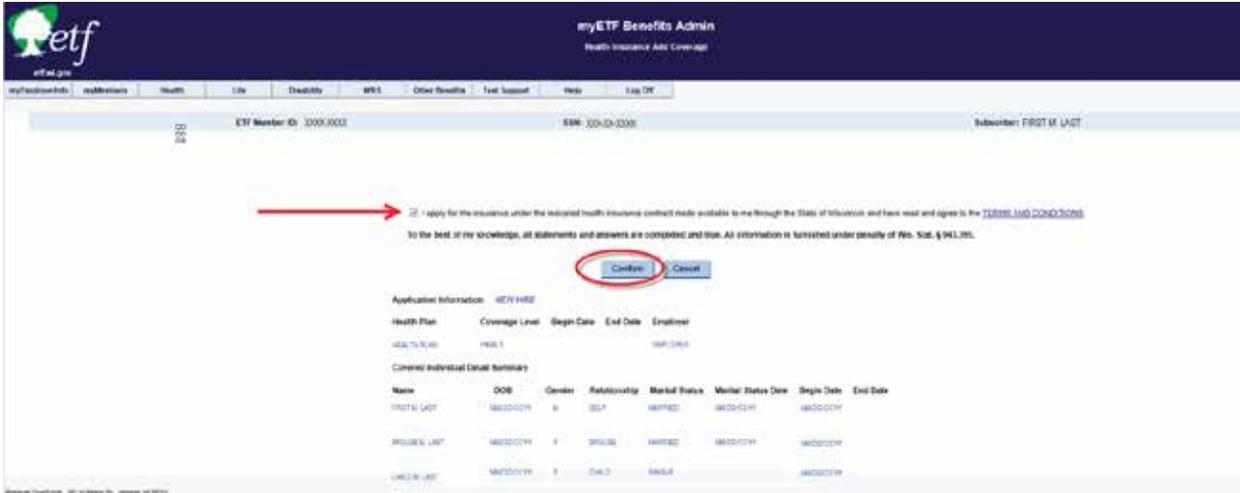
9. Enter the Event Date (hire date).
10. Enter the Received Date (date application received by the employer).
11. Select the Coverage Effective Date and hit Tab. You may need to click on it a second time to get it to stay.
 - a. If you click on 'As soon as possible,' move onto the next step.
 - b. If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

The screenshot displays the myETF Benefits application interface. At the top, there are navigation tabs and user information. The main form is divided into several sections:

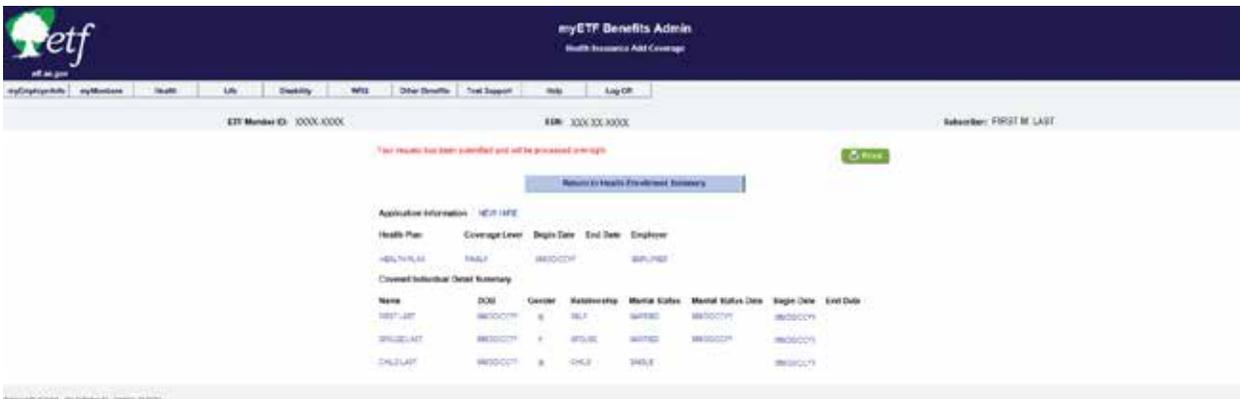
- Coverage Plan:** A red box highlights this section, which includes a dropdown for the plan and date pickers for start and end dates.
- Employment Details:** This section contains fields for employee ID, hire date, and other employment-related information.
- Contact Information:** Fields for the employee's name, address, and phone number.
- Dependent Information:** A table with columns for ID, name, DOB, gender, relationship, marital status, and market status. Each row has a green plus sign and a red minus sign for adding or removing dependents. Red arrows point to these signs.
- Submit Button:** A red circle highlights the 'Submit' button at the bottom center of the form.

 A small text box at the bottom right of the dependent table reads: "Click on the green plus sign to add additional rows for family coverage or click on the red minus sign to remove a row."

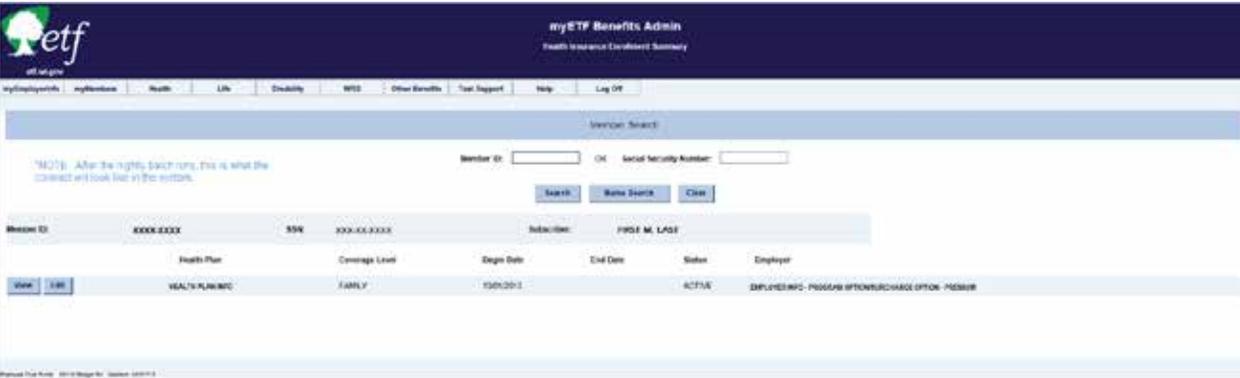
17. Verify all the information on the review page.
 - a. If all the information is correct, check the 'Terms and Conditions' box and click the 'Confirm' button.



- b. If the information is not correct, click the 'Cancel' button and return to the previous screen to make changes.
18. Print a copy of the confirmation screen (if desired) by clicking on the green print button in the upper right hand corner of the screen.



After the nightly batch runs, you can go in on the following day and view the contract you entered.





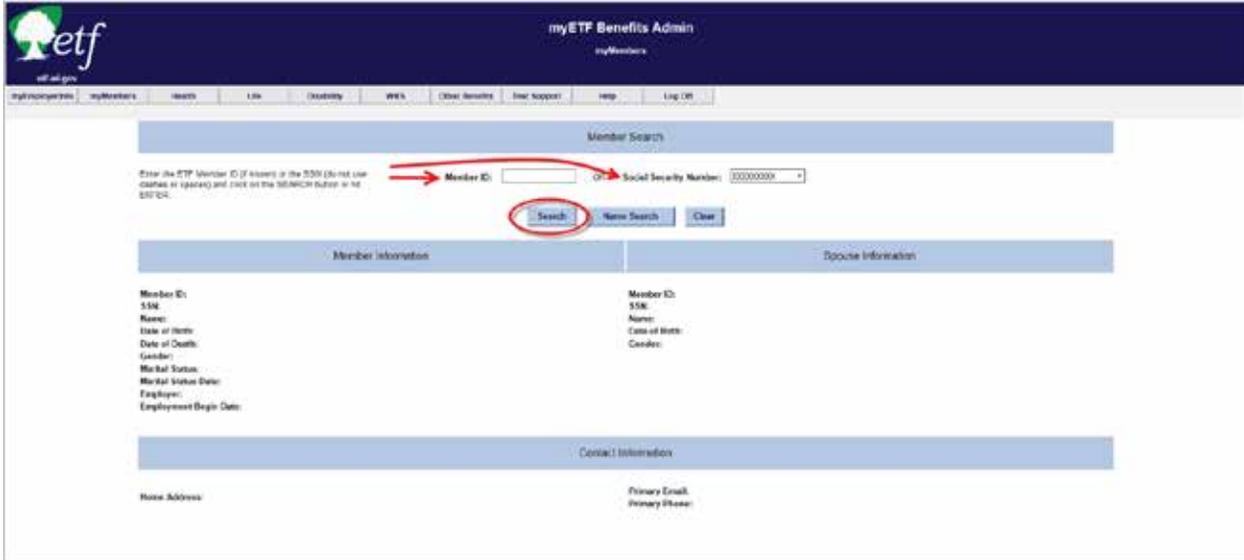
C-3. Add Dependent

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

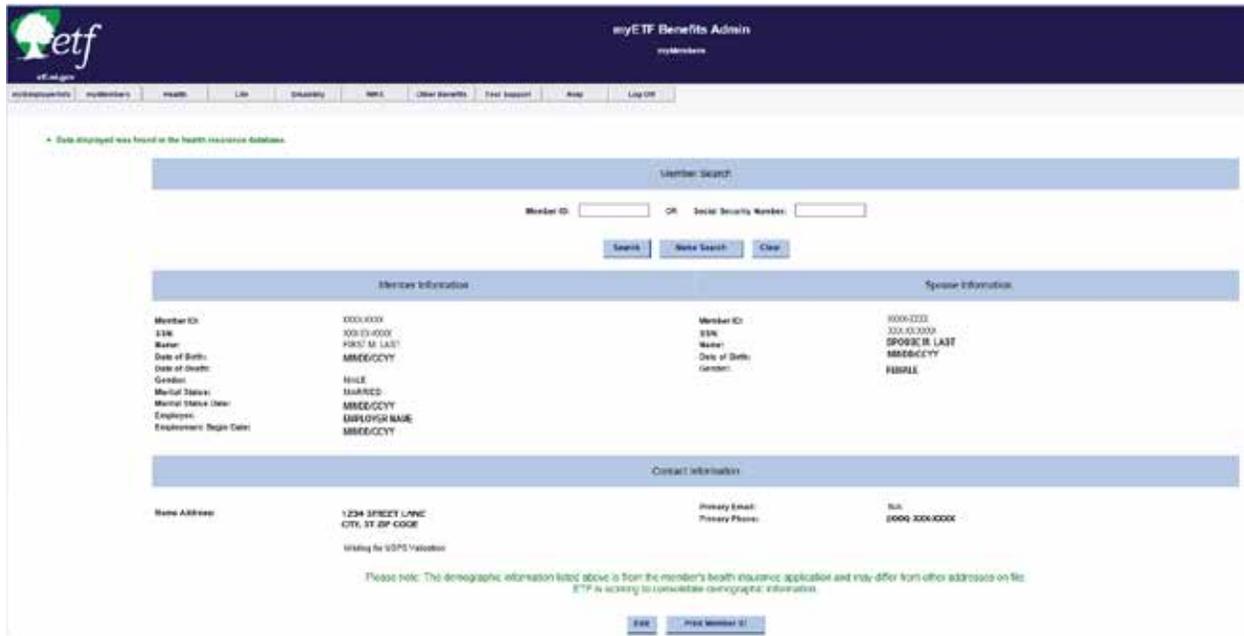
1. In myETF Benefits, highlight the myMembers tab and select myMembers from the drop down list.



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



3. Verify that all demographic data is current.



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

The screenshot displays the 'myETF Benefits Admin' web interface. At the top, there is a navigation bar with the 'etf' logo and the text 'myETF Benefits Admin' and 'myMembers'. Below this is a menu with tabs for 'myEmployers', 'myMembers', 'Health', 'Life', 'Disability', 'WRS', 'Other Benefits', 'Text Support', 'Help', and 'Log Off'. The 'Health' tab is selected, and a dropdown menu is open showing 'Member Enrollment' and 'Premium'. A message below the menu states: '* Data displayed was found in the health insurance database.'

The main content area is titled 'Member Search' and contains two input fields: 'Member ID:' and 'Social Security Number:'. Below these fields are three buttons: 'Search', 'Name Search', and 'Clear'.

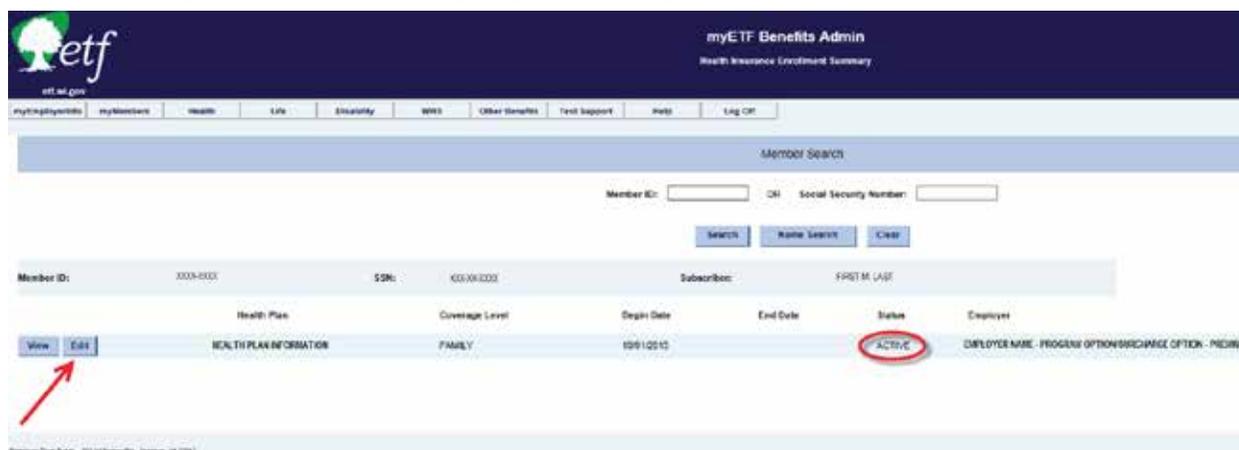
Below the search section, there are two columns of information: 'Member Information' and 'Spouse Information'. Each column lists various fields with their corresponding values, some of which are masked with asterisks.

