

Optional Employee Pay-All Insurance Administration Manual



For use with these Insurance Plans:

Anthem DentalBlue
EPIC Benefits+
EPIC Dental Wisconsin
The Hartford Accidental Death and Dismemberment*
VSP Vision Service Plan

Note: ETF expects that Hartford will be replaced by Zurich as the AD&D Insurer effective 1-1-17. An addendum will be published of any vendor-specific exceptions to this manual.

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Section A

I. Introduction

Optional Employee-Pay-All Insurance Plans (Optional Plans) are types of insurance that are:

- Generally supplementary to group health insurance, providing coverage for dental, vision, hospital, or surgical procedures, accidental injury, or accidental death.
- Voluntary for eligible Employees and for Annuitants 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 Annuitants 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\(1\)\(a\)](#).
- See etf.wi.gov for links to certificates outlining insurance plans currently available to eligible State of Wisconsin (State) Subscribers.

State Group Health Insurance (SGH) is referenced occasionally in this manual, for reference or contrast. ETF has made efforts to align administrative policy and procedure for Optional Plans with those for SGH, where practical and where contracts and business reasons allow.

Note that the University of Wisconsin System (UWS) and the University of Wisconsin Hospitals and Clinics (UWHC) have been authorized by the Board to offer plans that were approved prior to 2016, and to not offer new plans that may be approved by the Board. See Appendix 1 for table of which plans are available through each payroll center.

II. Definitions

Annuitant: A WRS Member who has retired and is eligible for group health insurance plans under the WRS, or is the surviving Spouse/Domestic Partner of an Annuitant. Eligible Annuitants include those who meet at least one of the following criterion:

- receive a disability annuity under [Wis. Stat. §40.63](#),
- receive a disability benefit under Long Term Disability Insurance (LTDI) under Subch. III of Wis. Admin. Code Ch. 50,
- 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.
- It does NOT include beneficiaries who were not the Spouse/Domestic Partner of the Subscriber, nor those who have received a lump sum after separation (vs. retirement.)

Board: Group Insurance Board (Board) that oversees benefits provided under Wisconsin Statutes, [Chapter 40](#). Some sources or members may call the Board the “G.I.B.”

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

Courts: The payroll system for employees of the Circuit Courts, Court of Appeals, and Supreme Court.

Domestic Partner: An individual who certifies in an affidavit along with his or her partner that they are in a Domestic Partnership as provided under [Wis. Stat. §40.02 \(21d\)](#), which is a relationship between two individuals that meets **all** of the following conditions:

- Each individual is at least 18 years old and otherwise competent to enter into a contract.
- Neither individual is married to, or in a Domestic Partnership with another individual.
- The two individuals are not related by blood in any way that would prohibit marriage under Wisconsin law.
- The two individuals consider themselves to be members of each other's immediate family.
- The two individuals agree to be responsible for each other's basic living expenses.
- The two individuals share a common residence. Two individuals may share a common residence even if any of the following applies:
 - Only one of the individuals has legal ownership of the residence.
 - One or both of the individuals have one or more additional residences not shared with the other individual.
 - One of the individuals leaves the common residence with the intent to return.

Employee: Has the meaning of Eligible Employee, as defined in Wis. Stat. §40.02(25) (b). It includes state employees eligible for the Wisconsin retirement system, elected state officials, and graduate and teaching assistants employed at least 1/3 time and 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.

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.

Insurer: Company providing an Insurance plan approved by the Board as an optional, Employee-pay-all benefit.

It's Your Choice: It's Your Choice (IYC), is a designated open enrollment period that is offered to Employees, Annuitants, surviving spouses and dependents who are eligible under the State of Wisconsin Group Health Insurance Program. It is an opportunity to enroll, change plans, change coverage level, or cancel coverage. Changes made become effective January first of the following year. See also Open Enrollment.

Leave of Absence: any period in which an Employee is not working for, or receiving earnings from, the Employer and has not terminated the Employer-Employee relationship as defined in [Wis. Stat. § 40.02 \(40\)](#). For the purpose of Optional Insurance, a Leave of Absence ends when the Employee has returned to active work.

Member: Means a member of a household enrolled in an insurance plan, or eligible for COBRA, or depending on context in this document may mean Member of the Wisconsin Retirement System.

Plan: Insurance plan approved by the Board as an optional, Employee-pay-all benefit, and/or benefit available to Annuitants.

Optional Insurance Plan: Has the same meaning as Plan.

Open Enrollment: A defined period during which eligible Employees and/or annuitants may enroll, change, or cancel participation in any specific insurance plan. The time frame is established by the Board, usually for 4 weeks beginning in early to mid-October. For optional insurance, the opportunity to enroll may be further designated by the Insurer, only in agreement with the Board, to limit the employment status or other characteristics that offer eligibility to enroll.

Qualifying Event: Life event that provides an opportunity for a Subscriber to add, cancel, or change coverage. Events can include: marriage, entering/terminating a domestic partnership, birth or adoption, legal placement of a ward, a dependent child turning age 26, divorce or annulment, leave of absence, death, and loss of comparable coverage. However, not every event listed here allows each type of change. See specific sections for enrollment, change, and cancellation. Source: HIPAA and Internal Revenue Code.

Records: Electronic data or paper files with Subscriber-related information, maintained by the Employer, payroll center, or Insurer.

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 (most administrative agencies) and the legislature.

State Group Health. or SGH: Group health care benefits for Employees, Annuitants, and their Dependents eligible for coverage offered by the Group Insurance Board as required by Wis. Stat. § 40.51 and 40.52.

Subscriber: An active Employee or Annuitant who has enrolled in an Optional Insurance 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. Has its own optional dental insurance, and a separate AD&D contract.

UWS: University of Wisconsin Systems, an Employer with its own payroll system. Does not offer the exact array of Plans as the balance of state agencies.

Ward: An individual for whom a legal guardian has been appointed, under Chapter 54.10 Wis. Stats. Also “legal ward.”

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

WRS: Wisconsin Retirement System.

III. Eligibility

1. Who is an eligible Employee?

An active Employee who is eligible for the State-sponsored health insurance plan, with or without Employer contribution.

2. When is an Employee eligible to enroll?

Eligible Employees may enroll within the first 30 days of their Hire Date. **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 if transferred, if employed by a new state agency
 - Treat the Subscriber records as a reinstatement, as if there was no break, if returns to the same agency within 30 days.
- University of Wisconsin System (UWS) Graduate assistant Employees may enroll within 30 days of beginning their first WRS participating appointment.
- A WRS-covered Limited Term Employee (LTE) or an Employee who is eligible for State group health insurance but appointed to work less than half time as defined by [Wis. Stat. §40.05 \(4\) \(ag\)](#) has another 30-day enrollment opportunity under the following conditions: (these do not apply to UWHC)
 - 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 State group health insurance; or
 - The Employee is appointed to a permanent position and qualifies for the full share of the Employer contribution towards State group health insurance.

If an eligible Employee applies more than 30 days following an eligibility event date, the application will be rejected by the automated system or by the Insurer, and the Employee's coverage will not become effective under the policy. The Employee will be considered a late enrollee; he or she will be eligible to apply for coverage only when an enrollment opportunity for that purpose is offered, or the Employee has a qualifying event. (See also Employer Error, and Late Open Enrollment, Sections A.V and A.XVI.)

3. Transfer between State Employers

Does an Employee moving between State WRS Employers have an opportunity to enroll in an Optional Insurance plan if they had not enrolled in the plan with the prior agency?

The Employee is eligible to enroll only if the specific insurance plan was not offered at the prior agency. The Employee is not eligible to enroll if the Plan was available at the agency of previous employment but he/she waived that coverage. See Appendix 1.

