State of Wisconsin Supplemental Benefit Plans Administration Manual

For use with these insurance plans:

Delta Dental of Wisconsin

VSP Vision Service Plan

Zurich North America

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I. Introduction

Supplemental Benefit Plans (Supplemental Plans) are types of insurance that are:

- Generally supplementary to group health insurance, providing coverage for dental, vision, accidental injury, or accidental death.
- Voluntary for eligible Employees and Retirees as determined by Group Insurance Board (Board) contract.
- Paid for by Employees via payroll deduction—Subscribers are responsible for the entire cost of premiums.
- Paid for by Retirees using a direct pay method arranged with the Vendor (sick leave conversion does not apply).
- Approved and offered by a contract with the Board under provisions of Wis. Stat. § 40.03(6) and § 20.921(1)(a).

The Group Health Insurance Program (GHIP) is referenced occasionally in this manual, for reference or contrast. ETF has made efforts to align administrative policy and procedure for Supplemental Plans with those for State Group Health, where feasible.

II. Definitions

Beneficiary: Any individual identified as the recipient of benefits in the event of the subscriber's death (http://etf.wi.gov/publications/et2320.pdf); generally, an Employee's Spouse, child(ren) and/or stepchild(ren).

Beyond Vision: An Employer with its own payroll system. Also known as Wiscraft.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), also known as Continuation Coverage. COBRA requires that the state offer subscribers (employees/members) and their covered dependents (qualified beneficiaries) temporary extension of identical coverage at the same rate as current employees are paying for a maximum of 18 months (36 months under certain circumstances) following specific events, referred to as "qualifying events". Wisconsin State Statute §632.897 also applies. When Federal and State laws are in conflict, the law that is more beneficial to the employee must be applied.

Complaint: Any expression of dissatisfaction to the Vendor by the insured or an insured's authorized representative, about a Vendor or the providers with whom the Vendor has a direct or indirect contract.

Continuant: An Employee or Dependent who is eligible for coverage under COBRA. See Section XI of this manual for a detailed breakdown of qualifications of continuants.

Coverage: The specific benefit levels for which an employee and/or Dependent is eligible under the Supplemental plan.

Dependent: Means a Subscriber's:

- Spouse
- Child
- Legal Ward; who becomes a legal ward of the Subscriber or the Subscriber's Spouse, prior to age 19,
- Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896
- Stepchild
- Grandchild if the parent is a Dependent child under 18 years of age.

Eligibility Termination Date: This is the date a Subscriber or their Dependent's supplemental insurance coverage through the State of Wisconsin comes to an end.

Employee: Same as 'Eligible Employee' as defined in Wis. Stat. §40.02(25) (b). It includes state employees eligible for the WRS, elected state officials, and graduate assistants employed at least 1/3 time who are expected to be employed for at least six months.

Employer: The Employer's office of Human Resources, Payroll and/or Benefits, and the Payroll Center that serves that WRS participating State Agency.

ETF: Department of Employee Trust Funds.

Fox River Navigational System Authority: An Employer with its own payroll system.

Group Insurance Board or Board: Eleven (11) member board that sets policy and oversees administration of the group health, life insurance, and income continuation insurance plans for state employees, retirees and the local employers who choose to offer them. The Board also can provide other insurance plans, if employees pay the entire premium. The Board's authority is governed by Wis. Stat. § 40.03 (6). For more information on the Board visit: http://www.etf.wi.gov/boards/board_gib.htm

HIPAA: Health Insurance Portability and Accountability Act, a United States federal law that includes privacy standards to protect personal health information.

Hire Date: For purposes of insurance effective date, the first day of active benefits-eligible employment upon hire, also called eligibility date.

Leave of Absence (LOA): Under Wis. Stat. § 40.02 (40), "Leave of absence" means any period during which an employee has ceased to render services for a participating employer and receive earnings and there has been no formal termination of the employer−employee relationship.

Legal Ward: An individual for whom a permanent legal guardian has been appointed under Wis. Stat. §54.10

Limited-Term Employee (LTE): An Employee who is eligible for the GHIP but is appointed to work less than half time as defined by Wis. Stat. §40.05 (4) (ag).

Member: An individual enrolled in a Supplemental Plan.

National Medical Support Notice (NMSN): The NMSN is a federal requirement used to enforce medical support orders for minor children. It is to be used throughout the United States to enroll children in employment related health insurance coverage. NMSN occurs when a court orders the parent in question to provide coverage for their child(ren).

Plan or Supplemental Plan: Supplemental Plan approved by the Board as an optional employee-pay-all benefit, and/or benefit available to Employees and/or Retirees

Open Enrollment: A defined period when eligible Employees and/or Annuitants may enroll, change, or cancel participation in any Supplemental Plan. The time frame is established by the Board, usually for 4 weeks beginning in early to mid-October.

Qualifying Event: Life event that provides an opportunity for a Subscriber to add, cancel, or change coverage. See specific sections for enrollment, change, and cancellation opportunities.

Retirees: A Wisconsin Retirement System (WRS) member who has retired and is eligible for group health insurance plans under the WRS or is the surviving Spouse of a Retiree. Eligible Retirees include those who meet at least one of the following criterion:

- Receive a disability annuity under Wis. Stat. §40.63,
- Receive duty disability benefits under Wis. Stat. § 40.65,
- Left State service with at least 20 years of creditable service under the WRS, regardless of age, or
- Have received a retirement lump-sum payment.

Note: This does NOT include Beneficiaries who were not the Spouse of the Subscriber.

Spouse: Person in a marriage recognized in the State of Wisconsin.

STAR: “State Transforming Agency Resources.” The automated payroll and benefits system for State agencies used by Central Payroll, the Legislature and the Wisconsin Courts System.

State: State of Wisconsin.

State Group Health Insurance Program (GHIP): Group health care benefits for Employees, Retirees, and their Dependents eligible for coverage offered by the Board as required by Wis. Stat. § 40.51 and §40.52.

Subscriber: An active Employee or Retiree enrolled in a Supplemental Plan who is not enrolled as the Dependent of another Subscriber.