Member Information		Spouse Information	
Member ID:	XXXX-XXXX	Member ID:	XXXX-XXXX
SSN:	XX-XX-XXXX	SSN:	XX-XX-XXXX
Name:	FIRST M. LAST	Name:	SPOUSE M. LAST
Date of Birth:	MMDDCCYY	Date of Birth:	MMDDCCYY
Date of Death:		Gender:	FEMALE
Gender:	MALE		
Marital Status:	MARRIED		
Marital Status Date:	MMDDCCYY		
Employer:	EMPLOYER NAME		
Employment Begin Date:	MMDDCCYY		

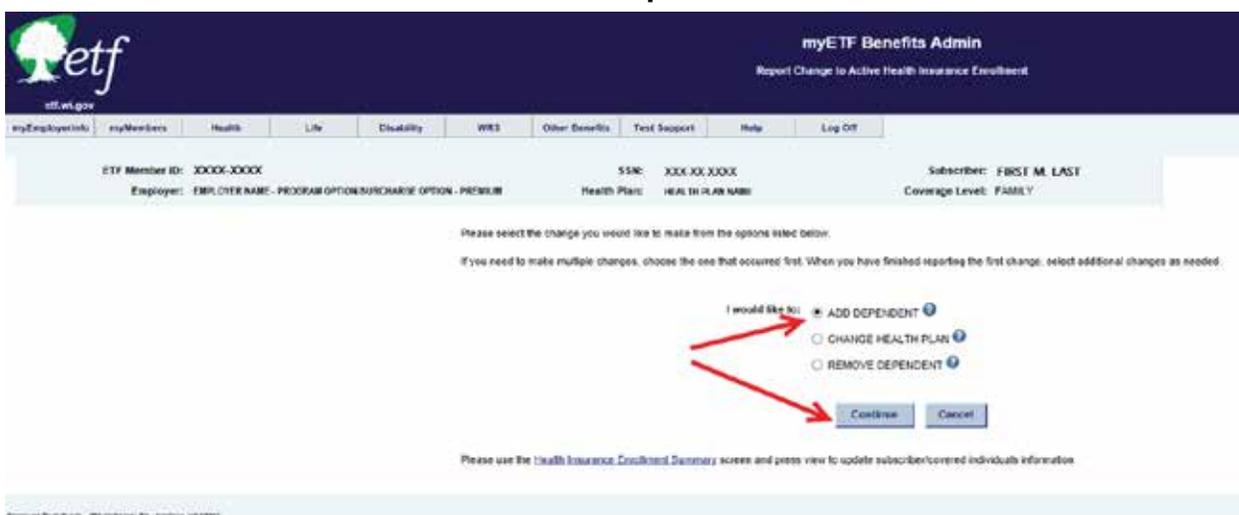
Below the member information, there is a 'Contact Information' section with the following details:

Home Address:	1234 STREET LANE CITY, ST ZIP CODE	Primary Email:	N/A
	Waiting for USPS Validation.	Primary Phone:	(000) 200.0000

6. Click the 'Edit' button on the line for the **Active** contract.



7. Select the "Radio" button next to **Add Dependent** and click the 'Continue' button.



8. Select the "Reason for Adding Dependent" from the drop-down menu. (For Example – Loss of Other Coverage).

The screenshot shows the 'myETF Benefits Admin' interface. At the top, there is a navigation bar with links for myEmployer, myMembers, Health, Life, Disability, WBS, Other Benefits, Tool Support, Help, and Log Off. Below the navigation bar, the user's information is displayed: ETF Member ID: XXXX XXXX, Employer: STATE HEALTH INSURANCE ADMINISTRATION, WBSID: 118: XXX.XX.XXX, Health Plan: HEALTH PLAN, Subscriber: FIRST M. LAST, Coverage Limit: \$1000.

The main form is titled 'Reason for Adding Dependent'. It contains several sections:

- Reason for Adding Dependent:** A dropdown menu with options: ADOPTEE, ADOPTEE PLACEMENT FOR ADOPTION, BIRTH, DEPENDENT OF DOMESTIC PARTNER/SPouse, DEPENDENT OF DEPENDENT OF DEPENDENT, FUTURE DEPENDENT NOT REPORTED ON INITIAL ENROLLMENT, LOSS OF OTHER COVERAGE, EMPLOYEE CONTRIBUTION, MEDICARE, MEDICAL RESISTANCE, SUPPORT NEEDED, NATURALIZATION/ACKNOWLEDGMENT, and NATURALIZATION.
- Event Date:** A date input field.
- Employer Received Date:** A date input field.
- Effective Date:** A date input field.
- Identification Section:**
 - First Name: [Text Input]
 - Middle Initial: [Text Input]
 - Last Name: [Text Input]
 - Suffix: [Text Input]
 - Gender: [Dropdown Menu]
 - Date of Birth: [Date Input]
 - Date of Death: [Date Input]
 - Marital Status: [Dropdown Menu]
 - Marital Status Date: [Date Input]
- Other Information:**
 - The Dependent: [Dropdown Menu]
 - Disability: [Dropdown Menu]
 - Begin Date: [Date Input]
 - End Date: [Date Input]
 - ETF's Insurance: [Dropdown Menu]
 - Relationship: [Dropdown Menu]
 - Standard Plan Rate Indicator: [Dropdown Menu]
- Other Health Insurance:** [Dropdown Menu]
- Medicare:** [Dropdown Menu]
- Physician:**
 - National Provider ID: [Text Input]
 - Physician Last/First Name: [Text Input]
 - Physician Prof/Name: [Text Input]

At the bottom of the form, there are 'Submit' and 'Cancel' buttons.

9. Enter the Event Date (date of the qualifying event).
10. Enter the Employer Received Date (date application received by the employer).
 - Note:** The Effective Date will auto-populate based on the Event and Received dates entered.
11. Complete the “Identification Section” for the dependent being added.
12. Complete the “Other Health Insurance.”
 - a. Select **No** from the drop down if there is **no** other health insurance coverage listed on the application for the member.
 - b. Select **Yes** from the drop down if there **is** other health insurance coverage listed on the application for the member.
13. Complete the “Medicare” section for the dependent being added.
 - a. Select **No** from the drop-down if there is **no** Medicare coverage for the member.
 - b. Select **Yes** from the drop down if there **is** Medicare coverage for the member.
14. Complete the “Physician” Section for the dependent being added.
15. Verify data entered and click the ‘Submit’ button.

18. Review the summary screen and print the confirmation (if desired).

The screenshot shows the 'Add Additional Eligible Dependent' confirmation screen in the myETF Benefits Admin system. At the top, there is a navigation bar with the myETF logo and 'myETF Benefits Admin' title. Below the navigation bar, there is a header section with member and employer information. The main content area contains several sections: 'Reason for Adding Dependent', 'Identification', 'To/Dependent Info', 'Other Health Insurance', 'Medical Info', and 'Physician'. A red circle highlights a message at the top left, and a red arrow points to a 'Print' button on the right side of the 'Reason for Adding Dependent' section.

19. Additional Changes on same application (if applicable).

- a. If you have additional dependents to add for the same reason / same effective date, click the 'Add Additional Dependent' button and follow the steps for adding a dependent.

The screenshot shows the navigation bar of the myETF Benefits Admin system. It includes the member ID, employer name, and other identifying information. Below this, there are three buttons: 'Return to Enrollment Summary', 'Return to Report Enrollment Change', and 'Add Additional Eligible Dependent'. Red arrows point to the first and third buttons.

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

The screenshot shows the 'Member Search' screen in the myETF Benefits Admin system. It features a search bar with fields for 'Member ID' and 'Social Security Number'. Below the search bar, there are 'Search', 'Reset Search', and 'Clear' buttons. Below the search bar, there is a table listing member information. The table has columns for Member ID, Health Plan, Coverage Level, Begin Date, End Date, Status, and Employer. The table contains one row of data for a member with ID 2000000000 and Health Plan HEALTH PLAN.

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

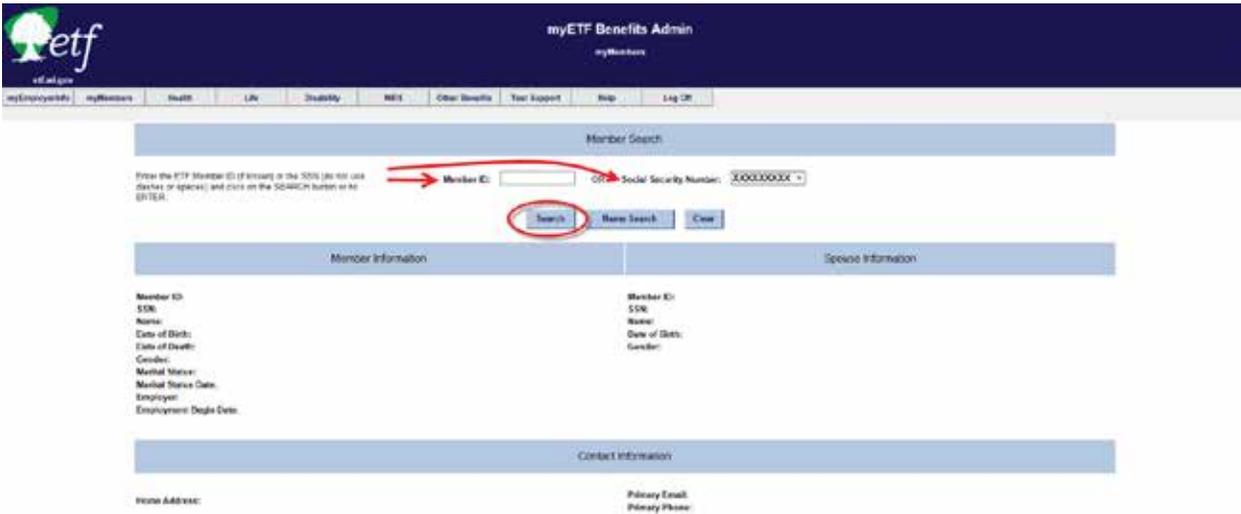
C-4. Remove Dependent

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

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



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



3. Verify that all demographic data is current.

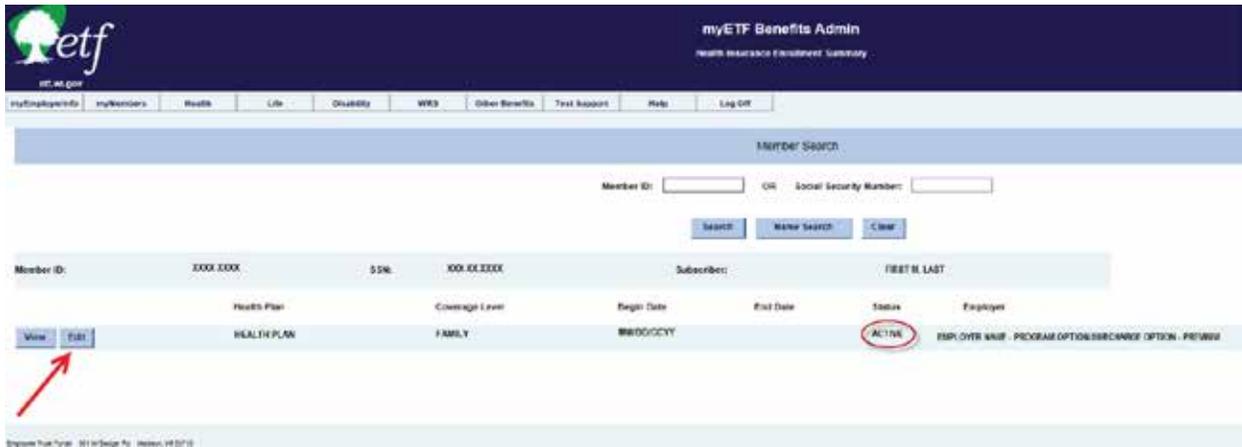


4. If any updates/changes need to be made, then click the 'Edit' button at the bottom of the screen.
 - a. Make any updates/changes to the appropriate editable fields.
 - b. If it was an address update, an address validation program will run and ask you to verify and select the correct address from the bottom of the screen.
5. Select the "Finalist" address which includes the ZIP+4, and click the 'Submit' button again.