Exception: *The Hartford Accidental Death and Dismemberment plan allows enrollment for eligible Employees at any time of year, without a qualifying event.*

4. Who is an eligible Annuitant?

For purposes of Optional Insurance, unless specified in the insurance certificate, an Annuitant is a WRS Member who has retired and is eligible for group health insurance plans under the WRS, or is the surviving Spouse/Domestic Partner of an Annuitant. Eligible Members include those who:

- receive a disability annuity under [Wis. Stat. §40.63](#),
- receive a disability benefit under Long Term Disability Insurance (LTDI) under Subch. III of Wis. Admin. Code Ch. 50,
- receive duty disability benefits under [Wis. Stat. § 40.65](#),
- have at least 20 years of creditable service under the WRS, (regardless of minimum retirement age); or
- have received a retirement lump sum payment.

This list does **not** include beneficiaries who were not the Spouse/Domestic Partner of the Subscriber, nor those who have received a lump sum after separation (vs. retirement).

Exception: *VSP includes Annuitants who are receiving an annuity as a named survivor who are not a Spouse or Domestic Partner.*

Employees who subscribe to an Optional Insurance plan while active may **continue** that insurance on a direct-pay basis following retirement.

- For AD&D insurance, the subscriber may convert their insurance plan to an individual plan.
- All other types require a continuation form to be completed and filed with the Insurer upon retirement (See Continuation, section XIII)
Insurers may offer an enrollment opportunity for Annuitants during the It's Your Choice period. ETF's website, etf.wi.gov will include a table listing Annuitant enrollment opportunities each year.
- Upon request ETF will supply a list file of eligible annuitants annually to optional insurance vendors, prior to the designated IYC period. Vendors must contact the ETF optional plans manager to make this request between May 1 and August 1 each year. All lists will be delivered through a secure file site.

Annuitants who return to work in a WRS position may enroll in Optional Insurance if they have suspended their annuity and become eligible to enroll in WRS insurance as an active Employee.

- The Employer is responsible to offer enrollment to an eligible rehired retiree who is enrolled in the Wisconsin Retirement System (WRS).
- If receiving an annuity while employed, a member remains in Annuitant status and does not have a qualifying event based on return to work. The annuitant does not use payroll deduction, but continues to pay the Insurer directly.

5. Who are eligible Dependents?

Dependent, for Optional Insurance, means the Subscriber's:

- Spouse
- Domestic Partner (see definitions)
- Child
- Legal Ward who becomes a legal ward of the Subscriber, Subscriber's Spouse or Insured Domestic Partner prior to age 19,
- Adopted child when placed in the custody of the parent as provided by [Wis. Stat. § 632.896](#)
- Stepchild
- Child of the Domestic Partner insured on the policy
- Grandchild if the parent is a Dependent child.

A grandchild ceases to be a Dependent at the end of the month in which the 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. A Domestic Partner and his or her children cease to be Dependents at the end of the month in which the domestic partnership is no longer in effect.

All other children cease to be Dependents at the end of the month in which they turn 26 years of age, except that:

- 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, as long as the child remains disabled and he or she is Dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed on tax filing.
 - The State Group Health Plan will monitor eligibility annually, notifying 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 the Optional Insurance of any support requirement changes.
 - STAR has a field to record disability status, with an as-of date. Other payroll systems must note in their records the disability status of adult child dependents. Employers are not required to transmit disability status of dependents with enrollment records but are responsible to provide the designation to the insurer on request.

- For adult children of Annuitants, or Subscribers whose primary health insurance is something other than SGH, the Subscriber is responsible to provide verification of disability to the Insurer.
 - For Anthem: If the physician does not say the disability is permanent, the Insurer will request a new verification annually from the Subscriber. Anthem will provide a form to be completed by the family and physician.
 - EPIC: Does not have a specific form, but may ask the Subscriber to obtain verification and submit directly to EPIC.
 - VSP: Records disability status of Dependent, self-reported by Subscriber upon enrollment. No regular verification required.
 - Hartford AD&D requires verification of disability, to continue a Dependent's enrollment past age 26.
- 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. Note: 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 in order to enroll the dependent. Insurers will enroll based on the Employer's approval.
 - For an Annuitant Subscriber whose adult child fits this situation, the Insurer may require that the Subscriber submit verification.
- If an adult child becomes insured as a WRS-eligible Employee, the Insurer will notify the Employers and/or Subscribers *if* that Plan does not permit an individual to be covered both as a Dependent and as a Subscriber, or as a Dependent under two plans (i.e. adult child and Spouse). Only VSP allows dual coverage.

A child born outside of marriage becomes a Dependent of the father on the date of the court order declaring paternity or on the date the Acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of Wisconsin) or the date of birth with a birth certificate listing the father's name.

- The effective date of coverage will be the date of birth if 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.

Eligible Dependents of foreign nationals who arrive in the United States after the Employee's initial enrollment period will be allowed to enroll in Optional Insurance if the Employee is already enrolled and the Dependents are eligible to enroll in the plan due to loss of other coverage. This enrollment period will coincide with their enrollment opportunity for State Group Health insurance.

6. Are “non-tax” Dependents eligible for coverage?

Yes. A Domestic Partner and his/her children do not need to be dependent upon the Employee for care or support to be eligible as Dependents. However, if the Domestic Partner or his/her children do not qualify as a tax Dependent or qualifying relative under Internal Revenue Code ([IRC](#)) [§ 152](#), the Employee must so indicate on the application or advise the Employer of their tax status prior to the start of a new calendar year. If coverage is elected for any “non-tax” Dependents, the entire premium is taken on a post-tax basis. If the “non-tax” Dependent loses coverage during the year, premium deductions may then be taken on a pre-tax basis, at the discretion of the Employer.

7. Are Dependent students on medical leave eligible for coverage?

The information below applies only to Dependent students who were called to active duty in the National Guard or Reserve component of the United States Armed Forces prior to age 27 and have now returned to school on a full-time basis.

If, while covered under Optional Insurance, a Dependent student needs to reduce his/her course load or leave school due to a medically necessary leave of absence, the Dependent student may be eligible to continue coverage.

The Insurer may require documentation of the medical necessity of the academic leave of absence from the Dependent’s attending Physician. Continuation coverage begins the date on which the Dependent ceases to be a full-time student due to the medically necessary academic leave of absence.

Coverage during academic leave will continue until any of the following occurs:

- The Dependent advises the Insurer that he/she does not intend to return to school full-time.
- The Dependent becomes employed full-time.
- The Dependent obtains other comparable insurance coverage.
- The Dependent marries and is eligible for coverage under his or her Spouse’s coverage.
- Coverage of the student’s subscriber parent is discontinued or not renewed.
- One year has elapsed since the Dependent’s continuation coverage began and the Dependent has not returned to school full-time.

IV. Enrollment

Application & effective dates: This chart is an overview of enrollment opportunities for active Employees. Annuitants who are already enrolled may add Dependents in the event of marriage, domestic partnership, birth, adoption or placement of a legal ward; those are not enrollment opportunities for an Annuitant who is not a Subscriber at the time of the event. Further detail is outlined in the text that follows.