UWHC: University of Wisconsin Hospitals and Clinics, an Employer with its own payroll system.

UWS: University of Wisconsin System administration, an Employer with its own payroll system. Includes all University of Wisconsin campuses.

Vendor: Company providing an insurance plan approved by the Board as a Supplemental Plan.

WEDC: Wisconsin Economic Development Corporation, an Employer with its own payroll system.

WHEDA: Wisconsin Housing and Economic Development Authority, an Employer with its own payroll system.

WHEFA: Wisconsin Health and Educational Facilities Authority, an Employer with its own payroll system.

WRS: Wisconsin Retirement System.

III. Eligibility & Enrollment

Employee Eligibility

An active Employee who is eligible for the GHIP, with or without Employer contribution.

Employee Enrollment

Eligible Employees may enroll within the first 30 days of their Hire Date. Coverage is effective on the 1st of the month that first occurs during the 30-day enrollment period.

For Accidental Death and Dismemberment (AD&D) Insurance ONLY: Coverage is effective on the 1st of the month on or following the 30-day enrollment period.

In addition, Employees have the following enrollment opportunities:

- If previously eligible under WRS, an Employee may enroll if he or she has had more than a 30-day break in employment.
- If an Employee previously eligible under WRS has less than a 30-day break between state Employers.
    - Treat the Subscriber Records as a transfer, as if employed by a new State agency
    - Treat the Subscriber Records as a reinstatement with no break in coverage if the Subscriber returns to the same agency within 30 days.

      Note: If the break in employment crosses the 1st of the month, that coverage is still continuous
- Under Wis. Stat. §40.52(3), §40.02(25)(b)2 and §40.02(25)(b)2g a University of Wisconsin System (UWS) graduate assistant may enroll in supplemental benefits within 30 days of beginning their first eligible appointment; however
    - 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.
- LTEs have an additional 30-day enrollment opportunity under the following conditions:
- The hours of employment increase due to a change in the position appointment and the Employee now qualifies for full share of Employer contribution towards the GHIP; or
- The Employee is appointed to a different position and newly qualifies for the full share of the Employer contribution towards the GHIP.

Declining Enrollment

An eligible Employee may choose to decline or waive coverage. In this case, the Employer must retain a record of the Employee's choices to waive each Plan, showing that the Plan was offered in a clear and timely way but was declined. Note: if no election is made, this is considered waiving coverage.

State Transfers

If an employee transfers to a different state agency under the same payroll center (i.e. STAR), coverage is continuous. If the transfer occurs across different payroll centers, a new application must be submitted.

An Employee is eligible to enroll in Supplemental Plans after a transfer only if the Plan was not offered at the prior agency. The Employee is not eligible to enroll if the Plan was available at the previous Employer, but they waived coverage.

Retiree Eligibility

Any Retiree who is eligible for the GHIP is also eligible for the Supplemental Plans.

Employees enrolled in a Supplemental Plan while active may continue coverage on that Plan on a direct-pay basis following retirement either as a retiree or as a continuant.

All Plans require a completed Continuation Form within 60 days of retirement (See Continuation section) in order to continue coverage. **Note**: AD&D insurance coverage is not available for Retirees.

Re-hired Retirees may enroll in Supplemental Plans if they have suspended their annuity and are eligible to enroll in the GHIP as an active Employee. The Employer is responsible to offer enrollment to an eligible re-hired Retirees. A Member remains in Retiree status if:

- The Retiree does not have a Qualifying Event
- The Retiree is receiving an annuity while employed.
- The Retiree does not use payroll deduction but continues to pay the Vendor directly.

Dependent Eligibility

Eligible children cease to be Dependents on a Supplemental Plan at the end of the month in which they turn 26 years of age, except in the following circumstances:

- A grandchild ceases to be a Dependent at the end of the month in which the covered Dependent child (parent) turns age 18.
- A Spouse and Step-child(ren) cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment or the date that the Continuation Notice for each plan is provided to the divorced spouse.
- Full-time students called to active duty prior to age 27
    - After attaining age 26, as required by Wis. Stat.§ 632.885(2)(b), a Dependent includes a child who is a full-time student, regardless of age, who was called to

federal active duty when the child was under the age of 27 years and while the child was attending, on a full-time basis, an institution of higher education.

  - The adult child must apply to an institution of higher education within 12 months after completing his/her active duty obligation.
  - The Employer will verify this status to enroll the Dependent. Vendors will enroll Dependents based on the Employer's approval.
  - For a Retiree Subscriber whose adult child fits this situation, the Vendor may require that the Subscriber submit verification.

- Adult Disabled Dependents
  - An unmarried Dependent child who is incapable of self-support because of a physical or mental disability that began prior to age 26 and can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age.
  - The child remains a disabled Dependent as long as at least 50% of the child's support and maintenance is provided by the Subscriber and/or the Subscriber's Spouse, as demonstrated by the IRS Pub. 501.
  - The GHIP will monitor eligibility annually of members and dependents that receive insurance in the GHIP and will notify the Employer and ETF when terminating coverage prospectively upon determining the Dependent is no longer disabled and/or no longer meets the support requirement. The Employer will notify their Employer Services (ESS) contact at ETF of any support requirement changes.
  - Employers are not required to transmit disability status of Dependents with enrollment records, but are responsible to provide the designation and/or verification as follows:
    - **Delta Dental of Wisconsin**: If Employer indicates dependent is permanently disabled on electronic enrollment via an Electronic Data Interchange (EDI) transmission or online enrollment, no further verification is needed. If dependent becomes permanently disabled after enrollment or is not reported as previously stated, a form will be provided to the Subscriber for completion by a physician for verification.
    - **VSP:** Records disability status of Dependent, self-reported by Subscriber upon enrollment. No regular verification required.
    - **Zurich:** May require verification of disability

Additional Eligibility Rules

Child born outside of marriage

- A child born outside of marriage becomes a Dependent of a parent when the parent completes the enrollment change form, therefore making the child eligible to be added to parent's supplemental coverage. Single parents must include the following documentation, and eligibility will be determined based upon the latter of the dates provided on the:

- Date of the court order declaring paternity; or
- Date the Acknowledgement of Paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin); or
- Date of birth on birth certificate listing the parent's name; or
- Date specified on a National Medical Support Notice that occurs when a court orders the parent in question to provide coverage for their child(ren) or
- Date that a court makes a final order granting adoption by the member or the date the child is placed in custody of the subscriber in a pre-adoption placement. Whichever date occurs first; or
- Date that a court awards permanent guardianship of a legal ward before the age of 19 to either the member of spouse; or
- Date of birth if the statement or court order of paternity is filed within 60 days of the birth and the parent completes the enrollment change request within 60 days of filing that paternity order. If the Subscriber submits the eligibility change request more than 60 days after the paternity filing, the coverage effective date must be set to the first of the month following receipt of application.

