Health Insurance Application/Change For Retirees & COBRA Continuants

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

There are certain times throughout the year when you may enroll in health insurance or change your coverage. Visit It's Your Choice 2019 at etf.wi.gov/IYC2019 to learn more about choices available to you, view an eLearning and see instructions on how to enroll. **Return this completed form to ETF.**

1. Applicant Information *Only the subscriber applying for coverage should complete this form.*

Name *First*	*M.I.*	*Last*	ETF ID or SSN

Former/Maiden (if applicable)	Telephone ( )	Email

Mailing address	City	State	ZIP code	Country

Physical street address *if different from above*	City	State	ZIP code	Country

Note: If you are selecting Medicare Advantage and use a P.O. Box for your mailing address, you must also provide a physical street address to comply with Medicare requirements.

Birth date	Gender ☐ Male ☐ Female	Primary care physician or clinic

Check here if your name, phone, address, email or marital status has changed: ☐

Check your marital status:
☐ Married Date: _____ ☐ Divorced Date: _____ ☐ Widowed Date: _____
☐ Single *(no change date required)*

Please check which applies to you (this determines your eligibility)
☐ Retiree ☐ Disability recipient ☐ COBRA recipient ☐ Surviving dependent

2. Spouse Information

Name *First*	*M.I.*	*Last*	*Former/Maiden*	SSN

Birth date	Gender ☐ Male ☐ Female	Primary care physician or clinic

Check here if your spouse's information has changed: ☐ Is your spouse a tax dependent? ☐ Yes ☐ No

3. Dependent Information *Only list dependents you are adding or removing.*

☐ Check if you are only *updating* dependent information

Name *You may attach additional pages if more space is needed*			SSN	Birth date	Gender (M/F)	Relationship (child, stepchild, legal ward, dependent of minor dependent)	Disabled (Y/N)	Tax dep. (Y/N)	Primary care physician or clinic
First	*M.I.*	*Last*							

Is any dependent listed here your or your spouse's grandchild? ☐ Yes ☐ No
If yes, name of parent: _____

4. Why are you making a change?

Reason for application: Select a reason for enrolling or changing your coverage or health plan:

- ☐ It's Your Choice enrollment
- ☐ Eligible life event change Life event (e.g. marriage, divorce, etc.) :_____ Event date:_____
- ☐ New retiree
- ☐ Eligible move to a new service area *(may only change health plan)* Move date:_____
- ☐ Death of dependent or subscriber
- ☐ Newly eligible for local annuitant health program (LAHP) *(you are a new retiree or turned age 65 within the last 30 days)*
- ☐ Disability approval (*ETF use only*)

Eligible life event changes, which allow you to make a change outside of the annual IYC open enrollment, include marriage, divorce or guardianship.

State retirees with escrowed, accumulated sick leave conversion credits may re-enroll in health insurance during IYC open enrollment, or after an eligible life event change. The retiree must have comparable health insurance coverage. For more information see the *Sick Leave Credit Escrow Application* (ET-4305) at etf.wi.gov/publications/et4305.pdf.

Visit etf.wi.gov for a *Life Change Event Guide*. You may be required to provide supporting documentation. *If adding or removing dependents, see section 3.*

5. Choose an It's Your Choice (IYC) Plan Design

Compare factors like monthly payments, coverage levels and out-of-network benefits availability.

Retirees with Medicare:

- ☐ Medicare Advantage
  (Your health plan will be UnitedHealthcare®. Skip section 6.)
  Note: You may only select Medicare Advantage if **everyone** covered by your health insurance is enrolled in Parts A and B.
- ☐ Medicare Plus
  (Your health plan will be WEA Trust. Skip section 6.)
- ☐ Health Plan Medicare
  (You must select a health plan in section 6.)

Retirees without Medicare:

- ☐ IYC health plan
  (You must select a health plan in section 6.)
- ☐ Access Plan
  (Your health plan will be WEA Trust. Skip section 6.)
- ☐ High Deductible Health Plan (HDHP)
  (You must select a health plan in section 6.)
- ☐ Access High Deductible Health Plan (HDHP)
  (Your health plan will be WEA Trust. Skip section 6.)

Individual or family coverage? ☐ **Individual** ☐ **Family**

With or without dental? ☐ **With dental** ☐ **Without dental**

Local Wisconsin Public Employer (WPE) retirees: You may only choose Uniform Dental Benefits if your former employer offers it. Check with ETF if you are not sure.