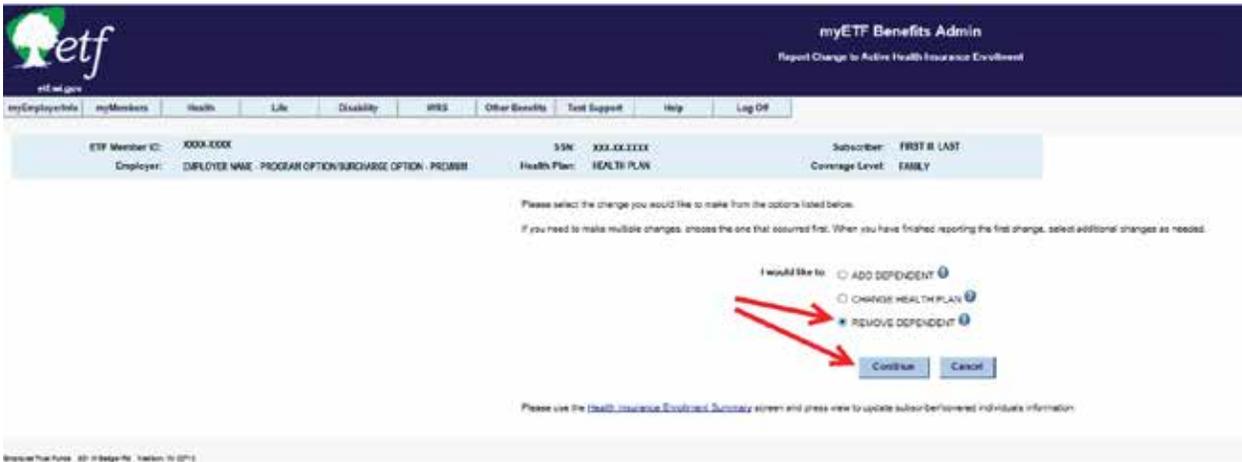
Note: If the address returns to the validation screen, you may be missing the apartment number or unit number designation. Either contact the member to verify the address or if you know it is correct, then select the 'Radio' button in front of the address as keyed and click the 'Submit' button.
6. Once you are on the review page, review the data (any changes / additions will appear in red).
 - a. If all corrections/additions are correct, click the 'Confirm' button.
 - b. If additional changes are needed, click the 'Cancel' button and return to the previous screen and follow the procedures under Number 3.
7. If you wish to print the confirmation page, click on the green 'Print' button in the upper right corner.
8. At the top of the screen, highlight the Health Tab and select Member Enrollment from the drop-down.

The screenshot displays the 'myETF Benefits Admin' web application. At the top, there is a navigation bar with the 'etf' logo and the text 'myETF Benefits Admin'. Below this is a menu bar with options like 'myMembers', 'Results', 'List', 'COUNCILS', 'SFC', 'Other Benefits', 'Tool Support', 'Help', and 'Log Off'. A message at the top left states: 'Data displayed was found in the health insurance database.' The main content area is titled 'Member Search' and includes input fields for 'Member ID' and 'Social Security Number', along with 'Search', 'New Search', and 'Clear' buttons. Below the search section, there are two columns of member information: 'Member Information' and 'Social Information'. The 'Member Information' column lists fields such as Member ID, SSN, Name, Date of Birth, Date of Death, Gender, Marital Status, Marital Status Date, Employer, and Employment Begin Date. The 'Social Information' column lists Member ID, SSN, Name, Date of Birth, Gender, and FIBALS. Below these columns is a 'Contact Information' section with fields for Home Address, Primary Email, Primary Phone, and FIBALS. A note at the bottom states: 'Please note: The demographic information listed above is from the member's health insurance application and may differ from other addresses on file. ETF is working to consolidate demographic information.' At the bottom right, there are 'Print' and 'Print Member ID' buttons.

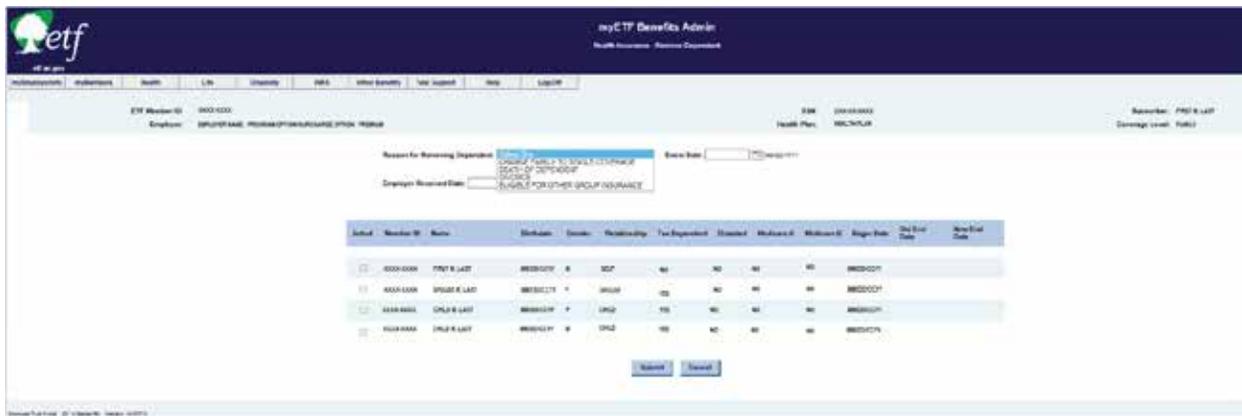
9. Click the 'Edit' button on the line for the **Active** contract.



10. Select the 'Radio' button next to **Add Dependent** and click the 'Continue' button.

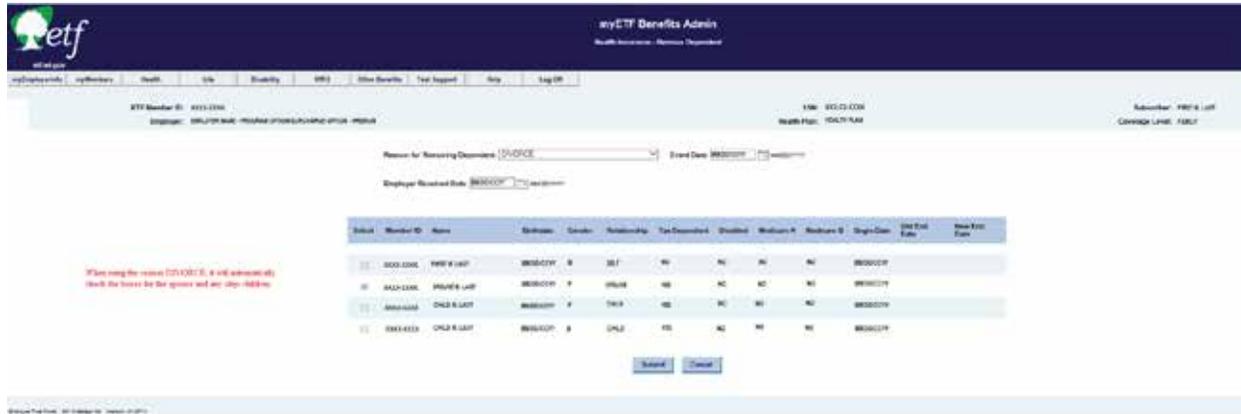


11. Select the "Reason for Removing Dependent" from the drop-down menu. (For example – Divorce).

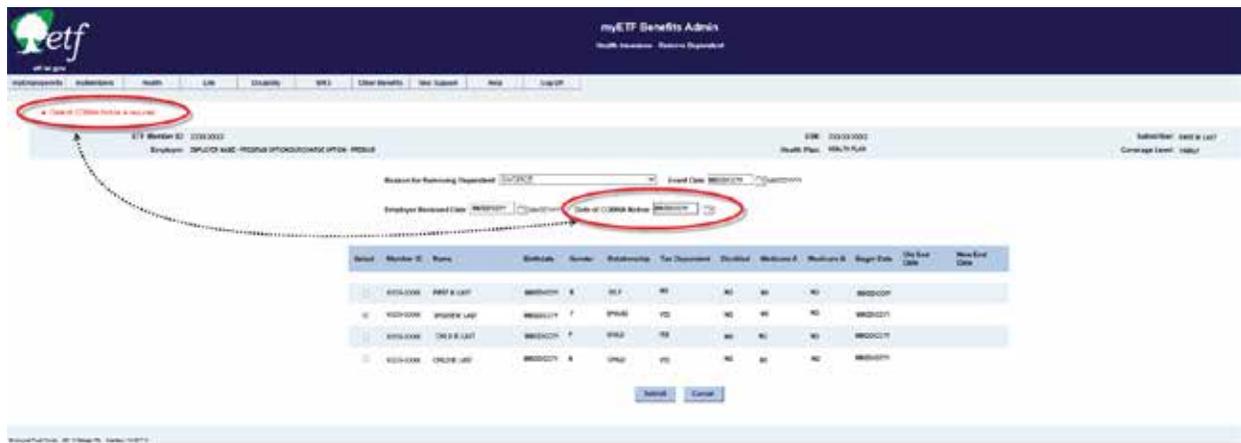


12. Enter the Event Date (date of the qualifying event).
13. Enter the Employer Received Date (date application received by employer).
14. Check the box/boxes next to the dependent(s) being removed.

- a. For **Divorce** the system will automatically check the box next to the spouse and for any step-children.
 - b. For **Change From Family to Single Coverage**, the system will automatically check the boxes next to all dependents other than the subscriber.
15. Click the 'Submit' button at the bottom of the screen.



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



- b. If removing spouse/step-children only, and family coverage will remain in place and the notification date is not within the same month as the divorce (event) occurred, the coverage will end the end of the month of the notification date or the application received date, whichever is later. (e.g., Divorce occurs 01/21/2014, ET-2301 received by employer 02/03/2014 and ET-2311 notification date (date sent to former spouse/dependents) is 02/05/2014 – coverage can not term until 02/28/2014).
- c. If switching from Family to Single Coverage due to the divorce (reason selected in myETF Benefits will be Change From Family to Single Coverage – not Divorce), then coverage will end the end of the month in which the divorce (event) occurred or the application received date, whichever is later. (e.g., Divorce occurs 01/21/2014, ET-2301 received by employer 01/27/2014

and ET-2311 notification date (date sent to former spouse/dependents) is 01/27/2014 – coverage ends 01/31/2014).

16. Check the box next to the Terms and Conditions Statement.

a. If there is a second check box stating that documentation is required and you have the documentation or are expecting the documentation, check the box.

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

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

When final coverage will remain in effect, the documentation required for ETF to approve the remove dependent transaction is a copy of the Custodian - Continuation Notice, ET-2311, sent to the former spouse.

By confirming this request, I agree to or am ending the transaction under the indicated health insurance contract (make available to me through the State of Missouri and have read and agree to the [Terms and Conditions](#).)

In the best of my knowledge, all statements and answers are complete and true. All information is furnished under penalty of perjury, 20 C.F.R. § 401.105.

Documentation is required to process the change. Acknowledge that it is my responsibility to provide the appropriate documents to my employer within 30 days.

Reason for Removing Dependent: 01-ORCS

Select	Member ID	Name	Enrollment	Gender	Relationship	Tax Dependent	Disabled	Medicare A	Medicare B	Begin Date	Old End Date	New End Date
<input type="checkbox"/>	0000-0000	PREP A LAST	MEM0001	M	SELF	NO	NO	NO	NO	MEM0001M		
<input type="checkbox"/>	0000-0000	SPH0000 LAST	MEM0001	F	SPOUSE	NO	NO	NO	NO	MEM0001F		MEM0001F
<input type="checkbox"/>	0000-0000	SH0000 LAST	MEM0001	F	CHILD	NO	NO	NO	NO	MEM0001F		
<input type="checkbox"/>	0000-0000	SH0000 LAST	MEM0001	M	CHILD	NO	NO	NO	NO	MEM0001M		

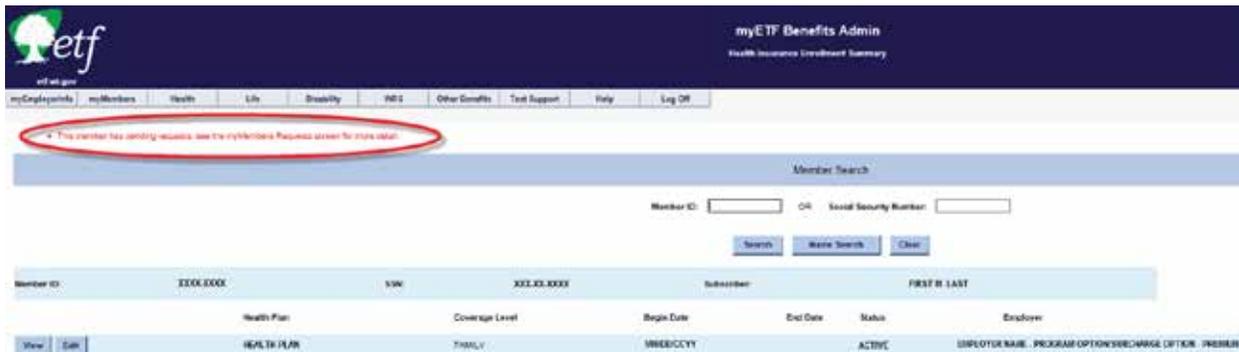
18. Review the summary screen and print the confirmation (if desired).

Your request has been submitted and will be processed overnight.

Reason for Removing Dependent: 01-ORCS

Select	Member ID	Name	Enrollment	Gender	Relationship	Tax Dependent	Disabled	Medicare A	Medicare B	Begin Date	Old End Date	New End Date
<input type="checkbox"/>	0000-0000	PREP A LAST	MEM0001	M	SELF	NO	NO	NO	NO	MEM0001M		
<input type="checkbox"/>	0000-0000	SPH0000 LAST	MEM0001	F	SPOUSE	NO	NO	NO	NO	MEM0001F		MEM0001F
<input type="checkbox"/>	0000-0000	SH0000 LAST	MEM0001	F	CHILD	NO	NO	NO	NO	MEM0001F		
<input type="checkbox"/>	0000-0000	SH0000 LAST	MEM0001	M	CHILD	NO	NO	NO	NO	MEM0001M		

19. If you have completed all necessary transactions from the application, click on the “Return to Enrollment Summary” button.