VSP, Delta and Zurich do not need copies of the documentation if the Employer has seen the documentation and is satisfied the above requirements were met. However, the supplemental providers do reserve the right to ask for a copy of the documentation at a later if the need arises.

Foreign nationals

- An eligible foreign national member who is:
  - A citizen of a country with national health care coverage that is deemed comparable to supplemental insurance coverage offered by ETF as determined by the Employer; and
  - Does not select supplement coverage when hired, during an open enrollment period, or during Qualifying Event; and
  - In the event Member or Dependent(s) lose eligibility for the national health care coverage offered by the foreign country the member may elect coverage under any plan by filing an application with the Employer within 30 days of the loss of eligibility. The member must provide evidence satisfactory to the Employer of the loss of eligibility; and
  - This enrollment period will coincide with their enrollment opportunity for the GHIP.

IV. Late Changes or Applications (see also Employer Error)

Note: An Employee or Retiree may cancel their enrollment in any Supplemental Plan up until December 31 for the subsequent year; this is not considered a Late Change. The cancellation will not be effective until the 1st day of the following calendar year.

Employees

If an Employee or eligible Subscriber failed to enroll or make a change during their eligibility period or Open Enrollment, they may request a review from the Employer which may need subsequent approval by ETF.

The review process for active Employees is as follows:

1. Employee submits an application after the end of the Open Enrollment period.
2. Employee submits a written request to their Employer. The request must outline the reason and/or circumstances for the late application.
    - *If the Employer rejects a late application*, the Employer provides the Employee with notice of the late application, and instructions for requesting a review.
    - The Employer's email must be sent encrypted. The subject line of the email should be "[SEND SECURE] Late Enrollment, Employer record."
3. The Employer will review and forward the request for review to ETF's Employer Services Section (ESS) ETFSMBEmployerInsurance@etf.wi.gov along with a cover memo outlining their actions to this point, and any circumstances they are aware of to support or refute the Employee's request.
4. ESS will review the request. If the circumstances fall outside the criterion outlined in ETF's supplemental policy as outlined in this manual ET-1158, ESS will forward the request to the Office of Strategic Health Policy (OSHP) for review.
5. ETF will advise the Employee and Employer of a decision within 30 days. If a late enrollment or change is allowed, premiums will be adjusted back to January 1st or the missed effective date.

Retirees

If a Retiree failed to submit enrollment or changes during Open Enrollment, he or she must submit their request for review directly to the Vendor. The Vendor has the final decision, based on standards set forth in the *State of Wisconsin Supplemental Benefit Plans Administration Manual* (ET-1158). The Vendor may consult ETF if the request has unique circumstances.

V. Changing Coverage

Specific Qualifying Events trigger opportunities for a Subscriber to enroll, cancel, or change supplemental coverage. They include:

- Marriage,
- Birth or adoption,
- Permanent placement of a Legal Ward,
- Dependent child turning age 26,
- Divorce or annulment,

- Leave of Absence, and
- Eligibility for or loss of comparable coverage.

Refer to the Life Event Change Guide for details on each Qualifying Event:
http://etf.wi.gov/members/IYC2019/et-2107leg.asp

Notification of Change - Employees

The Subscriber must notify the Employer and complete applicable forms and/or tasks necessary within the specified time limits for each Plan, and provide the required documentation as outlined below. The Employer is responsible for timely submission to the Vendor, and for making necessary changes to payroll deductions.

Notification of Change - Retirees

The Vendor and the Retiree communicate directly regarding changes in coverage. Retirees must use online portals, or call the Vendor's service center for forms, and submit change requests or notifications directly to the Vendor. The timelines below apply to Retirees as well as to active Employees.

Adding Dependents to Existing Coverage

Absent a Qualifying Event, a Dependent can be added only during an enrollment period designated for such action. The newly added Dependent will be subject to coverage limits applied to new enrollees if a Plan includes coverage limits.

Note: Unlike State Group Health Insurance, a Subscriber may elect which eligible Dependents to cover under Supplemental Plans.

Changing Coverage Upon Marriage

A covered Employee must complete and sign an Enrollment Application within 30 days of the date of marriage if the Employee wishes to insure the Spouse and any eligible Dependents of the Employee or Spouse.

Adding a Newly Eligible Dependent Child When Single, Individual + Child, or Individual + Spouse Coverage is in Force

The Subscriber must complete, sign and submit an Enrollment Application to the Employer within 60 days of the date of birth, adoption, or legal guardianship or within 30 days of the Qualifying Event that makes the Dependent eligible.

Note: Unlike the State Group Health Insurance policy, a Subscriber is not required to add all Dependent children when one or some are added. This allows blended families to avoid coordination of benefits issues.

Process When a Covered Employee Gets a Divorce or an Annulment

Refer to the Continuation Coverage section to determine if or how continuation must be offered to the former Spouse and his or her Dependents. If the covered Employee is removing

Dependents from coverage, the Employee must submit an Enrollment Application(s) to the Employer.

Dual Coverage for a Child Whose Parents are not Married to Each Other:

Zurich: An individual may only be covered once under each Plan policy. If both parents are eligible Employees for the same Plan, only one parent may cover the child(ren). Since Employers may be unaware of dual coverage, it is the Vendor's responsibility to monitor and report dual coverage issues.