State retirees: If you elect the High Deductible Health Plan (HDHP), you must also enroll in the state-sponsored health savings account (HSA). You are not eligible if you have Medicare, other health and/or flexible spending account (FSA) coverage. Dependents can have other coverage, and you can still have an HDHP policy.

Local WPE retirees: You may only choose an HDHP if your previous employer offered it; check with ETF if you are not sure.

6. Choose a Health Plan

All health plans provide the same in-network benefits. Choose a plan based on where you live or work, see health plan performance ratings and consider the monthly premium.

Enter the complete health plan name here. See your It's Your Choice materials for your options.	

7. Complete if you or any of your Dependents are Covered by Medicare

Complete for all persons covered by Medicare, including yourself. Eligibility reasons include age, disability or end-stage renal disease (ESRD).

Name (*first, m.i., last*)	Medicare number	Part A effective date	Part B effective date	Why eligible?
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD

Name: _____ Member ID: _____

8. Cancel Health Insurance Coverage **You may be required to provide supporting documentation*

Choose one reason for canceling coverage:

- ☐ It's Your Choice enrollment
- ☐ Retiree sick leave depleted. Effective coverage end date: _____
- ☐ I and all eligible dependents are now eligible for, and enrolled in, other coverage* – Event date: _____
- ☐ Spouse-to-spouse transfer – Event date: _____
- ☐ *COBRA only:* My employee premium share has increased significantly

9. Complete if you Have Additional Health Insurance/Coverage

Do you or any of your dependents have other medical coverage or health care flexible spending account coverage that has a balance available as of the effective date of this coverage? (excludes dental or vision) ☐ Yes ☐ No **If yes:**

Company	Policy number	Group number

Name(s) of insured (*first, m.i., last*)

10. Signature *Required*

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 agreed to the *Terms and Conditions* (see page 4). A copy of this application is 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. Providing false information is punishable under Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility.

Signature	Date

ETF Completes

EIN 0000001	☐ Retiree ☐ COBRA		Received date
Group number	Employee type	Coverage type ☐ Individual ☐ Family	Health plan name/suffix
Event date		Prospective coverage date	
Employer Communications Center 1-877-533-5020 608-266-3285			Date processed

Terms and Conditions

To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage, employment action, and/or criminal charges/sanctions under Wis. Stat. § 943.395.

I authorize the Department of Employee Trust Funds to obtain any information from any source necessary to administer this insurance.

I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.

I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me or any dependent(s). If medical records are needed, my health plan and/or ETF will provide me with an authorization form. I agree to respond to questions from health plans and ETF, including, but not limited to, audits, in a timely manner.

I have reviewed and understand the eligibility criteria for dependents under this coverage and affirm that all listed dependents are eligible. I understand that children may be covered through the end of the month they turn 26. Children may also be covered beyond age 26 if they: have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.

I understand that it is my responsibility to notify the employer, or if I am a retiree or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce, marriage or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependent(s).

I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependent(s)) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 18, 29, or 36 months, depending on the type of qualifying event, from the date of the qualifying event or the date of the notice from my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary(ies) and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.

I understand that if I am declining enrollment for myself or my dependent(s) (including spouse) because of other health insurance coverage, I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have (a) new dependent(s) as a result of marriage, birth, acknowledgement of paternity, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) if I request enrollment within 30 days after the marriage or within 60 days after the birth, acknowledgement of paternity, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am a retiree or continuant).

I understand that I am responsible for enrolling in Medicare Parts A and B when I am first eligible and required by this coverage, and that as the subscriber I am responsible for ensuring my spouse and any other eligible dependents also enroll in Medicare Parts A and B when they are first eligible, to ensure proper coordination of benefits with Medicare. In the event I or any eligible dependent does not enroll in Medicare Parts A and B when first eligible and required by this group health insurance program, I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

I understand that if I enrolled in Medicare Advantage with an individual or family contract and subsequently I or my dependents cancel Medicare coverage, I and all covered dependents on the contract will be unenrolled from the Medicare Advantage plan and enrolled in the IYC Medicare Plus plan effective the date of loss of Medicare coverage. I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the It's Your Choice materials.