Event	Enrollment Period	Effective Date of Coverage	Effective Date for Purpose of Premiums Owed
New Hire – first day if WRS eligible, or first day after attains WRS eligibility	Within 30 calendar days of first day of active work	First day of the month that first occurs during the 30-day enrollment period	Same date as coverage effective date
Increase in FTE /position hours that creates WRS eligibility.	Within 30 calendar days of event	First day of the month that first occurs within 30 days following the position change event, if worker files application during the 30-day enrollment period	Same date as coverage effective date
It's Your Choice Open Enrollment period	Established by Board, a 4-week period, usually begins early to mid-October	January 1 of year following "It's Your Choice"	Same date as coverage effective date
Loss of comparable coverage	Within 30 calendar days of event	On the event date, coverage can begin mid-month	First of the following month if coverage begins on or after the 16 th of a month. First of the event month if coverage begins prior
Reinstate lapsed coverage upon return from unpaid LOA	Within 30 calendar days of return from LOA	First of the month following first day of return to work.	Same date as active coverage effective date
Marriage/ Domestic Partnership	Within 30 calendar days of event	On the event date	<p>Courts, STAR, UWS, UWHC: If event is on or before the 15th of the month, premiums are due for the full month. If event is the 16th or after, premiums begin the first of the month following the event.</p> <p>WHEDA, WEDC: Premiums begin the first of the month following the event, unless there is a claim in that first partial month. If so, the Insurer calculates the proration and notifies the Employer.</p>
Birth, Adoption (For a child born outside of marriage, see Eligibility for timing of coverage)	Within 60 calendar days of event	On the event date.	
Legal Ward	Within 60 calendar days of event	On the event date.	

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 \(Newborns and adopted children\)](#) and as specified in the State Group Health Insurance contract.

Employees:

The eligible Employee must be actively at work or on an approved Leave of Absence and not totally disabled on his or her effective date of coverage under the policy or coverage will be delayed. However, if the Employee is not actively at work, but is considered an active Employee with the Employer, the plan will consider the Subscriber to be an eligible Employee and coverage will become effective.

For non-STAR payroll centers: To eliminate prorated premium following qualifying events in the above chart, *some* payroll centers set the effective date as the first of the month after the eligibility date provided the completed application has been submitted to the Employer. However, if claims are incurred during the partial month of coverage before the effective date, the Insurer will process the claims and the Subscriber will be responsible for any prorated premium the Insurer charged for the partial first month.

Infant Dependents:

Following the birth of a Dependent, coverage for a Dependent for whom the Subscriber applies within 60 days of the birth of a Dependent is effective on the date of birth.

For newborns, if family coverage is already in force, coverage for a newborn Dependent is effective on the date of birth. If additional premium is required for the newborn Dependent, coverage begins on the date of birth, if the Subscriber notifies the Insurer of the birth and pays the additional premium within one year of the birth. Retroactive premiums do not include interest in this case.

Adoption:

Following adoption or placement for adoption of a Dependent, if the Subscriber applies within 60 days of an adoption or placement for adoption, coverage of a Dependent is effective on the date of the adoption or placement for adoption.

Loss of comparable coverage:

If an Employee is seeking an enrollment opportunity based on loss of comparable coverage, the Employer has the responsibility to request a copy of the ID card or other identifying information for the plan that has been terminated (from a previous employer or spouse) from the Employee. If coverage was from a former spouse, the employer may need to contact that Insurer for documents. The Employer must submit documentation to the Insurer. If the Insurer needs further information, they will seek it directly from the applicant.

Note: This provision rarely enables enrollment in EPIC Benefits+ which is a unique plan, covering multiple claim types; therefore it is rare for another plan such as simple dental insurance to be considered “comparable.”

V. Late “It’s Your Choice” Applications (see also Employer Error)

1. If an Employee or Subscriber failed the opportunity to enroll or make a change during IYC, he or she may request a review from the employer, and then by ETF. The review does not guarantee approval. The request and review follows these steps for active employees:
 - Employee submits application after the end of the IYC period.
 - Employer may consider special circumstances and forward the application to the Insurer after discussion with Insurer’s enrollment specialist or with email outlining reason for exception processing.
 - If the Employer or automated payroll system rejects late application: Employer provides member with notice of late application and instruction for requesting a review.
 - Employee submits written request, via letter or email, to their Employer no later than February 10. The request must outline the reason and/or circumstances for the late application, and the remedy being sought. Appeals will not be considered if the individual simply failed to take action in a timely manner.
 - The Employer will forward the request for review to ETF’s Employer Services Section, along with a cover memo outlining their IYC procedure and any circumstances they are aware of to support or refute the Employee’s request.
 - The Employer’s email must be sent encrypted. The subject line of the email should be “Late It’s Your Choice, Employer record.”
 - ETF’s Employer Services Section (ESS) will review the request. If the circumstances fall outside the criterion outlined in ETF policy, ESS will forward the request to the Office of Strategic Health Policy (OSHP).
 - ETF will advise the Employee and Employer of a decision within 60 days. If a late enrollment or change is allowed premiums will be adjusted back to January 1 or the missed effective date.
 - **Exception:** AD&D insurance allows year-round enrollment. Therefore, any subscriber who misses an annual enrollment or qualifying event deadline will be allowed to enroll with a prospective effective date.
 - **Note:** An Employee or Annuitant may cancel their enrollment in any insurance up until December 31 for the subsequent year.
2. **Annuitants who miss the IYC time limit** for enrollment or change must submit their request for review directly to the Insurer. The Insurer has the final decision, based on standards agreed on with ETF. The Insurer may consult ETF if the request has unique circumstances

VI. Declining Coverage

What if an Employee wants to waive coverage?

For each type of Optional Insurance plan, if an eligible Employee declines the Insurance coverage(s), the Employer must retain a record of the Employee’s choices to waive, showing that the insurance was offered in a clear and timely way, but declined.

VII. Pre-tax or Post-tax Deduction of Premiums

What are the benefits of choosing pre-tax payroll deductions and what must a Subscriber do to choose?

The following Optional Insurance plans are eligible for inclusion in the automatic premium conversion component of the State of Wisconsin Employee Reimbursement Account (ERA) program:

- Anthem DentalBlue
- EPIC Benefits+
- EPIC Dental Wisconsin
- VSP

Under the ERA premium conversion component, eligible Subscribers (LTEs are not eligible) may have insurance premiums deducted from their salary before Federal, State and Social Security taxes are calculated. When premiums are deducted on a pre-tax basis:

- Changes to coverage may be made only at the beginning of a new plan year (January 1) unless the change is due to a valid qualifying event as per IRS Publication 501.
- 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.

Premiums for Optional Insurance 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 initial or subsequent applications.

If a Subscriber does not wish to have the Insurance premiums taken on a pre-tax basis, they must complete an ERA Automatic Premium Conversion Waiver. However:

- 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.
- If an employee changes deductions for State Group Health insurance, the employer may change optional plan deductions at the same time.

Exception: AD&D claims payments are taxable as income if the premiums were paid with pre-tax income. Therefore it may be advantageous for Subscribers to have AD&D premiums deducted post-tax. STAR automatically uses post-tax deductions for AD&D premiums; other payroll systems recommend post-tax deduction to enrollees.

Note: All Annuitant premiums are paid 'post tax' or paid directly from Subscriber to vendor. Therefore, policies and procedures related to pre- and post-tax do not affect Annuitants.

VIII. Naming a Beneficiary

Beneficiary records:

- Some optional insurance plans have a death benefit. For these, the Subscriber must be offered the beneficiary form specific to that plan.
 - As of 2016, these plans include EPIC Benefits+ and The Hartford AD&D
 - Procedures for maintaining beneficiary forms differ with each AD&D Insurer.
- Beneficiary designation for AD&D does not use either the ET-2203 or ET-2304 Beneficiary forms.
- **For The Hartford**, Beneficiary forms are to be kept on file by the Employer, and transferred in the Employee records if he/she moves to a new state agency.
 - If a claim is filed for death benefits for an active Subscriber, The Hartford will obtain a copy of the beneficiary designation from the Employer
 - Hartford will collect a new beneficiary form if a retiring member chooses to convert their policy.
- **For EPIC Benefits+**, the Subscriber or Employer must send a copy of the signed, dated designation form to EPIC.
- 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 optional insurance under contract with ETF, if a subscriber dies before receiving a benefit owed by the Insurer, ETF may release the contact information for the Chapter 40 beneficiary to the Insurer, upon request of the Insurer, per Ch. 40.07(1m).