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

C-5. Change Health Plans

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

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



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



3. Verify that all demographic data are current.

The screenshot displays the myETF Benefits Admin web application. At the top, there is a navigation bar with the myETF logo and the text "myETF Benefits Admin" and "myMembers". Below the navigation bar, there is a "Member Search" section with input fields for "Member ID" and "Social Security Number", and buttons for "Search", "New Search", and "Clear".

Below the search section, there are two columns of demographic information:

Member Information		Spouse Information	
Member ID:	XXXX-XXXX	Member ID:	XXXX-XXXX
SSN:	XX-XX-XXXX	SSN:	XX-XX-XXXX
Name:	FIRST, LAST	Name:	FIRST, LAST
Date of Birth:	MM/DD/YYYY	Date of Birth:	MM/DD/YYYY
Date of Death:		Gender:	MALE
Gender:	MALE		
Member Status:	MEMBER		
Member Status Exp:	EMPLOYER NAME		
Employer:	MEMBER ID		
Employment Begin Date:			

Below the demographic information, there is a "Contact Information" section with input fields for "Home Address", "Primary Email", and "Primary Phone".

At the bottom of the page, there is a "Print" button and a "Print Member ID" button.

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

myETF Benefits Admin
myMembers

Member Search

Member ID: OR Social Security Number:

Member Information		Spouse Information	
Member ID:	800.000	Member ID:	000.000
SSN:	XX.XX.XXXX	SSN:	XX.XX.XXXX
Name:	FIRST M. LAST	Name:	SPOUSE M. LAST
Date of Birth:	MM/DD/YYYY	Date of Birth:	MM/DD/YYYY
Date of Death:		Gender:	DEFAULT
Gender:	MALE		
Marital Status:	SINGLE		
Marital Status Date:	MM/DD/YYYY		
Employer:	EMPLOYER NAME		
Employment Begin Date:	MM/DD/YYYY		

Contact Information

Home Address: 00000 STREET, CITY, ST ZIP CODE

Primary Email: N/A

Primary Phone: (202) 555-5557

Waiting for USPS Update

Please note: The demographic information listed above is from the member's health insurance application and may differ from other addresses on file. ETF is seeking to consolidate demographic information.

9. Click the 'Edit' button on the line for the **Active** contract.

myETF Benefits Admin
Health Insurance Enrollment Summary

Member Search

Member ID: OR Social Security Number:

Member ID	SSN	Subscriber	Health Plan	Coverage Level	Begin Date	End Date	Status	Employer
0000.0000	XX.XX.XXXX	FIRST M. LAST	HEALTH PLAN	FAMILY	MM/DD/YYYY		ACTIVE	EMPLOYER NAME - PROGRAM OPTION SURCHARGE OPTION - PREMIUM

Please Note: This page displays the enrollment information for the member's health insurance. It may differ from other addresses on file. ETF is seeking to consolidate demographic information.

10. Select the 'Radio' button next to **Change Health Plan**.

myETF Benefits Admin
Report Change to Active Health Insurance Enrollment

ETF Member ID: XXXX.XXXX SSN: XXXX.XXXX Subscriber: FIRST M. LAST

Employer: EMPLOYER NAME - PROGRAM OPTION SURCHARGE OPTION - PREMIUM Health Plan: HEALTH PLAN Coverage Level: FAMILY

Please select the change you would like to make from the options listed below.
If you need to make multiple changes, choose the one that occurred first. When you have finished reporting the first change, select additional changes as needed.

I would like to:

- ADD DEPENDENT
- CHANGE HEALTH PLAN
- REMOVE DEPENDENT

Please use the Health Insurance Enrollment Summary screen and press view to update subscriber/enrolled individuals information.

11. Select the “Reason for Changing Health Plan” from the drop-down menu. (For Example – Move From Service Area).

The screenshot shows the 'myETF Benefits Admin' interface. At the top, there are navigation tabs: Home, Health, Life, Disability, WFL, Other Benefits, Tool Support, Help, and Log Off. The user is logged in as 'ETP Member ID: 3333-3333' and 'Employer: EMPLOYER NAME - PROGRAM INFORMATION OFFICE - HHS000'. The current health plan is 'HEALTH PLAN' with a coverage level of 'FAMILY'. The 'Reason for Changing Health Plan' dropdown menu is open, and 'MOVE FROM SERVICE AREA' is selected. Other options include 'OUT OF STATE', 'OUT OF COUNTRY OF DOMESTIC NATIONALITY', 'OUT OF NATIONALITY', and 'SUSPENSION CLAIM OF OTHER LIFE INSURANCE POLICY HELD'. Below the dropdown, there are fields for 'Event Date' (11/01/2014) and 'Employer Received Date' (11/01/2014). A table shows the current health plan details, and a list of members is displayed below with their personal and insurance information.

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

This screenshot shows the same 'myETF Benefits Admin' interface, but with the 'Reason for Changing Health Plan' dropdown menu set to 'MOVE FROM SERVICE AREA'. The 'New Residential County' dropdown menu is open, and 'FLORIDA' is selected. The 'Event Date' is 11/01/2014 and the 'Employer Received Date' is 11/01/2014. A red note states: '*NOTE - Remember to update the physician / clinic info per the application.' Below the note, the health plan details table and the list of members are visible, showing the same information as the previous screenshot.

18. Check the box next to the Terms and Conditions statement.
19. Review the data and if correct, click the 'Confirm' button.

myETF Benefits Admin
Health Insurance - Change Health Plan

ETP Member ID: 3333-0000
Subscriber: FRET R LAST
Coverage Level: FAMILY

You have requested a change to member's current health plan. To continue changing member's health plan, please confirm your request.

I agree to the Terms and Conditions. I agree to the terms and conditions of the selected health insurance contract made available to me through the State of Missouri and have read and agree to the [Terms and Conditions](#).

To the best of my knowledge, all statements and answers are complete and true. All information is furnished under penalty of perjury. (Mo. Stat. § 169.030)

Reason for Changing Health Plan: MOVE FROM SERVICE AIDA

Health Plan	Coverage Level	Begin Date	End Date	Status	Employer
CURRENT HEALTH PLAN	FAMILY	08/01/2017	08/01/2017	PENDING	EMPI OVER NAME - FOLSO - PEUBER
NEW HEALTH PLAN	FAMILY	08/01/2017		PENDING	EMPI OVER NAME - FOLSO - PEUBER

Current Individual Detail Summary

Name	DOB	Gender	Relationship	Begin Date	End Date
FRET, LAST	08/01/2017	MALE	SELF	08/01/2017	
CHIL, LAST	08/01/2017	FEMALE	CHILD	08/01/2017	
CHIL, JR	08/01/2017	MALE	CHILD	08/01/2017	

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

myETF Benefits Admin
Health Insurance - Change Health Plan

ETP Member ID: 3333-0000
Subscriber: FRET R LAST
Coverage Level: FAMILY

Your request has been submitted and will be processed overnight.

Before Doing This You Should Review and change member's coverage level by clicking on the Reason Change to Health Enrollment. To change to family coverage please check All dependent and IT's Your Choice. To change from family to single coverage please select Service User/Member.

Reason for Changing Health Plan: MOVE FROM SERVICE AIDA

Health Plan	Coverage Level	Begin Date	End Date	Status	Employer
OLD HEALTH PLAN	FAMILY	08/01/2017	08/01/2017	PENDING	EMPI OVER NAME - FOLSO - PEUBER
NEW HEALTH PLAN	FAMILY	08/01/2017		PENDING	EMPI OVER NAME - FOLSO - PEUBER

Current Individual Detail Summary

Name	DOB	Gender	Relationship	Begin Date	End Date
FRET, LAST	08/01/2017	MALE	SELF	08/01/2017	
CHIL, LAST	08/01/2017	FEMALE	CHILD	08/01/2017	
CHIL, JR	08/01/2017	MALE	CHILD	08/01/2017	

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

myETF Benefits Admin
Health Insurance Enrollment Summary

myEmployerInfo myMembers Health Life Disability IRAs Other Benefits Text Support Help Log Off

If this member has a pending request, see the myMembers Results screen for more detail.

Member Search

Member ID: OR Social Security Number:

Member ID:	DOB:	Subscriber:	FRET R LAST
3333-0000	XXX-XX-XXXX		

View	Edit	Health Plan	Coverage Level	Begin Date	End Date	Status	Employer
		HEALTH PLAN	FAMILY	08/01/2017		ACTIVE	EMPI OVER NAME - FOLSO - PEUBER

22. After the nightly batch runs, you can go in on the following day and view the contract changes you entered.

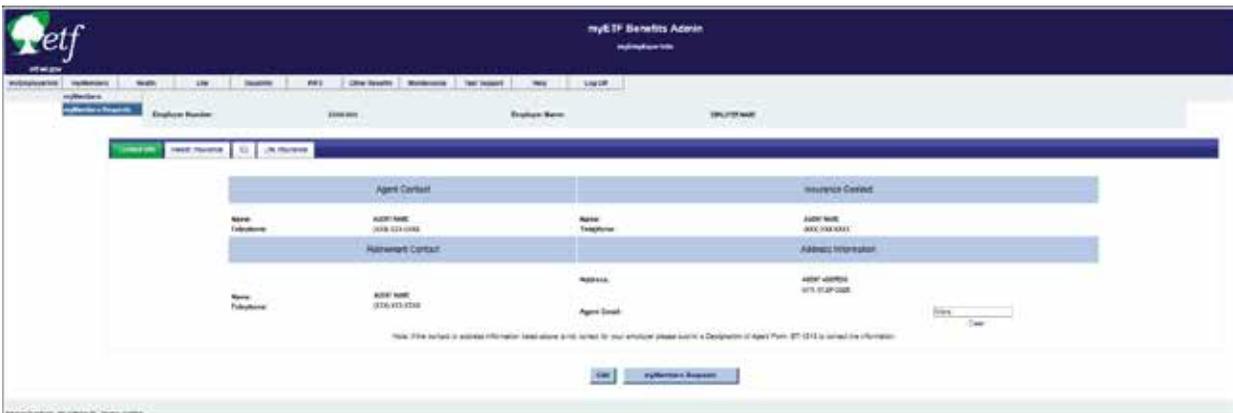
C-6. Termination of Coverage

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

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



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



2. Highlight the Health tab and select Termination of Coverage.

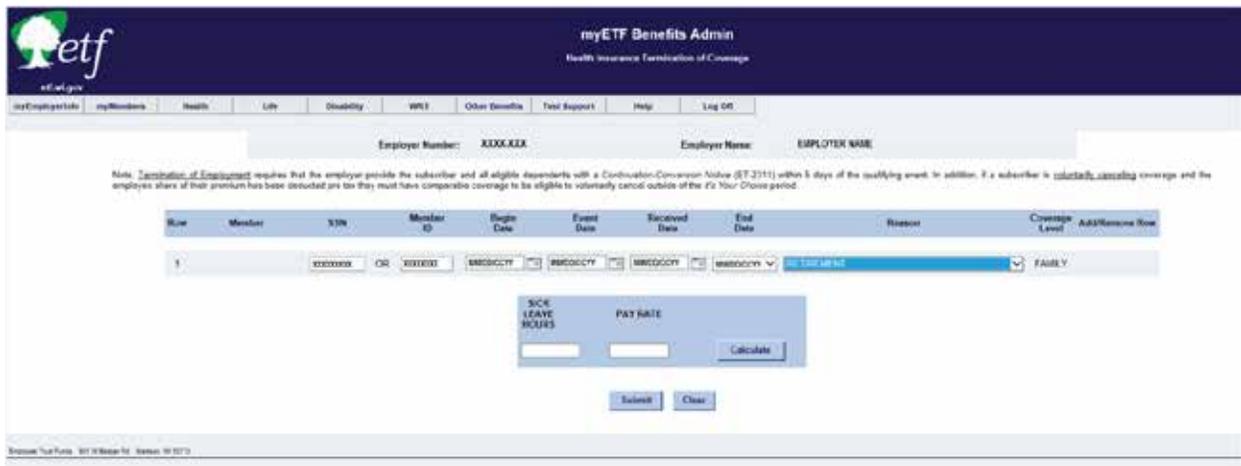


3. Enter the SSN or ETF Member ID.
4. Leave the Begin Date field blank.
5. Enter the Event Date.
6. Enter the Received Date (date the employer received app or term notice).
7. Enter the End Date (last day of health insurance coverage).
8. Select the Reason from the drop-down menu.
 - a. If you select the reasons Cancel Coverage, or Cancel Due to Spouse to Spouse transfer, you will receive a secondary drop-down menu asking you to select whether or not the employee share of the premium is deducted “Post-Tax” or “Pre-Tax.” If the premiums are deducted “Pre-Tax” then you select the appropriate qualifier.





- b. If you select the reason Retirement, a secondary box will pop up requesting you to enter the employee’s sick leave hours and pay rate.