VSP and Delta Dental allow dual coverage for a child but will not pay more than 100% of the covered amount for a service or item.

VI. Pre-Tax or Post-Tax Deduction of Premiums

Pre-Tax Deductions

Eligible Subscribers (LTEs are not eligible) may have premiums for the VSP and Delta Dental Supplemental Plans deducted from their paychecks before Federal, State and Social Security taxes are calculated.

- Changes to coverage may be made only at the beginning of a new plan year (January 1). **Note**: Changes to or cancellation of existing coverage are not permitted during the year without a Qualifying Event.
- Income records used for determining any other benefits that are based on salary, such as WRS retirement benefits, disability benefits and life insurance coverage will not reflect a decrease.

Employees premiums are automatically deducted on a pre-tax basis unless the covered Subscriber files a waiver or one or more enrolled Dependents are not eligible tax-dependents or qualifying relatives under the Internal Revenue Code (IRC) §125 as indicated on the application.

Post-Tax Deductions

If a Subscriber does not wish to have their premiums taken on a pre-tax basis, they must complete an Automatic Premium Conversion Waiver/Revocation of Waiver form. If the application reflects enrollment of at least one Dependent whose coverage is not tax deductible under IRA Publication 501, the full premium must be deducted post-tax even if the Subscriber does not complete an ERA Automatic Premium Conversion Waiver.

Premiums for LTEs must always be deducted post-tax. **Note**: AD&D Insurance premiums are only deducted post-tax.

VII. Naming a Beneficiary

Beneficiary Records

Zurich AD&D is the only Supplemental Plan that has a death benefit. A Subscriber must be offered the Beneficiary form specific to that plan. The following are provisions for naming a beneficiary for Zurich AD&D only.

- Beneficiary forms are to be kept on file by the Employer and transferred in the Employee records if he/she moves to a new agency.
- If a claim is filed for death benefits for an active Subscriber, Zurich will obtain a copy of the beneficiary designation from the Employer.
- Zurich will collect a new beneficiary form if a retiring Member chooses to convert their policy.
- Zurich will honor existing beneficiary forms from The Hartford if a new form is not submitted.
- If the Subscriber dies without a named Beneficiary, the standard sequence applies as outlined in Wis. Stat. § 40.02(8)(a)2.

Benefits Payable After Death of the Subscriber

For any Supplemental Plan under contract with ETF, if a Subscriber dies before receiving a benefit owed by the Vendor, ETF may release the contact information for the Chapter 40 Beneficiary to the Vendor, upon request of the Vendor, per Wis. Stat. § 40.07(1m).

VIII. Both Parents or Spouses Employed by a State Employer

1. **May two married, covered Subscribers (Employees and/or Retirees) each subscribe to family coverage for the same Supplemental Plan?**

   VSP and Delta Dental allow a person to be a Subscriber on one plan and a Dependent on another. If a Member is covered by more than one Vision or Dental Supplemental Plan and has duplicate coverage, VSP and Delta Dental will allow coverage for two separate sets of service, or “stacking,” wherein both plans pay for one set of services. Zurich AD&D does not allow this.

   For Zurich AD&D Payroll Centers are responsible to identify dual family plans within their agencies. The Vendor is responsible to identify dual family plans if the Subscribers are Employees of different payroll centers or if one is a Retiree and one is active.

   If Zurich notes that both Spouses are enrolled with overlapping coverage, the Zurich will notify the Subscribers, who will have 60 days to decide how to change coverage. Zurich will refund up to 90 days of premium.

2. **What is the difference if two eligible married Employees elect two separate policies (single for each versus limited-family or family coverage)?**

Coverage would be equal for adults in the dental and vision plans, as each Member has the exact same level of benefits.

For the AD&D Insurance plan, the Subscriber is covered at a higher level than the Employee who is designated as a Dependent.

3. **Can two covered Employees change from two single plans to family coverage?**

   If Spouses are both Subscribers, work for the same or different Employer, and each carries single coverage, one Spouse can change to family coverage if they experience a Qualifying Event and apply within 30 days of the event. This new family coverage could include both spouses if one of the adults drops their individual plan.

   If two people, who are each Subscribers in the same Plan, become married, this provides an enrollment opportunity to choose which type of coverage they want to keep.

   If there is no Qualifying Event, these changes can only be made during the Plan's Open Enrollment and will be effective on the following January 1.

4. **Can two Subscribers who are married do a Spouse-to-Spouse transfer of coverage?**

   Spouses who are both employed by the State and have individual +child(ren)or family coverage may change the Subscriber under the Plan from one Spouse to the other within 30 days of the following events:

   - The Employee designated as the Subscriber terminates. The change will be effective on the first day of the month following the date of termination or retirement of the Subscriber.
   - The Employee designated as the Subscriber goes on an unpaid or military Leave of Absence. The change will be effective on the first day of the calendar month following the first date of the Subscriber's unpaid or military Leave of Absence.
   - The Employee may also make the change during the Open Enrollment period, which will be effective on the following January 1.

   Retirees may apply for a spouse-to-spouse transfer any time during the year, because their premiums are direct and not via pre-tax, payroll deduction.

   Delta Dental and VSP's Summary of Benefits for 2019 can be found on at this link: http://etf.wi.gov/members/IYC2019/et-2107epa.asp

IX. Leave of Absence

Leave of Absence (LOA) Procedures

A Leave of Absence is any period in which a Subscriber is not working for, or receiving earnings from, the Employer and has not terminated the Employer-Subscriber relationship as defined in Wis. Stat. § 40.02 (40).

To continue benefits for up to 36 months during LOA, the Subscriber must pay the monthly premium to the Employer or payroll center, which will submit payment to the Vendor.

- The Subscriber must pay the Employer, on terms determined by the Employer. The Employer must make timely payments to the Vendor to maintain coverage.
  - Employers may arrange to collect payments in advance for up to three months of premiums, using payroll deduction (to preserve the pre-tax opportunity).
    - If an Employer sends a lump sum payment to the Vendor in advance of premium due dates, the Employer must clearly identify the months of coverage the lump sum represents.
    - If the payroll center's payment system allows, the Employer holds the personal checks and applies them to the remittance to the Vendor in the month due.
- If the Subscriber's payments to the Employer lapse, the Employer will notify the Vendor to lapse coverage. Vendors should only lapse coverage if instructed by the Employer and/or noted in enrollment/change files from a payroll center, and not on the basis of non-payment on remittance reports.