IX. Changing Coverage

Specific qualifying events trigger opportunities for a Subscriber to change coverage. They include:

- marriage,
- entering a domestic partnership,
- birth or adoption,
- legal placement of a ward,
- a Dependent child turning age 26,
- divorce or annulment,
- Leave of Absence, and
- loss of comparable coverage.

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

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

1. 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 waiting periods applied to new enrollees if a Plan includes waiting periods or coverage limits.

Unlike state group health insurance, a Subscriber may elect which eligible Dependents to cover under optional insurance.

2. 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.

3. Enrolling a domestic partner:

If the **Employee** is enrolling the Domestic Partner for "Chapter 40" benefits, he or she must submit the completed ETF Affidavit of Domestic Partnership, form [ET-2371](#), to ETF. ETF will respond to the Employee with an Acknowledgement Letter, which indicates an effective date of the partnership for benefit purposes. The Employee must provide the Employer with the Acknowledgment Letter, and must submit the application for insurance within 30 days of the date of the Acknowledgment Letter.

The partnership is established for benefit purposes on the date ETF issues the Domestic Partner Acknowledgement Letter.

The Domestic Partner's Dependents are eligible and may enroll with the Domestic Partner.

An **Annuitant** may add a Domestic Partner and the Domestic Partner's Dependents after the Subscriber/Annuitant submits the [ETF Affidavit of Domestic Partnership \(ET-2371\)](#) to ETF and receives an Acknowledgment Letter. Upon receipt of the Acknowledgment Letter, the Annuitant must submit a copy of the letter and a completed application directly to the Insurer within 30 days of the partnership effective date on the ETF Acknowledgment Letter.

4. If the covered Employee and his/her covered Domestic Partner get married, must the Subscriber submit an application?

Yes, an Employee must submit an application to the Employer that reflects the change in status from Domestic Partner to Spouse. A [Termination of Domestic Partnership Affidavit](#) may be submitted to ETF as well, but is not required. On the Insurance application, this must be designated as a "Change" with the date of marriage indicated.

Tax implications:

UWHC reviews the tax status and changes it to pre-tax, unless the Employee waives pre-tax deduction.

UWS considers a request to change tax status for SGH to apply to all insurance types.

Note: If the covered Employee previously executed an Affidavit of Domestic Partnership, but did not enroll the Domestic Partner at that time, the marriage *does* create a new enrollment opportunity for the Spouse and Dependents.

5. If a covered Annuitant and his/her covered Domestic Partner get married, must the Subscriber submit an application?

Yes, the Subscriber must submit an application to the Insurer within 30 days of the marriage, to change the status from Domestic Partner to married. Insurers do not require the Acknowledgment form except:

- For Anthem verification is only required if there is a name change
- For VSP or EPIIC, verification is not routinely required, though the Insurer may request verification on a single case.

6. Adding a newly eligible Dependent child when single or limited family 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 (e.g., Subscriber marries a person with eligible children, eligible adult child loses comparable coverage or becomes disabled and dependent before age 26). See also Section IV- infant dependents.

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.

7. Process when a **covered Employee gets a divorce, annulment or terminates a Domestic Partnership:**

Refer to the [COBRA section](#) to determine if or how continuation must be offered to the former Spouse/Domestic Partner 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.

Dependents of a divorced covered Employee remain eligible for coverage under that Employee's family coverage even if they do not reside with the covered Employee.

Coverage ends at the end of the month in which the divorce was final or the Domestic Partnership terminated, except that under State law, the ex-Spouse remains covered until the end of month in which he/she is notified of continuation rights. (Wis. Stat. [§ 632.897](#))

In the case of fraud or misrepresentation, there may be no adjustment, or an Employee may have to repay benefits.

Note: Wisconsin statutes requiring continuation do not apply to Domestic Partners or their Dependents who are losing eligibility for coverage. However, by contract, Insurers offer the same continuation rights to a Domestic Partner and their child(ren) as are offered to Spouses and natural children—insurance ends at the end of the month of the termination date on the Acknowledgment letter. However, if a Subscriber fails to provide timely notification of termination of the domestic partnership, the new ex-partner is responsible for premiums following the month of termination, even if the Subscriber did not notify the Insurer until several months after the termination event.

Exception: The Hartford's AD&D insurance ends for the non-Subscriber divorced Spouse as of the date of the divorce, regardless of when the Insurer or Employer was notified, because payments for AD&D claims would be made to the Subscriber. The Hartford will allow a premium refund within the full amount of the coverage year for the difference between single and Dependent coverage.

8. **Dual coverage for a child whose parents are not married to each other:**

For EPIC Benefits+ and Dental Wisconsin, Anthem DentalBlue, and Hartford: An individual may **only** be covered *once* under a given 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 Insurer's responsibility to monitor and report dual coverage issues.

VSP allows dual coverage for a child, but will not pay more than 100% of the covered amount for a service or item.

X. Both Parents or Spouses Employed by a State Employer

1. May two covered Subscribers, (Employees and/or Annuitants) who are married or in a Domestic Partnership, each subscribe to family coverage for the same insurance plan type?

No. Spouses or Domestic Partners who are both employed by the State may not cover each other or Dependents under dual family or 1+1 contracts. One Subscriber may elect to cover the Spouse or Domestic Partner and any eligible Dependent children or they may maintain two single plans if there are no Dependent children covered.

Payroll Centers are responsible to identify dual family plans within their Agencies. The Insurer is responsible to identify dual family plans if the Subscribers are Employees of different payroll centers or if one is an Annuitant and one is Active.

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

Exception: VSP would 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 Plan, (whether it be another carrier or another VSP plan), and has duplicate coverage, VSP will allow coverage for:

- two separate sets of service or
- “stacking:” both plans paying for one set of services.

Determine Primary and Secondary Plan for VSP

When a Member has duplicate coverage and wants to coordinate benefits, VSP must determine the order of assignment.

- The plan that covers the Member as an Employee is “primary”
- The plan that covers the Member as a Dependent is “secondary”

If the Member is a Dependent child and is covered under both parents’ plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, or the parent decreed by the court to be responsible is primary.

Primary Plan: The primary plan must pay or provide its benefits as if the secondary plan or plans do not exist.

Secondary Plan: If a VSP plan is the secondary plan, the Member will receive allowances (exam, lenses, and frame) that will be used to pay up to, but not more than the billed amount.

2. If two eligible Employees are married or in a Domestic Partnership, is there an advantage to electing two separate policies (single for each versus limited-family or family coverage)?

- Coverage would be equal for adults in the dental, hospital/surgical, or vision plans, as each Member has the exact same level of benefits.
- For the Accidental Death and Dismemberment (AD&D) Plans, the Subscriber is covered at a higher level than the Employee who is designated as a Dependent (Spouse or Domestic Partner).
- An Employee can only be covered once under any Plan (the Employee cannot be covered as Subscriber and also as a Dependent, except under VSP).