Documentation Requirements

Reason for Change or Enrollment	Type of Documentation
*Adoption	Recorded copy of court order granting adoption or letter of placement for adoption.
*Cancel coverage/remove adult dependent due to enrollment in other health insurance coverage	Copy of medical ID card or letter from health plan indicating effective date of other coverage. Must be received within 30 days of enrollment in other coverage.
*Death	Original death certificate.
*Disabled, age 26+	Copy of letter from health plan approving disabled status.
*Divorce (Family coverage remains in place when more dependents than spouse/stepchildren covered.)	Copy of *Continuation-Conversion Notice* (ET-2311) sent to ex-spouse of the subscriber. (ETF may request copy of divorce decree from clerk of courts showing date of entry of divorce if needed per the Terms and Conditions.)
*Eligible **and** enrolled in Medicare	Copy of Medicare card and *Medicare Eligibility Statement* (ET-4307). (**Note**: If you are on COBRA Continuation and the subscriber or dependents become Medicare eligible after the COBRA effective date, subscriber or dependent is no longer eligible to continue on COBRA.)
*Legal change of name (other than due to marriage or divorce)	Copy of court order.
*Legal ward	Court Order (Letters of Guardianship) granting **permanent** guardianship of person.
*Loss of other coverage or loss of employer contribution to premiums (applies to member and dependents)	The following items on letterhead from the previous insurer or former employer, dated and issued after termination of coverage. Materials providing prospective termination dates are not acceptable. 1. Who was covered (must list the name of the member who is requesting this special, late enrollment) 2. Name of Health Insurer 3. Subscriber name 4. Date coverage was terminated 5. Reason for the cancellation (that is voluntary such as due to non-payment of premium vs. involuntary such as due to job loss). COBRA notice is acceptable if the coverage end date, covered individuals and health plan are indicated. If loss of employer premium contributions, letter from employer indicating they no longer contribute toward their employee's premium.
*National Medical Support Notice	Copy of National Medical Support Notice.
*Paternity	Court order declaring paternity, Voluntary Paternity Acknowledgement filed with DHS or birth certificate.
*Social Security number change	Copy of card or letter from Social Security Administration.
*State retiree re-enroll	Same as loss of other coverage and a *Sick Leave Re-enrollment Application* (ET-4317). During It's Your Choice, no documentation required.
Birth	Birth certificate required for single parent. (ETF may request documentation for married couples per the Terms and Conditions.)
Change of address/telephone	No documents required but ETF may request per the Terms and Conditions.
Divorce (family to individual)	No documents required but ETF may request per the Terms and Conditions.
Marriage	ETF may request original or certified copy of marriage certificate per the Terms and Conditions.

*Documentation required/must be submitted to ETF.

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) and (d)(1)
The Wisconsin Department of Employee Trust Funds complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Officer, Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 711; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020 （TTY：711）

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 711)

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 711)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 711).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 711).

Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-533-5020 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 711) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-533-5020 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 711).

Health Plan Contact Information

Dean Health Insurance
1277 Deming Way
Madison, WI 53717
Telephone: 1-800-279-1301
Fax: 608-827-4212
Dean On Call: 1-800-576-8773
Website: deancare.com/wi-employees

Dean Health Insurance-Prevea360 Health Plan
P.O. Box 28467
Green Bay, WI 54324-0467
Telephone: 1-877-230-7555
Prevea Care After Hours: 1-888-277-3832
Website: prevea360.com/wi-employees

Group Health Cooperative
of Eau Claire (GHC-EC)
P.O. Box 3217
Eau Claire, WI 54702
Telephone: 1-888-203-7770, 715-552-4300
Fax: 715-552-3500
Website: group-health.com

Group Health Cooperative of South Central Wisconsin
(GHC-SCW)
1265 John Q. Hammons Drive
P.O. Box 44971
Madison, WI 53717-4971
Telephone: 1-800-605-4327, 608-828-4853
Fax: 608-662-4186
Website: ghcscw.com

HealthPartners Health Plan
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-855-542-6922, 952-883-5000
Fax: 952-883-5666
Website: healthpartners.com/stateofwis

Medical Associates Health Plans
1605 Associates Drive, Suite 101
Dubuque, IA 52002
Telephone: 1-866-821-3992
Fax: 563-584-4760
Website: mahealthplans.com

MercyCare Health Plans
580 N. Washington Street
P.O. Box 550
Janesville, WI 53547-0550
Telephone: 1-800-895-2421 option 5
Fax: 608-752-3751
Website: mercycarehealthplans.com