If the Subscriber intends to let coverage lapse, the Employer must notify the Vendor that the Subscriber is on an approved LOA. **Best Practice Note**: Employers should advise employees *not to cancel* coverage during LOA, but instead choose to have *it lapse to preserve their rights to re-enroll when they return to work*.

If the Subscriber lets coverage lapse while on LOA, within 30 days of his or her return to work, he or she may re-enroll in the same level of coverage that was in force prior to the lapse of coverage. Coverage is effective the 1st of the month on or following return to work.

If an Open Enrollment period occurred while the Subscriber was on LOA, he or she may make any changes that were allowed during the Open Enrollment period.

A LOA ends when the Subscriber resumes active performance of duty for 30 consecutive days for at least 50% of the Subscriber's normal work time. If the Subscriber does not complete 30 days of duty, the Subscriber is not deemed to have returned from leave and coverage will continue as an employee on leave of absence.

An employee on LOA is subject to the same eligibility and enrollment provisions as an active employee.

Military Leave Procedure

A Subscriber and his/her covered Dependents may maintain their coverage(s) while the Subscriber is on active military duty for 30 calendar days or more, with the requirements set forth below:

- Premium(s) for Plan coverage(s) must be paid through the Employer. The Vendor will not bill the Subscriber directly.
- Employers that collect premiums in advance may collect up to one year of premium prior to deployment.

- The Employer will contact the Subscriber at least one month before prepaid coverage will lapse, to request notification from the Subscriber to extend or let the coverage lapse.
- The Subscriber provides documentation of military leave to the Employer for other HR purposes, but it is not necessary to send documentation of the military leave to the Vendor.

The Vendor does not terminate the coverage of a Subscriber and Dependents upon notification of active military status. Enrollment will remain active until the Subscriber or Employer notifies the Vendor to terminate coverage, using electronic enrollment file or paper enrollment/change form.

The Employer must notify the Vendor that the Subscriber is on military leave if the Subscriber intends to let coverage lapse. If the Subscriber allows coverage to lapse while on military leave, he or she may re-enroll in the same level of coverage that was in force prior to the lapse of coverage, if he or she does so within 30 days of his or her return to work. Coverage is effective the 1st of the month on or following return to work.

If an Open Enrollment period occurred while the Employee was on military leave, he or she may change the level of coverage or make any other changes that were allowed during the enrollment period.

Retirees

LOA is a status that does not apply to Retirees, unless a Retiree is deployed into active military service. In that situation, the Retiree must contact the Vendor to arrange for payment or temporary lapse of coverage.

X. Cancellation/Termination

Once enrolled, Subscribers must remain in the plan for the full calendar year unless there is a Qualifying Event as described below. Non-payment of premiums resulting in lapse of coverage may limit future re-enrollment opportunities. See further detail on timing and process below in the following tables.

Employees

Termination of Employment	Coverage ends at the end of the month in which the event occurs.
Retirement	Coverage ends at the end of the month in which the event occurs unless the retiree elects to continue coverage into retirement.
Unpaid LOA*	Coverage ends the end of the month for which premiums have been paid. While on LOA, Subscriber must continue to remit premiums to the Employer.
Active Military Duty*	Coverage ends the end of the month for which premiums have been paid. While on LOA, Subscriber must continue to remit premiums to Employer.
Subscriber Death	For single or family plans, coverage ends at the end of the month in which the event occurs.**
Transfer to another Agency	Coverage ends at the end of the month in which the transfer occurs, if the new Employer does not offer the same insurance plan.

** If coverage lapses, Employee may re-enroll within 30 days of return to work.*

*** For Zurich, coverage for Dependents ends on the date of the Subscriber's death*

State Transfer

- Coverage ends at the end of the month in which the transfer occurs. The payroll deduction to pay for supplemental coverage(s) are paid through the first Employer for that month, if the transfer occurs on or before the 16th.
- The First Employer makes the appropriate notations about coverage and paid-through dates on the Personnel Transfer Record (PTR).
- Many Employers choose to also send an email to the new Employer to reinforce any details related to benefits, at the time of transfer.

Dependents

Divorce*	End of the month in which the divorce is final, however, ex-Spouse and ex-stepchildren remain covered until end of month in which they are notified of continuation rights.
Child Ages Out	End of the month in which the Dependent turns 26.
Disabled Adult Child	Coverage ends at the end of month in which the child is determined to no longer be disabled by a physician.
Dependent Child Called to Active Duty While a Full-time Student	If the child is under age 27 and attending school on a full- time basis when called to active duty and returns to full- time student status within 12 months of fulfilling active duty. Coverage ends at the end of the month in which full-time student status ends.
Dependent Becomes Eligible for Comparable Coverage	End of the month in which the comparable coverage is effective. **Note**: if comparable coverage begins on the 1st of the month, the Dependent coverage will cease on the last day of the previous month.

**Natural and adopted children can remain covered along with the Subscriber. Coverage for stepchildren ends on the same day as coverage ends for the former Spouse.*

Adult child turning age 26

The Employer must terminate a Dependent's Plan enrollment at the end of the month in which they turn age 26. The Employer must issue a Continuation Coverage election form to the Dependent losing eligibility and adjust the records accordingly so that there is no excess premium deducted from the Subscriber's payroll.

Employers notify Subscribers that Dependents will be removed and advise whether coverage level changes will be made automatically due to the change. The Employee does not need to complete an application/change request.

Delta Dental will issue any Payroll Center a monthly report listing dependents reaching age 26. Payrolls centers should email ETFsales@deltadentalwi.com to request the report. Please note that the report can be emailed/to one email address per 18-digit group number (payroll center/plan).

Dependent Coverage Terminations

Absent a Qualifying Event, the Subscriber may only elect to remove covered Dependents during the annual Open Enrollment period. Coverage ends on December 31.