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

- If Spouses or Domestic Partners are both Subscribers and work for the same or different Employer Agencies, and each carries single coverage, one can change to family coverage within 60 days of the qualifying event if there is a new Dependent child (e.g., birth or adoption). This new family coverage could include both spouses if one of the adults drops their individual or limited family plan.
- If two people who are each subscribers in a type of EPIC Dental Wisconsin plan become married or domestic partners, that is a qualifying event, providing an opportunity to choose which type of coverage they want to keep. They **MUST** cancel one of the plans, as a person cannot be a subscriber on one version of Dental Wisconsin and a dependent on another.
- If two people who were each subscribers in a type of Anthem DentalBlue plan become married or domestic partners, that is a qualifying event providing an opportunity to choose which type of coverage they want to keep. They **MUST** cancel one of the Anthem Dental plans within 60 days of the event, as a person cannot be a subscriber on one version of an Anthem DentalBlue and a dependent on another.
- If there is no qualifying event, these changes can only be made during an enrollment period designated for this purpose and will be effective on the following January 1.

4. Can two Subscribers who are married or in a Domestic Partnership do a Spouse-to-Spouse transfer of coverage?

Spouses or Domestic Partners who are both employed by the State and have limited family, or family, coverage may change the Subscriber under the plan from one Spouse or Domestic Partner 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.
- During the annual "It's Your Choice" enrollment period for State of Wisconsin group health insurance. The change will be effective on the following January 1.

Annuitants 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.

XI. Leave of Absence

1. Procedures when Subscriber on approved Leave of Absence (LOA)

A Leave of Absence is any period in which an Employee is not working for, or receiving earnings from, the Employer and has not terminated the Employer-Employee relationship as defined in [Wis. Stat. § 40.02 \(40\)](#). For the purpose of Optional Insurance, a Leave of Absence ends when the Employee has returned to active work.

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 Insurer.

- The STAR payroll system will bill the Subscriber on LOA with an invoice sent monthly.
- For other payroll systems, the Subscriber must pay the Employer, on terms determined by the Employer. The Employer must make timely payments to the Insurer 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 Insurer 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 Insurer in the month due.
 - If the Subscriber's payments to the Employer lapse, the Employer will notify the Insurer to lapse coverage. Insurers 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 Insurer 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*.

For optional insurance, a Subscriber may **not** reduce level of coverage while on LOA.

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. (This timing is different than reinstatement of State group health insurance, per contract.) Coverage will be effective the first of the month following receipt of the application from the Subscriber, and return to work.

If an "It's Your Choice" enrollment period occurred while the Subscriber was on Leave of Absence, he or she may make any changes that were allowed during the enrollment period.

2. Procedure when Subscriber has a military leave for a duration of more than 30 calendar days:

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

- Premium for plan coverage(s) must be paid through the Employer. The Insurer will not bill the Subscriber directly (see non-military LOA).
- For Employers that collect premiums in advance, the Employer 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 Insurer.

The Insurer 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 Insurer to terminate coverage, using electronic enrollment file or paper enrollment/change form.

Benefits are not payable for an AD&D claim if the loss or death is due to an act of war.

Exception: For The Hartford: Military duty for an expected duration of 2 months or less is not considered active duty and does not exclude benefits. Beyond 2 months, coverage is terminated.

The Employer must notify the Insurer 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. Previously satisfied waiting periods do not need to be re-satisfied. If an "It's Your Choice" 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.

- 3. Annuitants:** Leave of absence is a status that does not apply to annuitants, unless an Annuitant is deployed into active military service. In that situation, the Annuitant must contact the Insurer to arrange for payment or temporary lapse of coverage.

XII. Cancellation/Termination

Once enrolled, Subscribers must remain in the plan for the full calendar year unless there is a qualifying event as described below. Cancellation of coverage may limit future re-enrollment opportunities in EPIC insurances for annuitants. See further detail on timing and process below in the following tables.

1. When does coverage end for a Subscriber and their covered Dependents in the following situations? (See also COBRA section for continuation)

Termination of Employment	Retirement	Unpaid LOA*	Active Military Duty*	Subscriber Death	Transfer to another Agency
Coverage ends at the end of the month in which the event occurs.	Coverage ends at the end of the month in which the event occurs.	Coverage ends the end of the month for which premiums have been paid. While on LOA, Subscriber may continue to remit premiums to Employer.	Coverage ends the end of the month for which premiums have been paid. While on LOA, Subscriber may continue to remit premiums to Employer.	For single or family plans, coverage ends at the end of the month in which the event occurs. **	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 The Hartford, coverage for Dependents ends on the date of the Subscriber's death					

- **Transfer from one State payroll system to another:** Coverage ends at the end of the month in which the transfer occurs. Premiums 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 date 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.

**2. When does coverage end for covered Dependents in the following situations?
(See also COBRA section for continuation)**

Domestic Partnership Termination*	Divorce*	Child Reaches Limiting Age	Disabled Adult Child	Dependent Child Called to Active Duty While a Full-time Student
End of the month in which the Domestic Partnership is terminated by ETF accepted Affidavit. (ET-2372)	End of the month in which the divorce is final, however, ex-Spouse remains covered until end of month in which he/she is notified of continuation rights.	End of the calendar month in which the Dependent turns 26.	Disability must begin before age 26. Coverage ends at the end of month in which the child is determined to no longer be disabled.	If under age 27 and attending school on a full-time basis when called to active duty 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.
*Natural and adopted children can remain covered along with the Subscriber. Coverage for stepchildren or a Domestic Partner's children ends on the same day as coverage ends for the former Spouse or Domestic Partner.				

3. When can the Subscriber remove Dependents from coverage?

Absent a qualifying event (e.g., loss of eligibility, enrollment in a comparable group plan), the Subscriber may only elect to remove covered Dependents during the annual IYC 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.

4. Adult child turning age 26

The Insurer will terminate a Dependent the end of the month in which they turn age 26. On a quarterly basis the Insurer reviews upcoming Dependent eligibility changes due to age, and provides this information to the Employer at least 2 months in advance of the event. The Employer may require the Subscriber to complete a new application but the application does not need to be provided to the Insurer. The Employer must issue a COBRA 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. (EPIC makes this adjustment for those payroll centers to which it sends a list bill.)

Payroll centers with automated systems may identify these dependents due for cancellation.

- UWS notifies its Subscribers that Dependents will be removed, and advises whether coverage level changes will be made automatically due to the change. The Employee does not need to complete an application/change request.

5. How does a covered Employee cancel coverage for an eligible Dependent?

Coverage can only be canceled mid-year if a Qualifying Event makes the Dependent ineligible for coverage. The Subscriber may submit an application/change request to the Employer by December 31 to remove the Dependent for the following calendar year (whether or not the Insurer is offering an open enrollment). However, Subscribers should be strongly encouraged to submit these changes during IYC.

To cancel 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, an Enrollment Application must be submitted indicating which Dependent is being canceled, the reason for the cancellation, as well as the date of the cancellation.

6. When and how can an annuitant cancel coverage for a Dependent?

Annuitants and their Dependents are committed to be enrolled for a full year, absent a qualifying event. Annuitants can obtain a change form on the Insurer's website, and must submit it directly to the Insurer at the address provided (**not** to ETF).

7. How does a Subscriber terminate coverage for a Domestic Partner if the partnership ends?

If a Domestic Partnership terminates, two forms must be submitted to the Employer:

- The Subscriber must submit an [ETF Affidavit of Termination of Domestic Partnership \(ET-2372\)](#) form to ETF. ETF will respond to the Subscriber with an Acknowledgement letter. Upon receipt of Acknowledgement letter, the Subscriber should provide a copy of the letter to the Employer's payroll/benefits office.
- A new Plan application(s) is required within 30 days of the event effective date, to remove the Domestic Partner and his/her Dependent(s) from coverage.

Coverage for the Domestic Partner and his/her Dependents ends on the last day of the month in which the Affidavit of Termination of Domestic Partnership was acknowledged by ETF.