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999
Telephone: 1-866-333-2757
Website: www.navitus.com

Navitus MedicareRx (PDP)
(Prescription drug coverage for
Medicare eligible retirees)
P.O. Box 1039
Appleton, WI 54912-1039
Telephone: 1-866-270-3877
Website: medicarerx.navitus.com

Network Health
1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Telephone: 1-844-625-2208, 920-720-1811
Fax: 920-720-1909
Website: networkhealth.com

Quartz
840 Carolina Street
Sauk City, WI 53583-1374
Telephone: 1-844-644-3455
Fax: 608-643-2564
Website: ChooseQuartz.com

Robin with HealthPartners Health Plan
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-855-542-6922, 952-883-5000
Fax: 952-883-5666
Website: healthpartners.com/etfrobin

Security Health Plan
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
Telephone: 1-844-813-7286, 715-221-9555
Fax: 715-221-9500
Website: securityhealth.org/state

UnitedHealthcare
P.O. Box 29675
Hot Springs, AR 71903-9675
Telephone: 1-844-876-6175
Website: UHCRetiree.com/etf

WEA Trust
45 Nob Hill Road
Madison, WI 53703-3959
Telephone: 1-866-485-0630
Fax: 608-276-9119
Website: weatruststate.com

Frequently asked questions about the new plan design for 2019, Medicare Advantage
See the It's Your Choice materials for complete details.

1. **Who will administer the It's Your Choice Medicare Advantage plan?**
   The Group Insurance Board selected UnitedHealthcare to administer the It's Your Choice Medicare Advantage plan, a new plan option under the State of Wisconsin Group Health Insurance Program.

2. **What is the difference between ETF's Medicare Advantage plan and an individual Medicare Advantage plan (that I can get somewhere else on my own)?**
   ETF's Medicare Advantage Plan is a group insurance plan; most plans that are advertised on TV or in magazines are individual plans. Group insurance plans are purchased by an organization on behalf of a group. Individual plans are purchased by individuals for themselves or their family, either through an insurance company or a broker. With a group Medicare Advantage plan, the state can negotiate plan enhancements that are not available via individual Medicare Advantage plans. For example, a group Medicare Advantage plan offered through ETF would not be subject to the prescription drug coverage gap, otherwise known as the "donut hole." The It's Your Choice Medicare Advantage plan will provide the Uniform Benefits, set by the Group Insurance Board each year. The prescription drug benefits will continue to be offered through Navitus.

3. **How will ETF's Medicare Advantage plan be different from the other options offered through the group health insurance program?**
   The It's Your Choice Medicare Advantage plan will cover the same uniform set of benefits as most of the other Medicare-coordinated plans ETF offers. However, UnitedHealthcare will offer some specialized services such as optional in-home preventive visits and SilverSneakers, a gym membership program.

4. **How can I determine if my health care provider is covered by this plan?**
   The It's Your Choice Medicare Advantage plan is a "passive" Preferred Provider Organization, or PPO, meaning you are not restricted to using network doctors, hospitals and other health care providers. You can see any provider that accepts Medicare and is willing to treat you and bill UnitedHealthcare. For services covered by the group health insurance program, you can continue to see your doctors if they have not opted out of Medicare and agree to see you. Both nationally and in Wisconsin, less than 1% of providers have opted out of Medicare.

5. **Does this plan include prescription drug coverage?**
   Your prescription drug coverage will continue to be provided by Navitus.

6. **What happens if an individual retires but is not age 65 or otherwise eligible for Medicare?**
   A retiring individual who is not eligible for Medicare will stay on his or her current plan. When the retiree turns 65 or otherwise becomes eligible for Medicare, he or she will move to the Medicare version of the plan they are currently enrolled in. A participant can change plans during the annual It's Your Choice open enrollment period each fall.

7. **What happens when a retiree turns 65 and becomes eligible for Medicare but dependent(s) remain under age 65?**
   When a retiree turns 65 and becomes eligible for Medicare, he or she will move to the Medicare version of the plan they are currently enrolled in. The retiree's existing coverage will remain the same for any dependent under age 65 until he or she becomes eligible for Medicare.

   Note: ETF members are only eligible for an It's Your Choice Medicare Advantage plan if *all* members on the family plan are enrolled in Medicare Parts A and B.