When the Dependent is removed, he or she may not be re-enrolled except during a designated enrollment period. There are no mid-year opportunities to remove a Dependent from coverage, except due to a Qualifying Event.

Dependents of employees:

- Coverage can only be canceled mid-year if a Qualifying Event makes the Dependent ineligible for coverage or the dependent gains access to comparable coverage. The Subscriber may submit an application/change request to the Employer by December 31 to remove the Dependent for the following calendar year in absence of a Qualifying Event.
- To remove a Dependent due to a Qualifying Event, the Subscriber must indicate the date of and reason for the loss of eligibility in the “Delete” section of the Enrollment Application.
- Even if family coverage will remain in force, a change form must be submitted indicating which Dependent is being canceled, the reason for the cancellation, as well as the date of the cancellation.

Dependents of retirees:

- Retirees and their Dependents are committed to be enrolled for a full year, absent a Qualifying Event. Retirees can obtain a change form on ETF’s website and must submit it directly to the Vendor at the address provided on the form (not to ETF).

Cancellation Rights

All Supplemental Plans require that once a Subscriber is enrolled for the calendar year, they must stay enrolled unless there is a Qualifying Event.

A Subscriber who wishes to cancel coverage for the following calendar year may do so without a Qualifying Event during Open Enrollment. However, any valid cancellation notice filed with the Employer (or with the Vendor, for Retirees) by December 31st will be honored effective January 1st of the following year.

If a premium has been deducted, the Employer will refund the payment on a subsequent payroll.

- The Vendor must notify ETF to adjust a premium paid through annuity deduction on the following month’s annuity (VSP only).
- If needed, the Vendor will make a refund to Subscribers who use direct pay.

If a Subscriber is disenrolled for non-payment of premiums, they may be ineligible to re-enroll in the Plan at a later date.

Any Subscriber who is a Retiree may cancel or move from Family, Individual+child(ren), or Individual+spouse to single coverage during the annual Open Enrollment period, even if the plan is not offering an enrollment opportunity.

XI. Continuation Coverage

Participants and their eligible Dependents have options available to them for the continuation of coverage of supplemental insurance in the event state employment is terminated. The Employer is responsible to notify each eligible insured person of their continuation rights, for those who were covered based on active employment. A Continuation Notice must be issued for each plan under which the participant is enrolled at the time of retirement or involuntary termination regardless of whether the former Member is eligible to continue coverage.

Retirees are only eligible to continue coverage for 18 months under federal continuation coverage and state continuation. Retiring Subscribers must complete the Vendor's specific continuation form.

It is up to the retiring Subscriber to register during an open enrollment period **before the 18 months of continuing coverage has expired to change their supplemental coverage from continuation coverage to retiree**. If the retiree's continuation coverage expires before the next open enrollment period, the retiree will go without coverage and must wait until the next open enrollment period to re-register for supplemental insurance.

Continuation Coverage Requirements

Supplemental Plans have the same continuation privileges offered under the State of the Group Health Insurance Plan.

Federal Continuation Coverage requires Employers to provide notice of the right to continuation of identical coverage to persons who are qualified beneficiaries (Dependents) under the law. For the purpose of Continuation Coverage, all participating agencies and payroll centers are considered to be one Employer (including the UWS and UWHC).

The Employer must complete all appropriate information on the bottom of the continuation form within five (5) days of notification of a Qualifying Event. The form must include the date the form was sent and the eligibility termination date.

Dependent Loss of Eligibility

The Subscriber is responsible for notifying the Employer of an event that makes a Dependent ineligible for coverage. Each covered Member has an independent right to elect to continue coverage.

- The Employer must ask the Employee for each Dependent's current address. If a Dependent's address is not available, send the notice to the last known address for the Dependent. If the last known address for a covered Dependent is different, even for a minor, send the notice to that minor's known address.
- If the individuals who are eligible to continue coverage live together in a common household, one notice to all eligible individuals is acceptable.

If a Spouse or child loses eligibility, the Subscriber must notify their Employer within 60 days of the event (such as divorce). Failure to notify the Employer in that period may make the Dependent ineligible to continue coverage. However, a continuation election form must still be

issued by the Employer. The Employer must provide the qualified beneficiary with the Vendor's appropriate continuation form.

- In the case of divorce, Wis. Statute 632.897 mandates that coverage remains in effect until the Ex-Spouse is notified of the right to continue coverage. Once the Continuation Notice is issued, the 60-day period to accept continuation begins.
- In the case of a Dependent child turning age 26, the Employer is responsible to issue a Continuation Coverage statement, even if the Vendor has an automated process for terminating enrollment.

Continuation Form Timeline

An Employee or Retiree has 60 days from the date they were notified of their Continuation Rights or the date that their coverage as an active Employee ends, whichever is later, to submit the continuation form to the Vendor.

Premium Due Dates

Once the Subscriber has submitted the continuation application, the Vendor bills the Subscriber directly based on his/her selection indicated on the application.

- The Subscriber may elect to receive and pay their bill by mail. The Vendor may charge a small billing fee and will advise the Subscriber of payment options, which may include annually, semi-annually, monthly or quarterly.
- The Subscriber may elect to pay premiums using electronic funds transfer from a bank account, semi-annually, quarterly or monthly.

If the divorced/widowed Spouse or other Dependent chooses continuation coverage, that Subscriber must pay premiums beginning the first of the month following the divorce effective date, or the original Subscriber's death.

Notification of Changes

If the Board approves a change to Retiree rates, the Vendor will send a letter to covered Retirees/surviving Dependents at least 60 days prior to the new premium effective date with the new premium amount. The letter is not a billing statement. The letter advises Subscribers that the increase will show as an adjustment on their first billing statement following the date of change.

All changes to premiums or benefits take place at the same time for Active Employees, Retirees and Continuation Coverage Subscribers. Premium change is usually effective as of January 1st for all Subscribers.

Duration of Continuation Coverage

The duration of coverage is as follows:

- An Employee who terminated employment may continue coverage for up to 18 months.
- A Spouse or Dependent child who lost eligibility due to Employee's termination may continue coverage for up to 18 months.