The Employer is responsible to update the Employee's monthly premium, if needed. (See also COBRA/Continuation.)

8. Cancellation during It's Your Choice or other open enrollment

A Subscriber who wishes to cancel coverage for the following calendar year may do so without a qualifying event, during IYC. However, any valid cancellation notice filed with the Employer or, for Annuitants received by the Insurer, by December 31 will be honored. If a premium has been deducted, the Employer will refund the payment on a subsequent payroll.

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

9. What are the cancellation rights for an Annuitant?

- All optional plans except AD&D require that once a Subscriber is enrolled for the calendar year, they must stay enrolled unless there is a qualifying event.
- Any Subscriber who is an Annuitant may cancel, or move from Family or 1+1 coverage to single coverage at IYC time, even if the plan is not offering an enrollment opportunity.

XIII. COBRA and Continuation

COBRA is a federal law that allows qualified beneficiaries (an Employee and his/her Spouse, child(ren) and stepchild(ren)) to continue coverage for a period of time in the event of an involuntary loss of coverage. State continuation law, [Wis. Stat §632.897](#) also applies. When the laws are in conflict, the law that is more beneficial to the qualified beneficiary must be applied.

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.

Domestic Partners and their Dependents are not considered to be qualified beneficiaries under Federal COBRA or State continuation. However, the right to continue coverage has been extended to these individuals by contract.

Retirees are only eligible to continue coverage for 18 months under Federal COBRA and State continuation. However, the right to continue coverage indefinitely has been extended to these individuals by contract or Optional Insurance plans covering dental and vision services. Subscribers who are enrolled at the time of retirement have the right to continue coverage indefinitely, as provided in the insurance contract (see definition of eligible Annuitant). Retiring Subscribers must complete the Insurer's specific continuation form.

Exception: The Hartford AD&D insurance ends at termination. No voluntary continuation is offered. A conversion notice for individual coverage should be issued by the employer.

1. What are the COBRA Continuation Coverage Requirements?

Dental and vision insurance plans have the same continuation privileges offered under the State of Wisconsin Health Insurance program.

Federal COBRA 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 COBRA, all participating agencies and payroll centers are considered to be one Employer (including the UWS and UWHC).

Within five (5) days of notification of a qualifying event, the Employer must provide the qualified beneficiary with the Insurer's appropriate continuation form, per [Wis. Stat. § 632.897](#).

2. How does an Employer provide the continuation election notice to a Dependent who has lost eligibility?

The Subscriber is responsible for notifying the Employer of an event that makes a Dependent ineligible for coverage. For example, if a Spouse, Domestic Partner or child loses eligibility through divorce or terminating a Domestic Partnership, 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.

In the case of divorce, Wis. Statute 632.897 mandates that, provided limited-family or family coverage is in force, coverage remains in effect until the Ex-Spouse is notified of the right to continue. Once the Continuation Notice is issued, the 60-day period to accept continuation begins.

In the case of termination of a Domestic Partnership, provided limited-family or family coverage is in force, coverage ends at the end of the month in which the Affidavit of Termination of Domestic Partnership is received by ETF. Once the Continuation Notice is issued by the employer, 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 COBRA statement, even if the Insurer has an automated process for terminating enrollment.

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 individuals who are eligible to continue coverage live together in a common household, one notice to all eligible individuals is acceptable. If the last known address for a covered dependent is different, even for a minor, send the notice to that minor's known address (for example, lives with grandparent).

The Employer must complete all appropriate information on the bottom of the Continuation form, including the date the form was sent and termination date (end of active Employee status or end of eligibility as a Dependent.)

3. What is the timeline for an Employee or Annuitant to complete a continuation form for Optional Insurance?

An Employee or Annuitant 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 Insurer.

4. Does the Subscriber sign a separate contract to continue the Plan insurance?

When the Subscriber completes a continuation form, it is not a contract between the Insurer and the Subscriber; it is only an application to continue the coverage through the Board's contract with the Insurer. The Insurer does not have a contract with the individual Subscriber.

5. When is payment of premium due for a continuation Subscriber?

Once the Subscriber has submitted the continuation application, the Insurer 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 Insurer may charge a small billing fee and will advise the Subscriber of payment options, which may include annually, semi-annually, 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 or 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.

6. How are continuing Annuitants/surviving Dependents/COBRA participants notified of changes in premium or benefits?

If the Board approves a change to Annuitant rates, the Insurer will send a letter to covered Annuitants/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, Annuitants and COBRA/Continuation Subscribers. Premium change is usually effective as of January 1st for all Subscribers.

7. How long can Subscribers continue their Insurance coverage?

Pursuant to COBRA continuation:

- An Employee who terminated employment may continue coverage for up to 18 months.
- A Spouse/Dependent child who lost eligibility due to Employee's termination may continue coverage for up to 18 months.
- An ex-Spouse due to divorce 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).
- Dependents who have lost coverage due to death of the Subscriber may continue coverage for up to 36 months.
- In limited situations, the length of the COBRA 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. The extension applies to everyone covered under that qualified beneficiary's COBRA coverage.

Under contract, continuation of coverage also allows:

- An Annuitant and his Dependent(s) may continue coverage indefinitely.
- Surviving Spouse or Domestic Partner may continue coverage indefinitely.
- Surviving Dependent children may continue coverage until they otherwise lose eligibility (such as reaching the limiting age of coverage).
- A former Domestic Partner and his/her children may continue coverage for up to 36 months (or until the children otherwise lose eligibility, such as reaching the limiting age of coverage).

8. Who is an eligible Annuitant for the purpose of indefinite continuation of coverage?

The following individuals are eligible to continue their coverage as long as premiums are paid in a timely manner:

- A Subscriber who retires, or who has 20 years of creditable service under the WRS regardless of age, and is eligible for the State group insurance plans issued pursuant to Wis. Stat. [Chapter 40](#).
- The surviving Spouse/Domestic Partner of an Annuitant as defined in Wis. Stat. [Chapter 40](#).
- Subscribers who are approved for disability retirement under [Wis. Stat. § 40.63](#) Long-Term Disability Insurance (an LTDI benefit under [Wis. Admin. Code ETF § 50.40](#)), or a duty disability under [Wis. Stat. § 40.65](#), must be offered COBRA, or may stay continuously covered. They must be also 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.

9. What is the process to notify dependents of Annuitants, when there is a continuation opportunity?

In the case of a divorce, termination of domestic partnership, or death of a Subscriber, it is the role of the Insurer, by contract, to provide written notice to the Dependents who are eligible to continue enrollment.

XIV. Retirement, Disability, or Long Term Disability

1. What if a Subscriber retires?

A Subscriber who terminates employment and qualifies as an Annuitant may complete and submit **to the Insurer** a Continuation form within 60 days of coverage termination as an active Employee or the date of the COBRA notice, whichever is later.

Most Subscribers should choose the retiree continuation opportunity, instead of COBRA. Otherwise, COBRA coverage will likely expire at a time other than the end of the plan year, and the Subscriber will have to wait for a designated enrollment opportunity to be eligible to re-enroll as an Annuitant. Annuitant coverage begins on the first of the month following the date on which employment terminates.

2. How are Annuitants and Continuants billed for coverage?

For VSP, most Annuitants 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.

Other Insurers use an individual billing method for former Employees and Annuitants who choose to continue their coverage, based on the selection the Subscriber indicates on the application. 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 rather than quarterly.

3. Are qualifying Events recognized to allow the Annuitant or COBRA subscriber to make changes?

Annuitants and COBRA subscribers have the same opportunities to make changes based on HIPAA qualifying events as do active Subscribers.