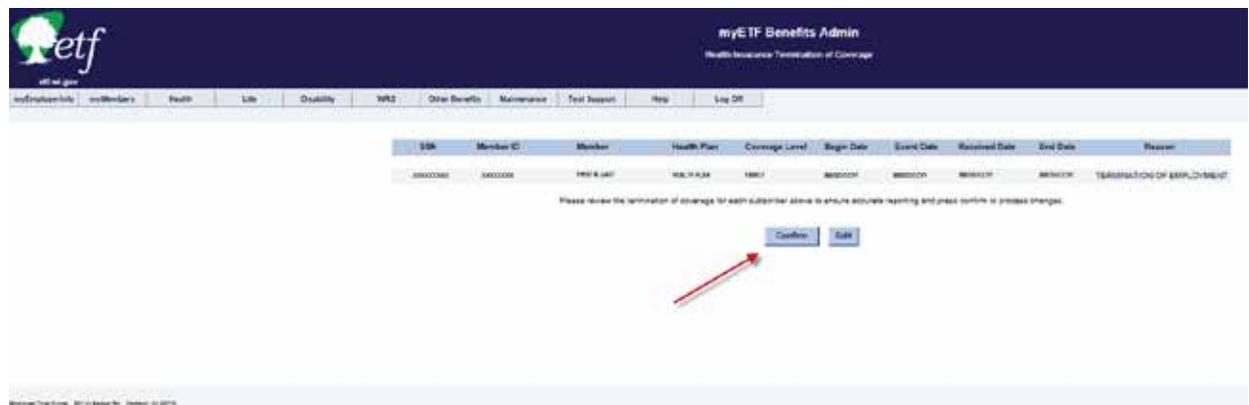
- 9. Hit tab or wait a few seconds, member information should populate, including the begin date of the current **Active** contract.



10. Click the 'Submit' button at the bottom of the screen.



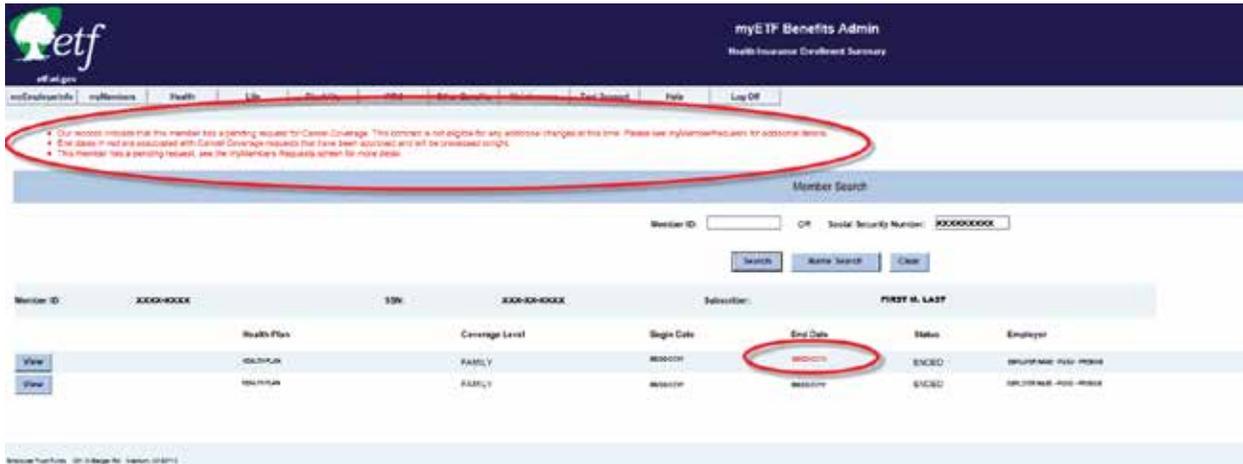
11. Review/verify that the information is correct and click the 'Confirm' button. The system will automatically take you back to a blank termination screen.



a. If you wish to review/verify the term processed highlight the Health tab and select Member Enrollment.



12. Enter the ETF Member ID or SSN and click the ‘Search’ button or hit ‘Enter.’ The term date should appear in **red**.



C-7. Pending Transactions

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

1. **Approved:** These are all the approved transactions that have been processed completely.
2. **Approved – Not Applied:** These are the transactions that have been entered that day that do not require ETF approval, or that ETF has approved, but are awaiting the nightly batch processing run.
3. **Approved – Processing Error:** The transactions that end up here, are here because some part of the data entry failed in the batch and may need to be re-entered.
4. **Cancelled:** These are transactions that either the employer or ETF cancelled prior to the nightly batch run. There could be several reasons why they were cancelled.
5. **Denied:** These are transactions that failed to meet eligibility requirements or the documentation supplied was insufficient/incorrect.
6. **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.
7. **Pending Sick Leave/Conversion:** When coverage is terminated by the employer using the reason “Retirement,” the employer is required to enter an estimated sick leave amount and an hourly pay rate. If the member is older than age 65 or if the sick leave total will not pay for three months of premiums as an annuitant, the transaction will be routed to this queue for ETF to address.
8. **Waiting for ETF Approval – Disabled:** This queue is where a transaction will go when a member is trying to add an adult dependent older than age 26 who is disabled. The transaction will stay in this queue until the disability verification process has been completed and ETF has received a copy of the health plan health plan

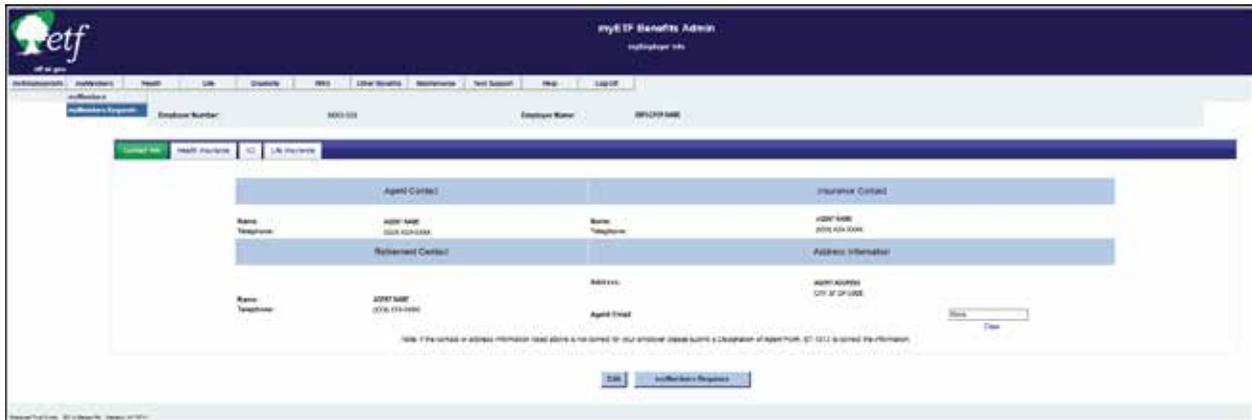
disability approval letter for that dependent.

9. **Waiting for ETF Approval:** This is the queue for all of the other transactions that require additional documentation prior to approval. If you had to check two boxes on the confirmation screen, it means that the transaction will go here until ETF receives and approves the relevant documentation and thus approves the transaction.

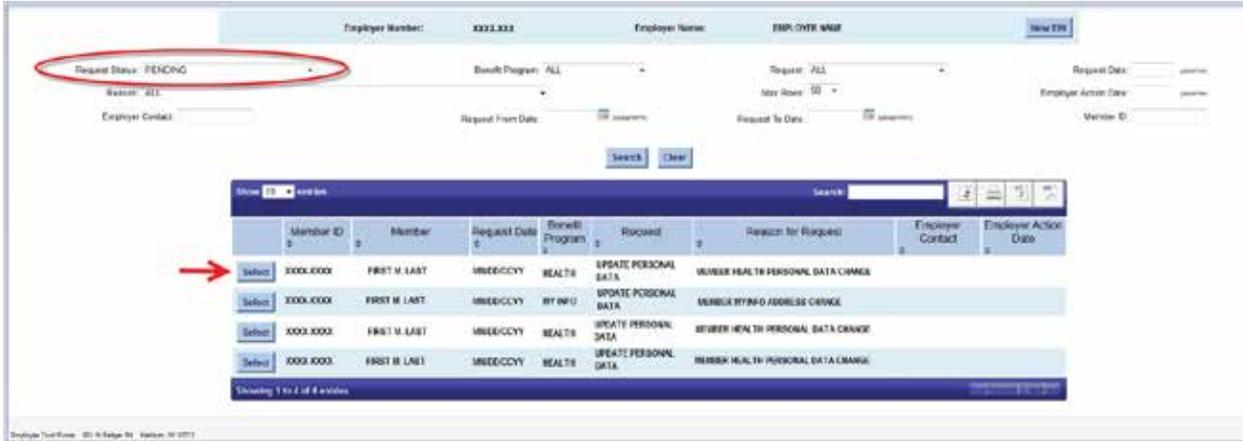
Transactions that are in *Pending, Approved-Not Applied, Waiting for ETF Approval – Disabled* and *Waiting for ETF Approval* can be edited, if necessary. They take you back to the entry screen and you follow the same submission procedures as before.

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

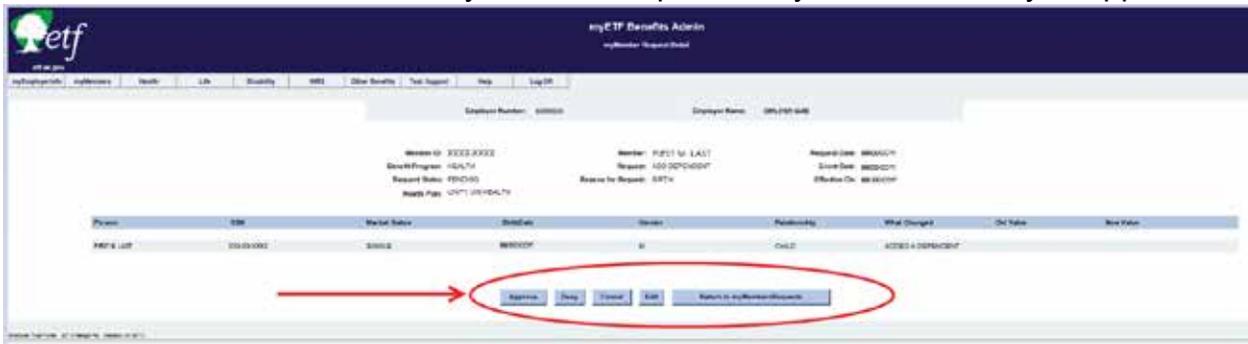
1. In myETF Benefits, highlight the myMembers tab and select myMembers Requests.



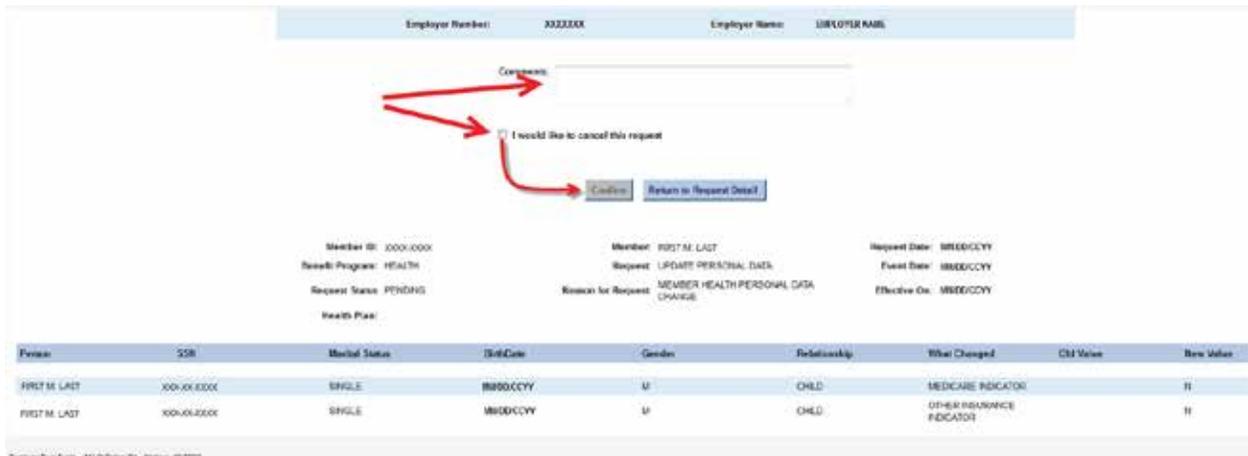
2. Select a "status" from the drop down menu. Define your search. The most common search is the default set up, however you can narrow the search by the following means:
 - a. Reason (the reason for the application).
 - b. Employer contact.
 - c. Benefit Program.
 - d. Request Type (Add Coverage, Add Dependent, Remove Dependent, etc.).
 - e. Max Rows (max number of rows to show).
 - f. Request Date.
 - g. Employer Action Date (date entered).
 - h. Member ID.
 - i. Range – Request From Date and Request To Date.
3. Click the 'Search' button. If there are more than 10 lines, you may need to select the number of lines to show from the drop down on the left, just above the displayed range of data.
4. Click the 'Select' button next to the transaction you want to view/approve.



- a. Review/verify that the information entered is correct. If the transaction is in the Pending queue, and all information is correct:
 - Click the 'Approved' button and it will automatically take you back out to the queue.
 - Click on "Return to myMember Requests", if you are not ready to approve.



- b. If the transaction is in the Pending queue, and all the information is not correct:
 - Click the 'Edit' button to update any information.
 - Click the 'Cancel' button to cancel the transaction, in which it will need to be re-entered by the member (employee).
 - Enter a reason for the cancellation.
 - Check the box next to "I would like to cancel this request."
 - Click the 'Confirm' button.



- c. If the transaction is in the Pending queue, and after the review of information the member is not eligible to make the requested change.
- Click the 'Deny' button.
 - Enter a reason for the denial.
 - Check the box next to "I would like to deny this request."
 - Click the 'Confirm' button.