- An ex-Spouse and his/her covered children (the Employee's stepchildren) may continue coverage for up to 36 months or until the children otherwise lose eligibility (such as reaching the limiting age for coverage).
- In limited situations, the length of the Continuation Coverage period is extended. If a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled before the 60th day of continuation coverage and the disability continues during the rest of the 18-month period of continuation coverage, coverage may be continued for a total of 29 months.

Indefinite Continuation Coverage

The following individuals are eligible to continue their coverage as long as premiums are paid in a timely manner, as defined in Wis. Stats. Chapter 40.

- Surviving Spouse may continue coverage indefinitely.
- Surviving Dependent children may continue coverage until they otherwise lose eligibility.
- Retirees and their Dependent(s) may continue coverage indefinitely until they otherwise lose eligibility for coverage.
- Subscribers who are approved for disability retirement under Wis. Stat. § 40.63 or a duty disability under Wis. Stat. § 40.65, must be offered Continuation Coverage, or may stay continuously covered. They must be offered the option to reinstate coverage even if no coverage was in effect while no earnings were being received or the Employee elected to discontinue coverage.

XII. Retirement, Disability, or Long-Term Disability

Retirement Continuation

A Subscriber who terminates employment and qualifies as a Retiree may complete and submit a Continuation form *to the Vendor*. This must be done within 60 days of coverage termination as an active Employee, or the date of the Continuation Notice, whichever is later.

Most retiring Subscribers should choose the retiree continuation opportunity, instead of Continuation Coverage. Continuation Coverage expires, and the Subscriber will have to wait for a designated enrollment opportunity to be eligible to re-enroll as a Retiree. Retiree coverage begins on the first of the month following the date on which employment terminates.

Continuation Forms are located at http://etf.wi.gov/publications/Employer.htm under "Other Insurance Programs".

Retirement and Continuation Billing

Vendors use an individual billing method for Continuants and Retirees who choose to continue their coverage. Subscribers should be advised to pay close attention to each plan's billing frequency, method, and possible fees for certain payment frequency (i.e. monthly vs. quarterly).

For VSP, most Retirees can have their premiums paid through WRS annuity deduction. The exception is those who were paid a lump sum rather than a monthly annuity, or those whose annuity amount is insufficient to cover premium deductions. Duty Disability benefits cannot have premiums withheld

Re-hired Retirees

A Retiree who returns to work for a state agency but continues to collect a WRS annuity is *not* eligible to enroll in Supplemental Plans at the time of hire. He or she can enroll as a retiree at the next Open Enrollment period and will pay premiums directly to the Vendor. If the Retiree is enrolled in the Plan(s) during retirement, he or she may continue coverage by paying premiums directly to the Vendor.

If a Retiree suspends his/her annuity upon return to work for a state agency, he or she is eligible to enroll in the Plans as an active Employee.

XIII. Death of a Subscriber or Dependent

Procedures Outline

The Employer must notify the Vendor of a covered Employee's death within 30 days, or by the end of the month in which the death is reported to the Employer, whichever is earlier.

For insurance that is paid via annuity deduction, ETF will notify the Vendor of a Subscriber death.

The Vendor must notify ETF if the Vendor is advised of the death but has not received this information from ETF within 30 days.

If a Dependent dies, follow process for Qualifying Event if appropriate to change coverage level.

Notification of Death

Coverage for the Subscriber and any Dependents will end at the end of the month in which the death occurred. Premiums are not refunded for partial months of coverage. Premiums withheld for a subsequent month will be refunded by the Employer on the final paycheck.

When an Employer is notified of the death of a covered Dependent, the Employer should assist the Subscriber in completing an application/change form. If a change to level of coverage is appropriate, the new premium rate is effective the first of the month following the death of the Dependent.

Continuation Coverage

Survivors of a deceased Subscriber have 60 days after the date of the Continuation Coverage notice to submit a Continuation Coverage form to the Vendor to request continuation (see Continuation Coverage section).

- If a covered Retiree dies, the surviving Dependent(s) must contact the Vendor. The Vendor will provide the appropriate forms to apply to remain covered or see forms at etf.wi.gov and follow links to the Plan page.

- **VSP process**: For Subscribers with an annuity deduction, ETF staff advise VSP of Retiree deaths. ETF does not automatically re-enroll Dependents. VSP issues a notice, and if Dependent survivor(s) qualify as a Retiree, the premium may be set up as an annuity deduction.

Vendor will arrange billing or other premium arrangements via direct pay. Coverage will be effective with the first of the month following the death of the original Subscriber.

If the survivor allows coverage to lapse, they must wait to re-enroll at the next available Open Enrollment period

Once coverage begins, new Dependents may be added if there is a Qualifying Event.

Important: If a death of the Employee (or Retiree) or one of the covered Dependents is due to an accident, the Employer or ETF may need to assist the survivor beneficiaries to submit a claim to the Vendor if there is accident Insurance coverage. Claim forms are located on the Vendor's website.

XIV. Employer Error

The following situations will constitute an Employer error:

- A monthly premium taken after a Subscriber has filed a cancellation notice with the benefits office: Payroll center must refund premiums and make adjustment of up to 60 days of premium cost in the next remittance to the vendor.
- Enrolling an Employee who is in an ineligible position: Employer must refund premiums if taken.
- **In no event, will premium refunds exceeding two months of premium be approved by the Vendor**: Premium refund requests more than three months should be submitted to the Employer's risk management department.
- Failure of the Employer to advise an Employee of his/her initial program eligibility, eligibility as a result of a change to an eligible position, or eligibility change if Employee makes Employer aware of a Qualifying Event.
- An Employee submitted an application, but the Employer did not deduct premiums.
- The coverage effective date may be retroactive only in the case of Employer error. For billing purposes, premiums must be collected based on the effective date of coverage.

In cases of Employer error the Employer must send an encrypted email detailing the error and member identification numbers of employees affected by the error to ESS at ETFSMBEmployerInsurance@etf.wi.gov. ESS, with the assistance of OSHP if requested, will work with Vendor and Employer to resolve error.