4. Can rehired Annuitants enroll in optional insurance?

An Annuitant who returns to work for a state agency but continues to collect a WRS annuity is not eligible to enroll in optional insurance plans at the time of hire. He or she can enroll as an Annuitant at the next Open enrollment period, and will pay premiums directly to the Insurer. Or the annuitant may continue with insurance already subscribed to, and continue to pay directly. Employers do **not** use payroll deduction for the premiums of WRS Annuitants.

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

XV. Death of a Subscriber or Dependent

1. Procedures following the death of a Subscriber or Dependent

- The Employer must notify the Insurer 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 Insurer of a Subscriber death.
- The Insurer must notify ETF if the Insurer 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.

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.

Covered surviving Dependents may elect COBRA continuation. See the [COBRA section](#).

If a covered Annuitant dies, the surviving Dependent(s) must contact the Insurer. The Insurer will provide the appropriate forms to apply to remain covered or cancel coverage, or see forms at etf.wi.gov and follow links to the plan page.

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

When an Employer is notified of the death of a covered Dependent, the employer should assist the Subscriber to complete 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.

Survivors of a deceased Subscriber have 60 days after the date of the COBRA notice to submit a COBRA form to the Insurer to request continuation. Insurer 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, he/she must wait to re-enroll at the next available IYC opportunity,

Once continuation of coverage begins, new Dependents may be added if there is a qualifying event.

Important: If a death of the Employee (or Annuitant) 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 Insurer if there is AD&D benefit coverage. Claim forms are located on the Insurer's website.

See [Section B](#) for the Insurer's website links.

XVI. Employer Error

1. 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 three months of premium be approved by the Insurer:** Premium refund requests in excess of 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 or eligibility as a result of a change to an eligible position.
- 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.

2. 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.
- 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.
- An 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.

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

- The employer furnishes sufficient information to the Department indicating one of the Employment Error criterion has been met.
- The employee files an application provided by the Department, which must be received by the employer within 30 days after the employee first becomes aware of the error, and
- The Department finds that the employee was denied coverage as a result of employer error as outlined above.

XVII. Subscriber Grievance

1. The procedure for filing a complaint or grievance with the Insurer, as well as with ETF is outlined in the policyholder certificate. See links for each Insurer in section B.
2. The [ETF Insurance Complaint \(ET-2405\)](#) form details the process for filing with ETF. Reference to this process is included in the Optional Insurance Plan Insurer contract.

In general, if a member or Subscriber receives a negative notice from an Insurer, he/she has the right to first question the action by contacting the Insurer. The procedure will be outlined on the letter or statement provided to the Subscriber by the Insurer.

Subscribers must first use the formal complaint process outlined by the Insurer to request review, following the timelines prescribed.

If the member is not satisfied with the resolution offered by the Insurer, the member may appeal to ETF, for either an informal review or departmental determination. Either type of request must be made within sixty (60) days of the written decision from the Insurer.

- 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.
- If the member seeks a departmental determination, ETF will attempt to provide that determination within ninety (90) days of the request.

A member may appeal ETF's departmental determination to the 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 the Appeals Coordinator, Department of Employee Trust Funds, PO Box 7931, Madison, WI 53707-7931.

Section B

I. Optional Employee Pay-All Insurance Resources: ETF Resource Links

Resolving member issues:

- State Employer with question about a policy outlined in this manual: Contact ETF Employer Services Section (ESS).
 - ETFSMBEmployerInsurance@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 Optional Plans Manager if necessary.
- State Employer or payroll center has an issue specific to a Subscriber's enrollment status, premiums owed, ID card, etc.: contact the Insurer directly using the Contact List linked below.
- For Annuitants
 - 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.
 - Annuitants may contact VSP directly, at the customer service number below.
 - For any optional insurance plan, ESS Retiree Insurance staff may refer annuitants to the designated Insurer contact for enrollment or premium issues. See contact information in this section.

Resource links for ETF staff assisting Employer or Member

Subscriber- Optional Employee Pay-All Insurance Programs:

http://etf.wi.gov/members/benefits_other_insurance.htm

The screenshot shows the ETF website interface. At the top left is the ETF logo with the text 'WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS'. Below the logo is a navigation menu with links for 'members', 'retirees', 'employers', 'governing boards', and 'careers at etf'. A search bar is located to the right of the menu. The main content area is titled 'Members' and features a section for 'Other Insurance Programs (State Employees Only)'. This section lists several insurance options: Accidental Death and Dismemberment, Aflac Accidental Injury Insurance, Anthem DentalBlue, Dental Plan Comparison, and EPIC Insurance - Benefit Information. The EPIC Insurance link includes a sub-link for 'Sample 2015 Employee Brochure' and another for 'Comparison Chart of 2015 Vision Coverage Options'. Below the list are links for '2015 Agency/Plan Table' and '2016 Agency/Plan Table'. A sidebar on the left contains a 'calculators' section with various links like 'member education', 'forms and publications', 'news', 'about etf', 'faq', 'contact etf', 'site map', 'related links', 'home', and 'top of page'. At the bottom of the page, there is a footer with the text '>>> supporting excellence in Wisconsin public service'.

Contact Persons for Optional Employee Pay-All Insurance Programs:

<http://etfonline.wi.gov/etf/internet/Employer/contacts-optional-plans.pdf>

(This summary list is for ETF staff and Employer payroll office staff only.)

II. Optional Employee Pay-All Insurance Resources: Links to Insurer Resources

The following Insurers have contracts to provide optional insurance to state Employees and Annuitants in 2016:



Anthem DentalBlue

General inquiries:

Call: (866) 589-0582 or email: StateofWIEmpsDnService@anthem.com

For It's Your Choice inquiries only:

Call (866)-511-4476 or email: StateOfWIEmpsDnEnrollment@anthem.com

Submit claims or correspondence to:

DentalBlue

P.O. Box 659444

San Antonio, TX 78265

Plan Summary, Find a Provider, Forms, or Benefit Handbook:

<https://www.anthem.com/dental-stateofwi/>



Premium billing and enrollment for all EPIC plans: Benefits+ and Dental Wisconsin

Address:

EPIC Specialty Benefits
Attention: Billing and Enrollment Department
PO Box 8430, Madison, WI 53708-8430

Phone:

(800) 520-5750 Monday-Friday 7:00 am to 6:00 PM Central

Fax: (608) 223-2159 or toll-free fax: (800) 236-7610

Email: wseeligibility@epiclif.com

General information:

<http://www.epiclif.com/wi-state-employees/>

Policy Information for Wisconsin State Employees:

<http://www.epiclif.com/policy-information-for-wi-state-employees/>

Benefits+ hospital and surgery claims

Address:

EPIC Specialty Benefits
Attention: Hospital/Surgical Claims
PO Box 8430, Madison, WI 53708-8430

Phone: (800) 520-5750 Monday-Friday 7:00 am to 6:00 PM Central

Fax: (608) 223-2159 or toll-free fax: (800) 236-7610

General information:

<http://www.epiclif.com/wi-state-employees/>

Benefits+ Accidental Death and Dismemberment (AD&D) claims:

Address:

EPIC Specialty Benefits
Attention: AD&D Claims
PO Box 8430, Madison, WI 53708-8430

Phone: (800) 520-5750 Monday-Friday 7:00 am to 6:00 PM Central

Fax: (608) 223-2159 or toll-free fax: (800) 236-7610

General information:

<http://www.epiclif.com/wi-state-employees/>

Epic Specialty Benefits Section, continued



Dental Claims and Benefits—Benefits+ and Dental Wisconsin

Note: Delta Dental is the administrator for EPIC’s dental benefits as well as the Uniform Dental Benefit. **The information below is for Employee-Pay-All Plans only.** It is *not* for the Uniform Dental Benefit.