Employer Number: XXXXXX Employer Name: EMPLOYER NAME

Comments:

I would like to deny this request

Confirm Return to Request Detail

Member ID: XXX-XXX-XXXX Member: FIRST M. LAST Request Date: MM/DD/YYYY
 Benefit Program: HEALTH Request: UPDATE PERSONAL DATA Parent Date: MM/DD/YYYY
 Request Status: PENDING Reason for Request: MEMBER HEALTH PERSONAL DATA CHANGE Effective On: MM/DD/YYYY
 Health Plan:

Person	SSN	Marital Status	DOB Date	Gender	Relationship	What Changed	Old Value	New Value
FIRST M. LAST	XXX-XX-XXXX	SINGLE	MM/DD/YYYY	M	CHILD	MEDICARE INDICATOR		N
FIRST M. LAST	XXX-XX-XXXX	SINGLE	MM/DD/YYYY	M	CHILD	OTHER INSURANCE INDICATOR		N

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

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

C-8 Enrollment Inquiry

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

1. In myETF Benefits, highlight the 'Health' tab.

myETF Benefits Admin
myEmployer Info

myEmployees myMembers **Health** Life Disability WVS Other Benefits Text Support Help Log Off

Inquiry
Member Enrollment
Premium
Administration of Premiums

3000-400 Employee Name: EMPLOYER NAME

Contract Health Insurance **CI** Life Insurance

Agent Contract		INSURANCE CONTRACT	
Name:	XXXX-XXXX	Name:	XXXX-XXXX
Telephone:	(000) 000-0000	Telephone:	(000) 000-0000
Reimbursement Contract		ADDRESS INFORMATION	
Name:	XXXX-XXXX	Address:	XXXXX ADDRESS
Telephone:	(000) 000-0000	Agent Email:	000.00@0000

Note: If the contact or address information listed above is not correct for your employer please submit a Disposition of Agent Form: ET-1112 to correct the information.

Clear More

ET-1118 myMembers Requests Employer Locations

Employee Tool Panel 8/14/2016 10:00 AM 10/15/2016

2. Highlight Inquiry.

The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes 'myETF Benefits Admin' and 'myEmployee Info'. The main menu has tabs for 'Health', 'Life', 'Disability', 'PERS', 'Other Benefits', 'Test Support', 'Help', and 'Log Off'. A dropdown menu is open under 'Inquiry', with 'Member Enrollment' and 'Premium Reports' highlighted. The 'Employee Name' field contains 'EMPLOYEE NAME'. Below this, there are tabs for 'Contact Info', 'Health Insurance', and 'Life Insurance'. The 'Life Insurance' section is active, displaying contact information for 'Agent Contact', 'Insurance Contact', 'Retirement Contact', and 'Address Information'. A 'Note' at the bottom states: 'Note: If the contact or address information listed above is not correct for your employer please submit a Designation of Agent Form, E-1113 to correct the information.' Buttons for 'Edit', 'myMembers Business', and 'Employee Location' are visible at the bottom.

3. Highlight Enrollment Reports.

This screenshot is identical to the one above, but the dropdown menu under 'Inquiry' is open to 'Enrollment Reports', with 'Enrollment Inquiry', 'Dependent Inquiry', and 'Address Inquiry' also visible. The rest of the interface, including the 'Life Insurance' section and the 'Note', remains the same.

4. Select Enrollment Inquiry.

The screenshot shows the myETF Benefits Admin interface. At the top, there is a navigation bar with the myETF logo and the text "myETF Benefits Admin" and "my employer info". Below this is a menu with options: Health, Life, Disability, WRS, Other Benefits, Test Support, Help, and Log Off. The main content area is titled "Enrollment Inquiry" and includes a sub-menu with options: Enrollment Inquiry, Employment History, Member Enrollment, Premium Reports, Dependents Inquiry, Premiums, Address Inquiry, and Termination of Coverage. The "Enrollment Inquiry" option is selected. The main content area displays a form for "Enrollment Inquiry" with the following fields: "Employer Name" (0001234567), "Agent Contact" (Name: AGENT NAME, Telephone: (000) 000-0000), "Insurance Contact" (Name: AGENT NAME, Telephone: (000) 000-0000), "Retirement Contact" (Name: AGENT NAME, Telephone: (000) 000-0000), and "Address Information" (Address: AGENT ADDRESS, CITY ST ZIP CODE). There are also fields for "Agent Email" and "Clear". A note at the bottom states: "Note: If the contact or address information listed above is not correct for your employee please submit a Designation of Agent Form ET-1113 to correct the information." At the bottom of the page, there are buttons for "EAB", "myMembers Requests", and "Employer Locations".

5. Select the Coverage Month.

The screenshot shows the myETF Benefits Admin interface. At the top, there is a navigation bar with the myETF logo and the text "myETF Benefits Admin" and "Health Insurance Enrollment Inquiry". Below this is a menu with options: Health, Life, Disability, WRS, Other Benefits, Test Support, Help, and Log Off. The main content area is titled "Health Insurance Enrollment Inquiry" and includes a sub-menu with options: Health Insurance Enrollment Inquiry, Employment History, Member Enrollment, Premium Reports, Dependents Inquiry, Premiums, Address Inquiry, and Termination of Coverage. The "Health Insurance Enrollment Inquiry" option is selected. The main content area displays a form for "Health Insurance Enrollment Inquiry" with the following fields: "Employer Number" (0001234567), "Employer Group" (0001-0001234567), "Coverage Month" (January), "Year" (2012), "Health Plan" (0001234567), and "Coverage Type" (0001234567). There are also buttons for "Clear" and "Save As".

6. Select the Coverage Year.

The screenshot shows the myETF Benefits Admin interface. At the top, there is a navigation bar with the myETF logo and the text "myETF Benefits Admin Health Insurance Enrollment Inquiry". Below the navigation bar, there are several tabs: myEmployees, myMembers, Health, Life, Disability, WBS, Other Benefits, Tool Support, Help, and Log Off. The main content area displays a form for selecting a coverage year. The form includes the following fields:

- Employee Number: 0001.000
- Employee Group: 0000 - EMPLOYEE
- Coverage Month: May (dropdown)
- Year: 2018 (dropdown)
- Health Plan: (dropdown)
- Coverage Type: (dropdown)

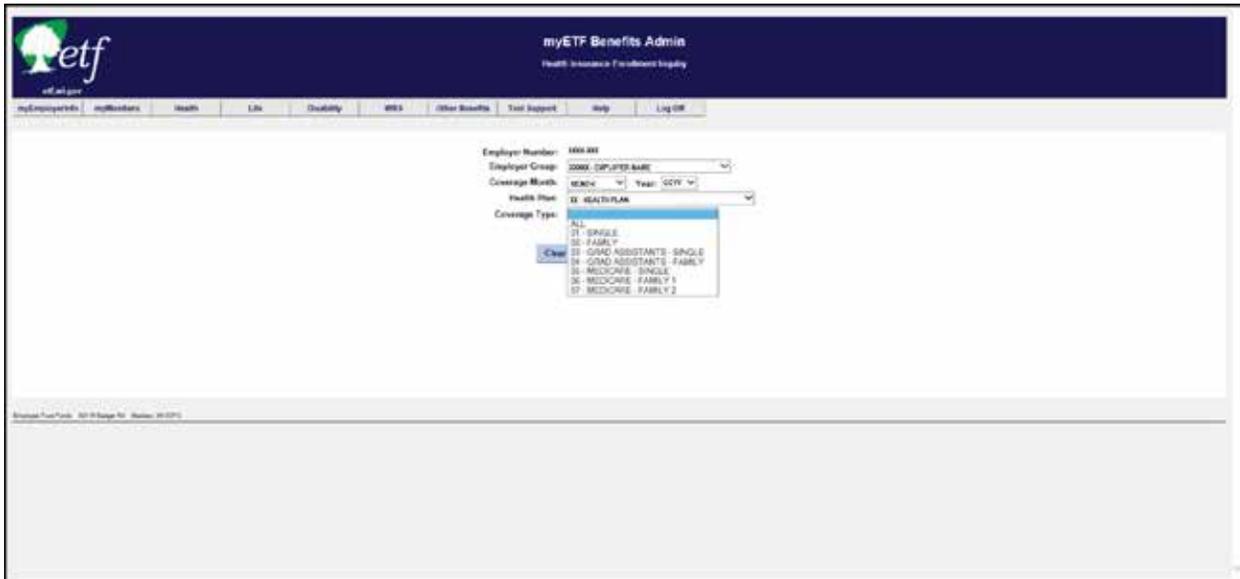
At the bottom of the form, there are three buttons: Clear, Display, and Save As.

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

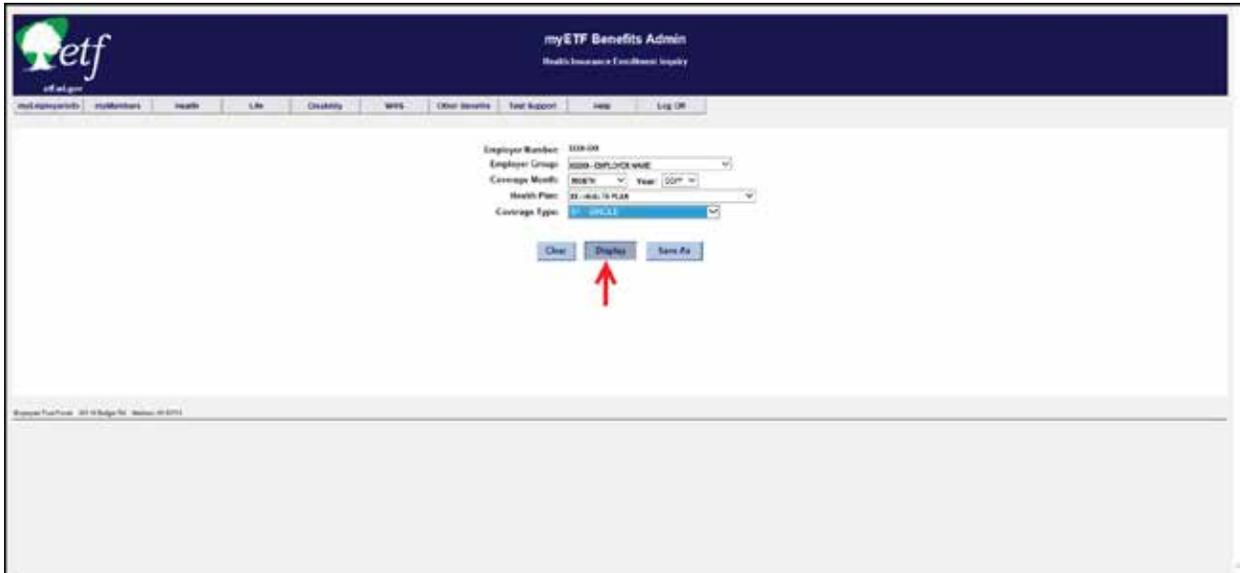
The screenshot shows the myETF Benefits Admin interface with the 'Health Plan' dropdown menu open. The form fields are the same as in the previous screenshot, but the 'Health Plan' field is now expanded to show a list of options. The list includes:

- ALL
- 01 - STANDARD PLAN
- 05 - SMP
- 11 - ANTHEM PPO IN SOUTHEAST
- 13 - ANTHEM PPO IN NORTHWEST
- 14 - ANTHEM PPO IN NORTHEAST
- 15 - DEAN HEALTH PLAN
- 17 - DEAN PPO PLAN
- 21 - HUMAN EASTERN
- 22 - HUMAN WESTERN
- 30 - IHC CAL CLARE
- 32 - IHC SDC
- 37 - GUNDESSON HEALTH PLAN
- 40 - ONYX COMMUNITY
- 47 - ANHEM HEALTH PLAN
- 48 - HEALTH TRADITION
- 53 - MEDICAL ASSOCIATES HEALTH PLAN
- 66 - MHC VISION HEALTH PLAN
- 70 - METFORM HEALTH
- 71 - SECURITY HEALTH PLAN
- 74 - PROGRESS PLUS
- 84 - WPA WPTO CHOICE SOUTHWEST
- 85 - HEALTH PARTNERS
- 88 - WEA TRUST PPO EAST
- 89 - WEA TRUST PPO NORTHWEST
- 89 - WPS METRO CHOICE NORTHWEST
- 89 - WEA TRUST PPO SOUTH-CENTRAL
- 90 - UNITY HEALTH
- 94 - UNITED HEALTHCARE

8. Select the Coverage Type option of your choice (default is ALL).



9. Click the 'Display' button to display the results of your query.



- a. You can select the number of entries to show at one time.
- b. You can Search for specific information (example: Employee Type, MID#, SSN, Last Name etc.)
- c. You can skip to a certain page, next page, or last page.
- d. You can sort by a specific column (small red arrows).