Not Considered an Employer Error

The following situations will not constitute an Employer error:

- **Initial Enrollment**: Failure of the Employee to submit a completed application to the Employer within required deadlines if advised of his/her plan eligibility prior to the filing deadline.
- **Coverage Changes Reported Late**: When an application to reduce coverage is not submitted and the omission is reported after the fact. The Employee must bear some responsibility in this situation. Refunds may be made for up to three months with extenuating circumstances, such as the death of a family member should have led to a different premium category, or the Subscriber was incapacitated.
- **Open Enrollment Periods**: Failure on the Employee's part to submit a completed paper or electronic application or change where notice has been given to the general Employee population. (Subscribers may cancel enrollment up to December 31).
- **Employee Misunderstanding of Benefits**: The exception to this rule is if the Employer misinformed an Employee as to the level of benefits available under a specific Plan—in this instance a Subscriber may be able to cancel coverage with a refund of up to three months of premium.

Correcting Errors

If Employer Error prevented timely enrollment, an application can be approved with the following procedures:

1. The Employer furnishes sufficient information to ETF indicating one of the Employer Error criterion has been met.
2. The employee files an application which must be received by the Employer within 30 days after the employee first becomes aware of the error, and
3. ETF finds that employee was denied coverage because of Employer error.

XV. Subscriber Grievance

A Member has the right to file a complaint or grievance against any Supplemental Plan Vendor. This may include issues like incorrectly denied claims, coverage termination, or poor customer service.

The procedure for filing a complaint or grievance with the Vendor, as well as with ETF is outlined in the policyholder certificate. The ETF *Insurance Complaint Form* (ET-2405) details the process for filing with ETF. Reference to this process is included in the Supplemental Plan Vendor contract.

In general, if a Member or Subscriber receives a negative notice from a Supplemental Plan Vendor, they have the right to first question the action by contacting the Vendor. The Vendor is required to respond to all Subscriber grievances by stating the reasoning why the Vendor made

the determination and a detailed outline of the formal complaint process a Subscriber must take to appeal the Vendor's decision.

Members must first use the formal complaint process outlined by the Vendor to request review, following the timelines given.

If the Member is not satisfied with the resolution offered by the Vendor, the Member may appeal within 60 days of the written decision from the Vendor. A Member may choose to begin the appeal process with the ombudsperson level or request a Departmental Determination as the first level of administrative review:

- **File a Complaint with Ombudsperson Services.** An informal review, this level allows the most latitude for resolution of the complaint. Ombudsperson Services staff provide information and assistance with filing a request for review by an Independent Review Organization. If the Member requests informal review by ETF, results of that review will be provided to the Member within sixty days of ETF's receipt of the request for review.
- **File a Request for Departmental Determination.** ETF has the authority to issue determinations based on the language of the contract, applicable Wisconsin statute or Wisconsin Administrative Code. This is a more formal process than the review by the ombudsperson. If the Member seeks a departmental determination, ETF will attempt to provide that determination within ninety (90) days of the request.
- **Appeal ETF's Departmental Determination to the Group Insurance Board**. The written request for appeal must be received by ETF within ninety (90) days of the date of the departmental determination. Appeals to the Group Insurance Board are conducted in accordance with Wisconsin Administrative Code ETF 11, and should be sent to:

  Attn: Appeals Coordinator
  Department of Employee Trust Funds
  PO Box 7931, Madison, WI 53707-733931.

XVI. ETF Resource Links

Member or Employer Resource

http://etf.wi.gov/members/IYC2019/et-2107leg.asp

Resolving Member Issues

State Employers with questions about a policy outlined in this manual, contact ETF Employer Services Section (ESS) at your assigned email group below:

- ETFSMBEmployerInsurance@etf.wi.gov
- ETFSMBSTARInsurance@etf.wi.gov

Each agency is assigned to a staff person in the Employer Services Section. The ESS worker will research the answer, including contacting the Supplemental Plans Manager, if necessary.

State Employer or payroll center has an issue specific to a Subscriber's enrollment status, premiums owed, ID card, etc. should contact the Vendor directly using the Contact List below.

Retirees

For VSP, ETF functions in the role of the Employer, managing annuity deduction and communicating with VSP to manage enrollment or premium changes based on Qualifying Events.

For any Supplemental Plan, ETF's Retiree Insurance Staff may refer Retirees to the designated Vendor contact for enrollment or premium issues. See contact information in the next section.

XVII. Vendor Resource Links

The following Vendors have contracts to provide supplemental plans in 2019.

Dental Claims and Benefits

Address:
Delta Dental of Wisconsin
2801 Hoover Road
PO Box 828
Stevens Point, WI 54481-0828

Phone: 1-844-337-8383
Call Center Open Monday – Friday
7:30 am to 5:00 pm Central Standard Time

ETFcustomerservice@deltadentalwi.com
www.deltadentalwi.com/state-of-wi

Accident Insurance Claims and Benefits

ZURICH

Address:
Zurich American Insurance Company
1299 Zurich Way
Schaumburg, IL 60196-1056

Claims:
Phone: 1-866-841-4771
musz_carecenter@zurichna.com
Fax: 1-866-590-0948

General Information:
https://zurichplaninfo.qwikcoverage.com/
General Email Inquiries: cms@zurichna.com

Vision Benefit

Address:
Vision Service Plan
Attn: Client Administrative Services, MS 229
PO Box 997100
Sacramento, CA 95899-9986

Address for direct pay premiums:
Vision Service Plan
PO Box 740260
Los Angeles, CA 90074-0260

UW System employees: uwsystem.vspforme.com/review
STAR agency employees: staractives.vspforme.com
All other employees: stateofwiemployees.vspforme.com
Retirees: stateofwiretirees.vspforme.com
Find a provider: vsp.com/go/voluntary-find-doctor-location.html
Phone: 1-800-400-4569 Mon-Fri: 10:00 a.m. to 10:00 p.m. Central Time

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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, ໂດຍບໍ່ເສັຽຄ່າ, 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).