Address:

EPIC Specialty Benefits
c/o Delta Dental of Wisconsin
PO Box 828
Stevens Point, WI 54481-0828

Phone: (800) 236-3712 Monday – Friday 7:00 am to 5:00 pm Central

Fax: (715) 343-7615

Email: claims@deltadentalwi.com

General information:

www.deltadentalwi.com



Vision Claims and Benefits

Address:

Vision Care Processing Unit
PO Box 1525
Latham, NY 12110

Phone: (877) 923-2847 Monday – Friday 8:00 am to 11:00 pm Eastern

General information:

www.davisvision.com



Address:

The Hartford Group Life/AD&D Claims Unit
PO Box 14297
Lexington, KY 40512-4297

Phone: (888) 563-1124

Fax: (866) 344-9747

Brochure: <http://etf.wi.gov/publications/addbrochure.pdf>

Claim form: <http://etf.wi.gov/publications/hartford-add-claim-form.pdf>

General information:

<http://www.thehartford.com/employee-group-benefits/life-accident-insurance>



Address:

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

Address to mail direct pay premiums for Members on COBRA or the Annuitant plan:

Vision Service Plan
PO Box 740260
Los Angeles, CA 90074-0260

Phone (member services): (800) 877-7195 Mon-Fri: 8:00 a.m. to 8:00 p.m. Pacific Time

General information:

www.vsp.com/go/stateofwiemployees

Find a provider:

<https://www.vsp.com/go/voluntary-find-doctor-location.html>

Section C: Administrative Roles and Procedures

Enrollment, changes, terminations:

- Electronic files are sent in a format agreed upon between the payroll center and the Insurer
- Paper forms can be found on each Insurer’s web page (see section B). Forms are submitted via mail, fax, or email image. If email, communications containing any private Member information must be transmitted using a secure server.
- During It’s Your Choice, paper forms may be sent via bulk mail daily or weekly.

Subscriber Unique Identifiers:

Insurers’ methods for assigning unique identifiers to Subscribers are outlined below. This may be important to know when making an inquiry about a particular Subscriber.

	Primary unique identifier	Format	Stores ID sent by payroll system	Alternate look-up identifiers	ID Cards- see description below table
Anthem DentalBlue	SSN and “Member ID,” generated by Anthem	3 numeric digits, one letter, 5 numeric digits. Example: 111M22222	No	Date of birth	Yes, with Anthem ID
EPIC-Benefits+	Customer ID generated by EPIC	All numeric, usually with leading zeros	Not currently.	SSN, date of birth	Yes, with EPIC customer number
EPIC Dental Wisconsin	Customer ID generated by EPIC *Note- if enrolled in both EPIC products, subscriber will have two numbers, two cards	All numeric, usually with leading zeros	Not currently.	SSN, date of birth	Yes, with EPIC customer number
Hartford	Does not keep subscriber census. Verifies individual enrollment upon claim.	NA	No	Date of birth, if in claim status. Employer.	No
VSP	Uses the ID provided by each payroll center	Varies by payroll center	Yes	After claim, date of birth, SSN.	No

ID cards:

- Anthem, EPIC Benefits+ and EPIC Dental WI will mail ID card(s) to each Subscriber in January following IYC. For newly hired Subscribers, cards will be mailed within one week of receipt of application by the Insurer.
- VSP does not send ID cards, but Subscribers can print their own from VSP’s website after creating an online account. The card does not contain an ID number. Providers check eligibility at time of service, and can inquire based on name and date of birth.

Billing: The method of billing varies by payroll center and by Insurer.

1. List Billing:

- For each plan, the Insurer sends a list to each payroll center monthly,
- The list includes names of Subscribers, unique ID number, agency “location,” and amount owed based on the type of coverage- (single, family, etc.), with a subtotal by agency and total for the payroll center
- The Employer compares the bill to its payroll records and notes corrections or adjustments

2. Self-Billing:

- Each payroll center sends the Insurer a periodic listing with additions, changes, and terminations identified.
- A monthly remittance report shows amount owed to the Insurer for that month, after adjustments have been calculated by the Employer for over or underpayments from previous months.

	Courts	STAR	WEDC	WHEDA	Wiscraft	How often reconciled
Anthem	List-bill (pending)	Self-bill	List-bill	List-bill	Self-bill	Monthly
EPIC	List-bill	Self-bill	List-bill	List-bill	na	Monthly
Hartford	Self-bill	Self-bill	Self-bill	na	na	Upon claim
VSP	Self-bill	Self-bill	Self-bill	Self-bill	na	At IYC

Remittance of Premiums:

- Premiums are due to the Insurer by the first of the month of coverage. There is a 45 day grace period.
- The payroll center may mail the remittance using a paper check, or transmit electronically via ACH, with an agreement and file exchange coordinated between the Insurer and the payroll center, as approved by ETF.

Retired Safety Officers:

Annuitants who qualify under the retired safety officer insurance premium deduction program may have premiums for dental or vision insurance deducted from their annuity, under Wis. Stat. 40.05(4r). See <http://etf.wi.gov/publications/et4330.pdf>

Appendix 1: Plan Offerings by Payroll Center

Table 1

2016 State Optional Plan Offerings¹

Relevant to Sections III.3, “Transfer between Agencies” and XII, “Cancellation”

Exceptions²

Agency	Anthem Dental Blue	EPIC Dental WI	EPIC Benefits Plus	VSP	Hartford AD&D	Zurich AD&D ³	Delta Dental
UWS		X	X	X		X	
UWHC			X	X		X	X
STAR Agencies	X	X	X	X	X		
WCS	X	X	X	X	X		
WEDC	X	X	X	X	X		
WHEDA	X		X	X			
Wiscraft/Beyond Vision	X						
WHEFA							
FRNSA							

¹ None of the non-STAR agencies offer supplemental dental, vision or AD&D coverage outside of what is listed in the table.

² Zurich Mutual and Delta Dental are in blue to indicate that they are exclusive to UWS and UWHC; these are not currently available to non-STAR agencies if there was an interest by any of them to offer these.

³ UWS/UWHC AD&D coverage began prior to 1970 under Continental Casualty; now under Zurich after various mergers over the years.

Table 2

2017 State Optional Plan Offerings⁴

All state agencies other than the UWS and UWHC must offer each Plan approved by the Board. In the chart below, X means offered in 2016. Y means newly offered effective 1.1.17.

Agency	Anthem Dental Blue	EPIC Dental WI	EPIC Benefits Plus	VSP	Zurich North America AD&D	Zurich AD&D⁵	Delta Dental
UWS		X	X	X		X	
UWHC			X	X		X	X
STAR Agencies	X	X	X	X	X		
WCS	X	X	X	X	X		
WEDC	X	X	X	X	X		
WHEDA	X	Y	X	X	Y		
Wiscraft/Beyond Vision	X	Y	Y	Y	Y		
WHEFA	Y	Y	Y	Y	Y		
FRNSA	Y	Y	Y	Y	Y		

⁴ None of the non-STAR agencies offer supplemental dental, vision or AD&D coverage outside of what is listed in the table.

⁵ UWS/UWHC AD&D coverage began prior to 1970 under Continental Casualty; now under Zurich after various mergers over the years.

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) and (d)(1)

The 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, 801 West Badger Road, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 1-800-947-3529; 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: 1-800-833-7813).

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: 1-800-947-3529).

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: 1-800-947-3529)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 1-800-947-3529)

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529)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: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 1-800-947-3529).

Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-533-5020 (TTY: 1-800-947-3529).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-533-5020 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

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: 1-800-947-3529).