State Agency Health Insurance Administration Manual
 Appendix C — myETF Benefits

myETF Benefits Admin
 Health Insurance Enrollment Inquiry

myEmployees myMembers Health Life Disability HSA Other Benefits Test Report Help Log Off

Employee Number: 000-000
 Employee Group: 0000 EMPLOYEE NAME
 Coverage Month: MONTH Year: 2017
 Health Plan: 00 - HEALTH PLAN
 Coverage Type: 01 - SINGLE

Clear Display Save As

Showing 1 to 10 of 1,302 entries

#	Employee Type Code	Member ID	SSN	Last Name	First Name	Birthday	Gender	Coverage Effective Date	Coverage Expiration Date
1	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
2	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
3	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
4	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
5	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	
6	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	
7	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	
8	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
9	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	
10	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	

Showing 1 to 10 of 1,302 entries

Export to Excel

10. Click the 'Save As' button to export the results to a Microsoft Excel spreadsheet.

myETF Benefits Admin
 Health Insurance Enrollment Inquiry

myEmployees myMembers Health Life Disability HSA Other Benefits Test Report Help Log Off

Employee Number: 000-000
 Employee Group: 0000 EMPLOYEE NAME
 Coverage Month: MONTH Year: 2017
 Health Plan: 00 - HEALTH PLAN
 Coverage Type: 01 - SINGLE

Clear Display Save As

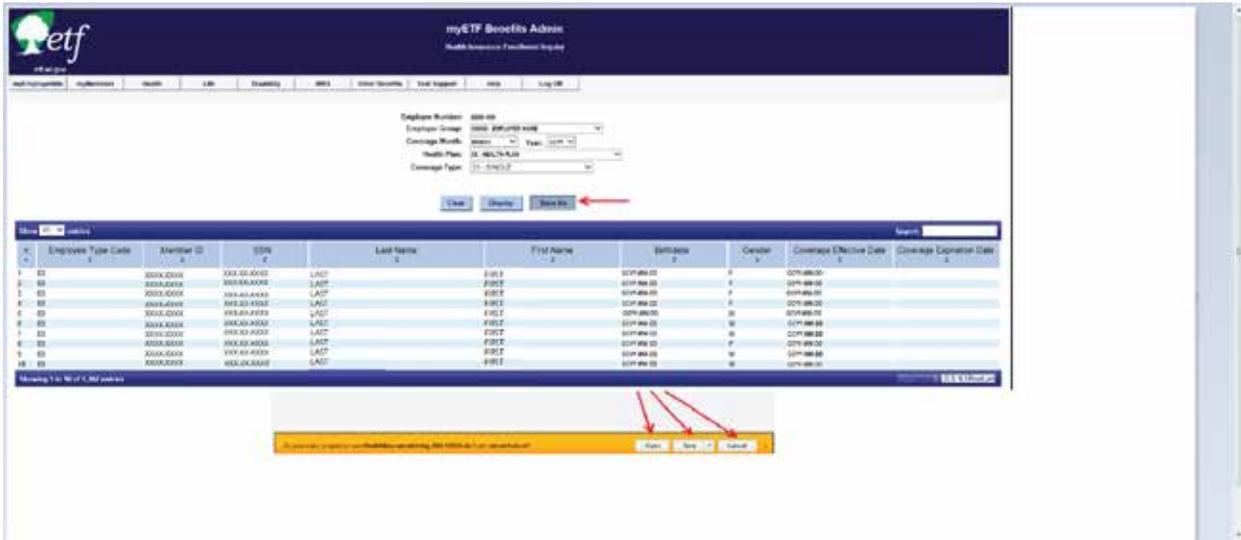
Showing 1 to 10 of 1,302 entries

#	Employee Type Code	Member ID	SSN	Last Name	First Name	Birthday	Gender	Coverage Effective Date	Coverage Expiration Date
1	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
2	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
3	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
4	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
5	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	
6	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	
7	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	
8	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	F	00/00/00	
9	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	
10	00	0000-0000	000-00-0000	LAST	FIRST	00/00/00	M	00/00/00	

Showing 1 to 10 of 1,302 entries

Export to Excel

- a. You will be given the option to Open or Save the Excel spreadsheet or Cancel the export.



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

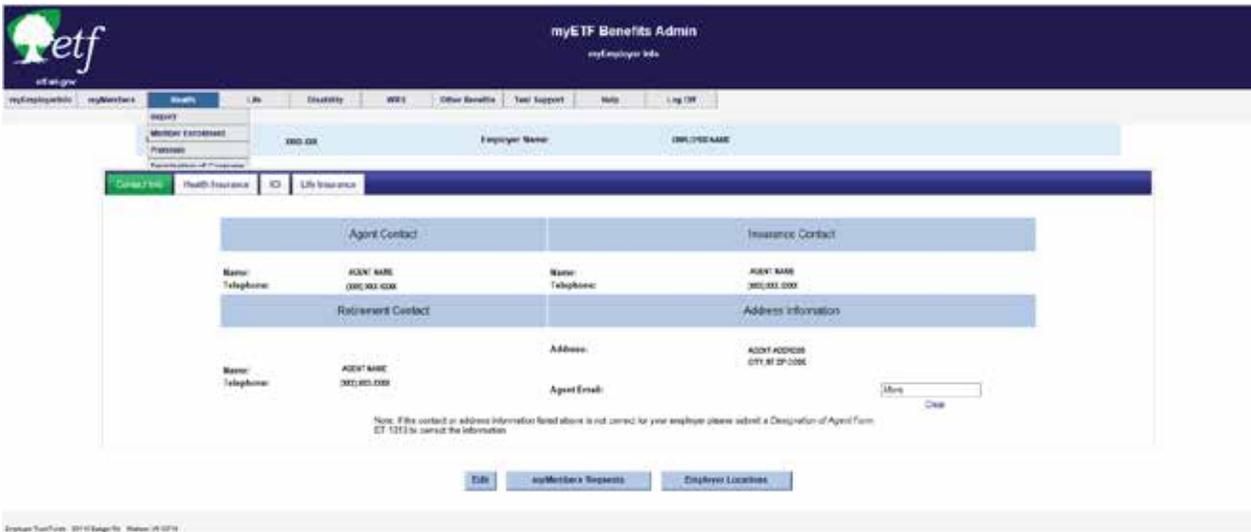
	A	B	C	D	E	F	G	H	I	J	K
	XXXXX - EMPLOYER NAME										
	MONTH - YEAR										
1											
2	Employee Type Code	Member ID	SSN	Last Name	First Name	Birth Date	Gender	Coverage Effective Date	Coverage Expiration Date	Health Plan	Coverage Type Code
3	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01
4	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	M	CCYY-MM-DD		XX	01
5	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01
6	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01
7	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	M	CCYY-MM-DD		XX	01
8	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01
9	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	M	CCYY-MM-DD		XX	01
10	XX	XXXXXXXX	XXXXXXXXXX	Last Name	First Name	CCYY-MM-DD	F	CCYY-MM-DD		XX	01

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

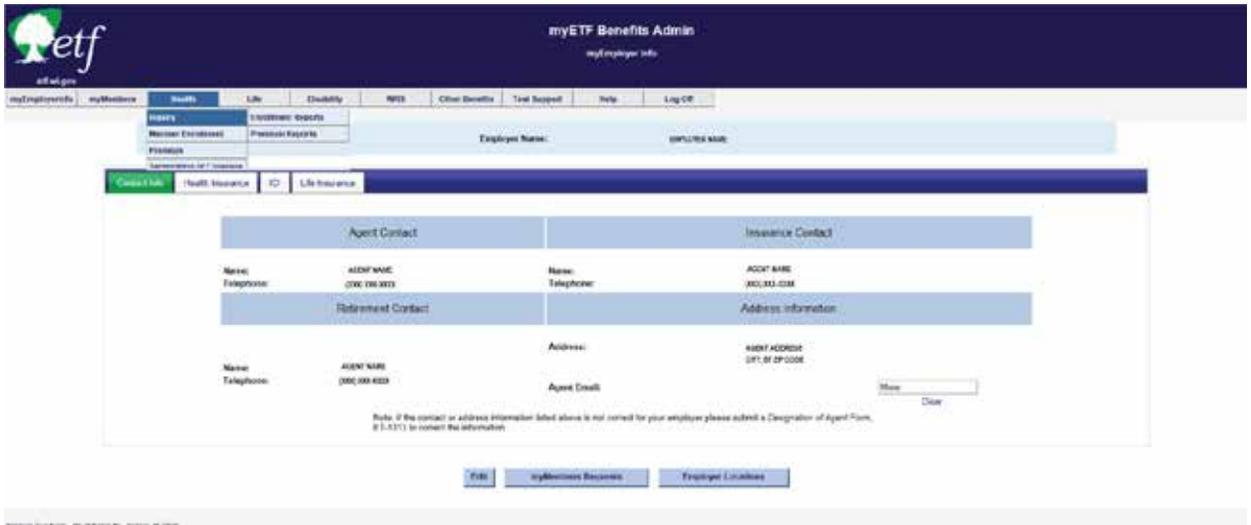
C-9. Dependent Inquiry

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

1. In myETF Benefits, highlight the 'Health' tab.



2. Highlight Inquiry.



3. Highlight Enrollment Reports.

The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes 'myEmployer Info' and a menu with 'Enrollment Reports' highlighted. Below the menu, there are tabs for 'Current Info', 'Health Insurance', 'Life Insurance', and 'Disability'. The main content area displays contact information for an agent and insurer, including names, phone numbers, and addresses. A note at the bottom states: 'Note: If the contact or address information listed above is not correct for your employee please submit a Designation of Agent Form, ET-1113 to correct the information.'

4. Select Dependent Inquiry.

The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes 'myEmployer Info' and a menu with 'Dependent Inquiry' selected. Below the menu, there are tabs for 'Current Info', 'Health Insurance', 'Life Insurance', and 'Disability'. The main content area displays contact information for an agent and insurer, including names, phone numbers, and addresses. A note at the bottom states: 'Note: If the contact or address information listed above is not correct for your employee please submit a Designation of Agent Form, ET-1113 to correct the information.'

5. Select the Coverage Month.

The screenshot shows the myETF Benefits Admin interface. At the top, there is a navigation menu with options: myEmployeesInfo, myMembers, Health, Life, Disability, PWS, Other Benefits, Tool Support, Help, and Log Off. The main content area contains the following fields:
- Employer Number: 0000-000
- Employer Group: 0000-000 (dropdown)
- Coverage Month: [Month] (dropdown) and Year: [Year] (dropdown)
- Health Plan: [Plan Name] (dropdown)
- Relationship: [Relationship] (dropdown)
- Coverage Type: [Type] (dropdown)
- Tax Dependents: ALL (dropdown)
Below these fields are three buttons: Clear, Display, and Save As.

6. Select the Coverage Year.

This screenshot is similar to the previous one, but the 'Year' dropdown menu is open, showing a list of years from 2011 to 2015. The 'Coverage Month' dropdown is also open, showing months from Jan to Dec. The 'Health Plan' dropdown is set to '0000-000'. The 'Relationship' dropdown is set to '0000-000'. The 'Coverage Type' dropdown is set to 'ALL'. The 'Tax Dependents' dropdown is set to 'ALL'. The 'Clear', 'Display', and 'Save As' buttons are visible at the bottom of the form.

7. Select the Health Plan option of your choice (default is **All**).

The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes the myETF logo and the text "myETF Benefits Admin Health Insurance Dependent Security". Below the navigation bar, there are several tabs: myETFBenefits, myBenefits, Health, Life, Disability, WBS, Other Benefits, Test Support, Help, and Log Off. The main content area displays the following fields:

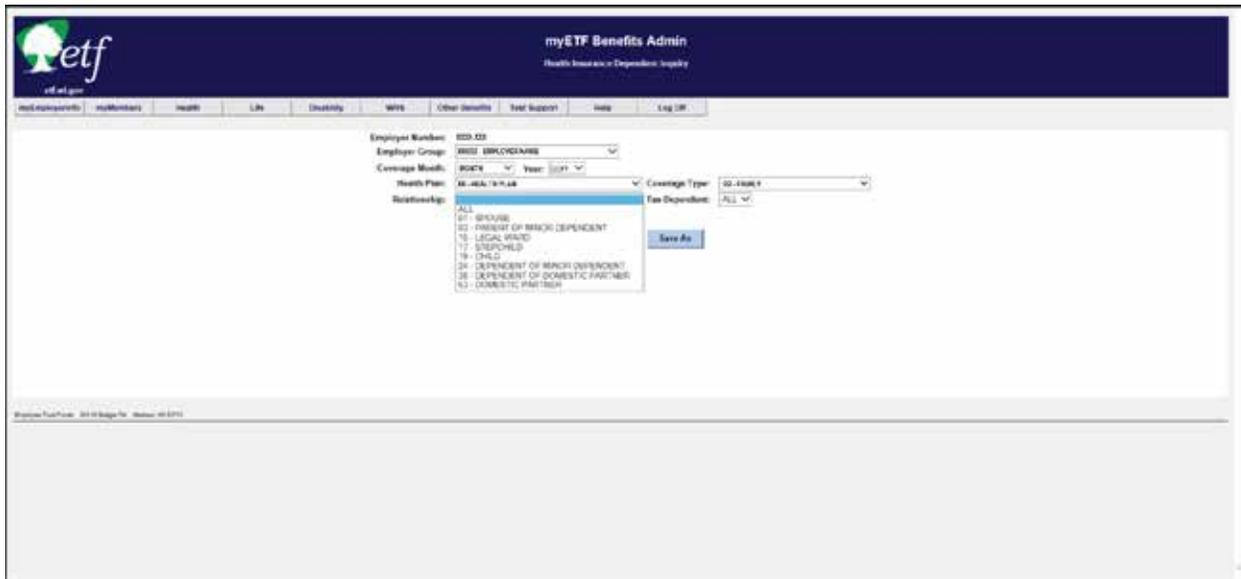
- Employer Number: 0000.000
- Employee Group: 0000.000 (dropdown)
- Coverage Month: 00/00 (dropdown) Year: 0000 (dropdown)
- Health Plan: A dropdown menu is open, showing a list of options including "All", "01 - SPANISH PLAN", "02 - SUP", "11 - ANTHEM BCBS SOUTHEAST", "12 - ANTHEM BCBS NORTH WEST", "14 - ANTHEM BCBS NORTH EAST", "16 - DGAR HEALTH PLAN", "17 - DGAR PROVIDER", "21 - FLORIDA LACATION", "22 - FLORIDA WESTERN", "30 - QHC EAST CLARIE", "32 - QHC WEST", "37 - GARDEN OF EARTH HEALTH PLAN", "40 - UNITY COMMUNITY", "47 - ANHEM HEALTH PLAN", "60 - HEALTH TRADITION", "62 - MEDICAL ASSOCIATES HEALTH PLAN", "64 - MERCY CARE HEALTH PLAN", "70 - MICHIGAN HEALTH", "71 - SECURITY HEALTH PLAN", "74 - PHYSICIANS PLUS", "84 - PREFERRED CHOICE SOUTHWEST", "85 - HEALTH PARTNERSHIP", "86 - PEA TRUST AND CARE", "87 - PEA TRUST AND NORTHWEST", "88 - PEA TRUST AND NORTHWEST", "89 - PEA TRUST AND NORTHWEST", "90 - UNITY FOR HEALTH", "91 - UNITY FOR HEALTH", "92 - UNITY FOR HEALTH".
- Coverage Type: (dropdown)
- Tax Dependent: All (dropdown)
- Save As (button)

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

The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes the myETF logo and the text "myETF Benefits Admin Health Insurance Dependent Security". Below the navigation bar, there are several tabs: myETFBenefits, myBenefits, Health, Life, Disability, WBS, Other Benefits, Test Support, Help, and Log Off. The main content area displays the following fields:

- Employer Number: 0000.000
- Employee Group: 0000.000 (dropdown)
- Coverage Month: 00/00 (dropdown) Year: 0000 (dropdown)
- Health Plan: 00 - HEALTH PLAN (dropdown)
- Relationship: (dropdown)
- Coverage Type: A dropdown menu is open, showing options "All", "01 - SINGLE", and "02 - FAMILY".
- Tax Dependent: (dropdown)
- Over (button)
- Editing (button)
- Save As (button)

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

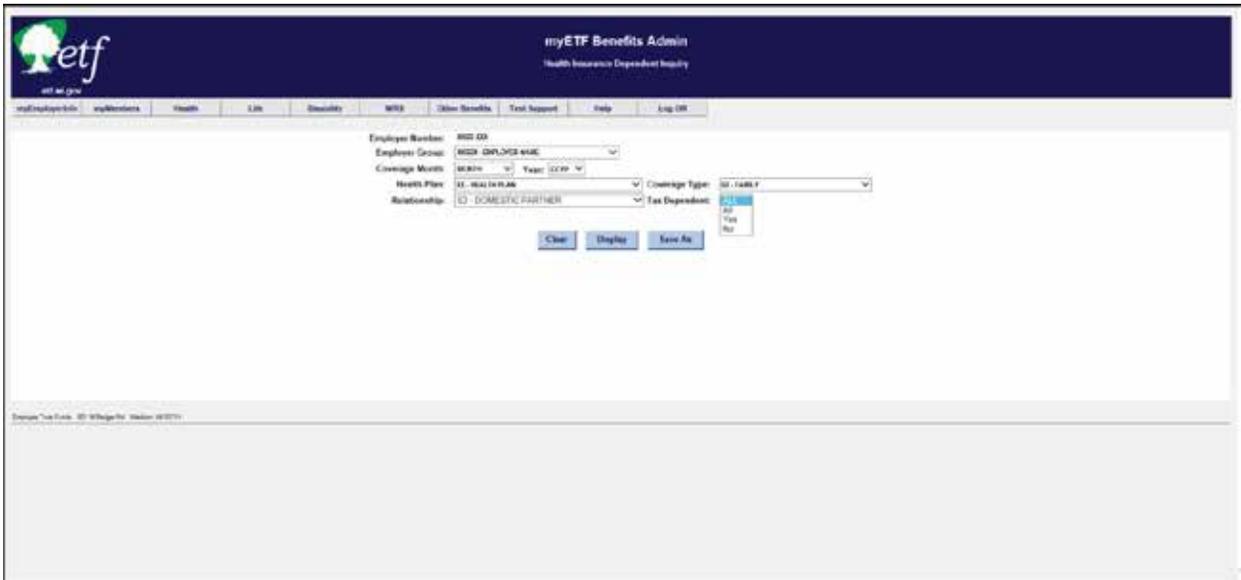


The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes the myETF logo and the text "myETF Benefits Admin" and "Health Insurance Dependent Inquiry". Below the navigation bar, there are several tabs: "myETFBenefits", "myETFBenefits", "Health", "LIFE", "Disability", "WFO", "Other Benefits", "Tool Support", "Help", and "Log Off". The main content area displays the following fields:

- Employee Number: 000 000
- Employee Group: 0000 EMPLOYEE
- Coverage Month: 0000 Year: 0000
- Health Plan: 00-ACA/19/14
- Relationship: A dropdown menu is open, showing the following options: ALL, 01- SPOUSE, 02- PARENT OF BENEF. DEPENDENT, 10- LEGAL WARD, 11- STEPCHELD, 19- CHILD, 24- DEPENDENT OF BENEF. DEPENDENT, 28- DEPENDENT OF DOMESTIC PARTNER, 31- DOMESTIC PARTNER.
- Coverage Type: 00- FAMILIAR
- Tax Dependent: ALL

A "Save As" button is located to the right of the Relationship dropdown menu. At the bottom of the page, there is a small text string: "Employee Tool Code: 00-00000000-00000000-00000000".

10. Select the Tax Dependent Status of your choice (default is **All**).

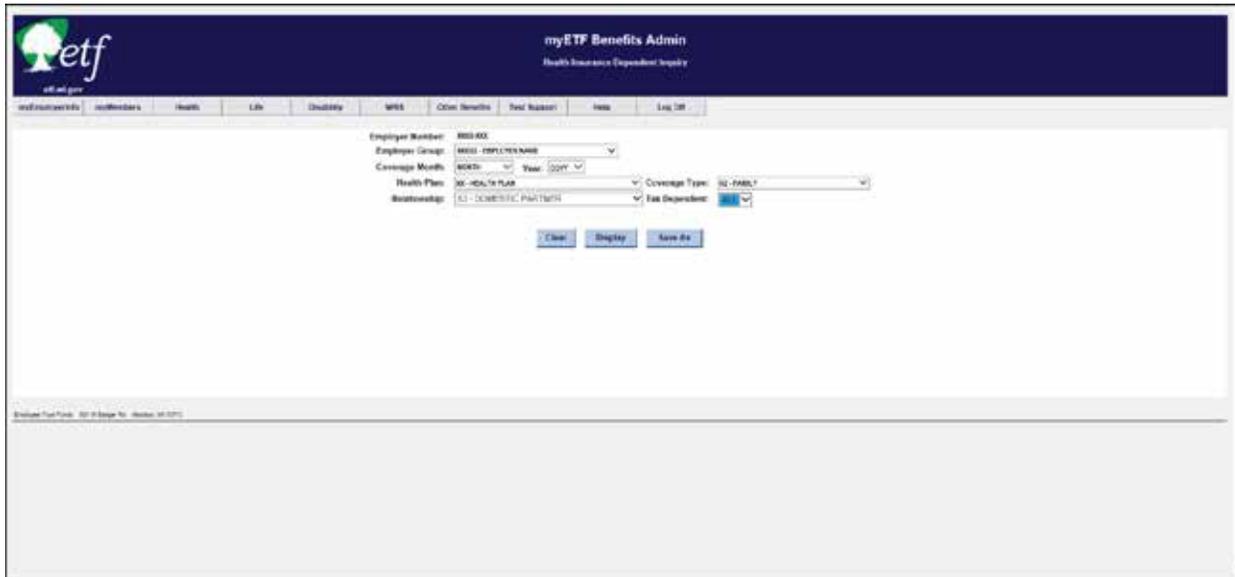


The screenshot shows the myETF Benefits Admin interface. The top navigation bar includes the myETF logo and the text "myETF Benefits Admin" and "Health Insurance Dependent Inquiry". Below the navigation bar, there are several tabs: "myETFBenefits", "myETFBenefits", "Health", "LIFE", "Disability", "WFO", "Other Benefits", "Tool Support", "Help", and "Log Off". The main content area displays the following fields:

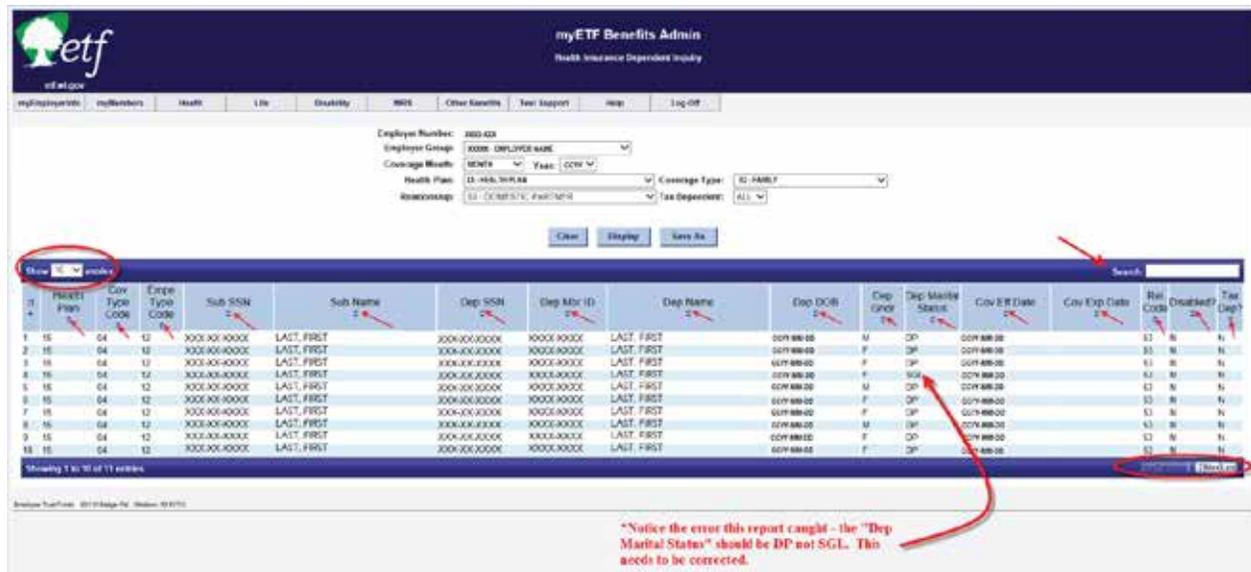
- Employee Number: 000 000
- Employee Group: 0000 EMPLOYEE
- Coverage Month: 0000 Year: 0000
- Health Plan: 00-ACA/19/14
- Relationship: 01- DOMESTIC PARTNER
- Coverage Type: 00- FAMILIAR
- Tax Dependent: A dropdown menu is open, showing the following options: ALL, Tax, Not.

Buttons for "Clear", "Display", and "Save As" are located below the Relationship and Tax Dependent dropdown menus. At the bottom of the page, there is a small text string: "Employee Tool Code: 00-00000000-00000000-00000000".

11. Click the 'Display' button to display the results of your query.



- You can select the number of entries to show at one time.
- You can Search for specific information (example: Health Plan, Coverage Type, Employee Type, Subscriber SSN, Dependent SSN, Dependent MID#, etc.)
- You can skip to a certain page, next page, or last page.
- You can sort by a specific column (small red arrows).



12. Click the 'Save As' button to export the results to a Microsoft Excel spreadsheet.

The screenshot shows the myETF Benefits Admin interface. At the top, there's a navigation bar with 'etf' logo and 'etf.nj.gov'. Below it, a menu bar includes 'Employees', 'myMembers', 'Health', 'Life', 'Disability', 'WFS', 'Other Benefits', 'Help', and 'Log Off'. The main area contains search filters for 'Employer Number', 'Employer Group', 'Coverage Month', 'Health Plan', 'Relationship', 'Coverage Type', and 'Tax Dependents'. Below the filters are buttons for 'Clear', 'Display', 'New ETR', and 'Save As'. A table of employee data is displayed below, with columns for Health Plan, Cov Type Code, Empl Type Code, Sub SSN, Sub Name, Dep SSN, Dep Mbr ID, Dep Name, Dep DOB, Dep Gender, Dep Marital Status, Cov Eff Date, Cov Exp Date, Rel Code, Disabled, and Tax Dept. A red arrow points to the 'Save As' button.

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

This screenshot is similar to the one above, showing the same search filters and employee data table. However, a dialog box is visible at the bottom of the screen, containing the text 'Do you want to export this data to an Excel spreadsheet?' and three buttons: 'Open', 'Save', and 'Cancel'. A red arrow points to the 'Save As' button in the interface above the dialog box.

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

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

1	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
2	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
4	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
5	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		01	N	Y
6	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		19	N	Y
7	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	F	SGL	CCYY-MM-DD		01	N	Y
8	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	F	MAR	CCYY-MM-DD		19	N	Y
9	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	MAR	CCYY-MM-DD		01	N	Y
10	XX	XX	XX	XXXXXXXXXX	LAST, FIRST	XXXXXXXXXX	XXXXXXXXXX	LAST, FIRST	CCYY-MM-DD	M	SGL	CCYY-MM-DD		19	N	Y

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

C-10. Address Inquiry

The Address Inquiry function within myETF Benefits is currently under construction and will be available some time in the future.