Frequently Asked Questions

General Information

This information is intended to provide understandable explanations of the Certificate of Coverage (ET-2180) and Schedule of Benefits. In the event of any conflict between the terms of the Certificate of Coverage or Schedule of Benefits and the information contained in the *Frequently Asked Questions* section, the terms of the Certificate of Coverage or Schedule of Benefits shall control.

1. What health and prescription drug insurance does the Local Annuitant Health Program (LAHP) offer me?

Members with Medicare: LAHP members on Medicare have coverage that supplements Medicare deductibles and coinsurance. You have your choice between plans that offer:

- Nationwide IYC Medicare Advantage plan, offered by UnitedHealthcare (UHC).
- Worldwide Medicare Plus supplement plan, offered by UHC. This plan includes a foreign travel rider.
- Local Health Plan Medicare.

You can choose between many health plans that offer the same benefits, called the Local Health Plan Medicare, but have different provider networks.

Coverage is provided for prescription drugs through a Medicare Part D plan offered by Navitus Health Solutions (Navitus). Navitus is LAHP's Pharmacy Benefit Manager (PBM). To avoid being double covered, see question 75. For more information, see the Medicare Information Section of this FAQ, especially the area regarding Medicare Part D.

For more information, see the benefit summary grids on pages 3-5. You may also find more information by calling ETF, the health plan you are interested in, or Navitus.

Members without Medicare: You have a choice of many HMOs that offer the same medical benefits, called the Local Health Plan. You can also choose the nationwide Local Access Plan PPO, offered by Dean Health Insurance. This plan has the broadest provider network.

You will have prescription drug coverage offered by Navitus. Navitus is LAHP's PBM.

For more information, see the benefit summary grids on pages 6-8. You may also contact ETF, the health plan you are interested in, or Navitus.

All Members: A more detailed description of the coverage is provided in the Certificate of Coverage and Schedule of Benefits for the Local Health Plan Medicare, Medicare Plus, Local Health Plan or Local Access Plan. Details about the IYC Medicare Advantage benefits appear in the Evidence of Coverage. All are available on our website or by calling ETF.

2. I am currently insured with LAHP. Do I need to do anything during It's Your Choice special enrollment?

You should review this guide, especially the "What is Changing" section and "Your Enrollment Checklist." If you choose to change health plans, you must file a *Health Insurance Application/Change for Retirees* (ET-2331) form during the special enrollment period. Your medical and prescription drug coverage with your new plan will begin January 1 of the following year. If you are happy with your current health plan and the plan is offering coverage for next year, you don't need to do anything. Your coverage will continue.

3. Will I be able to change health plans later?

In certain circumstances, yes. See the Other Enrollment Opportunities section.

4. Who is eligible for LAHP?

The LAHP is available to the following:

- Local government retirees (including their spouse and dependents) who are receiving a Wisconsin Retirement System (WRS) retirement annuity or received a lump-sum WRS retirement benefit within 60 days of termination of employment.
- The insured surviving spouse and eligible dependent children of a deceased local government retiree.
- The surviving spouse and eligible dependent children of a deceased active local government employee.

Not eligible to apply:

- *Individuals who are receiving only a § 40.65 duty disability or long-term disability insurance benefit.*
- *Individuals whose former local employer participates in the Wisconsin Public Employers Group Health Insurance Program.*
- *If you were previously insured in LAHP and canceled coverage, you may not re-enroll, except if you canceled due to enrolling in employee coverage offered to yourself or your spouse. See question 26.*

Eligible dependents are the spouse and children of the retired or deceased employee. No other relatives are eligible. Coverage for an eligible dependent child terminates on the end of the month in which they lose eligibility.

Medicare coverage is available to persons who are eligible for Medicare. All applicants must be enrolled in both Parts A and B of Medicare on the date this coverage becomes available. Persons with end-stage renal disease who have not completed their 30-month

Medicare waiting period must be enrolled in a non-Medicare plan and must continue their Medicare insurance. Once the 30-month waiting period has passed, you will be moved to the lower cost Medicare rates and Medicare secondary coverage.

5. I am eligible and not currently insured in LAHP. I want to enroll. When can I?

There are two enrollment opportunities available to you if you have not been insured under LAHP before:

- You and your dependents may enroll if you apply within 60 days after the date you retire from local government employment (that is, cease to be an active employee participating in the WRS) or are approved for a 40.63 disability annuity. Your annuity and health applications may be filed up to 90 days prior to the termination of your employment but you cannot apply for this insurance before you apply for your annuity. To ensure that your coverage begins as soon as possible after retirement, it is best to file for your annuity and health insurance before you retire; or
- If you are eligible, you may enroll when you become age 65 and/or first enroll in Medicare Part B if you are over age 65. If you are insured with individual coverage in this plan, and you have an eligible dependent who first turns age 65 and/or enrolls in Medicare Part B, you may change to family coverage when Medicare becomes effective. This open enrollment period extends for seven months: the three calendar months before you turn age 65 or enroll in Medicare Part B, the calendar month in which you turn age 65 or enroll in Medicare Part B, and the three calendar months immediately following the month you turn age 65 or enroll in Medicare Part B.

Coverage for new retirees will be effective on the first of the month following either receipt of the health application by ETF or the effective date of your annuity, whichever is later. At your request, the effective date can be delayed for up to 90 days from the date ETF receives the application or your termination date, whichever is later. Please note that your application must be received by ETF within 60 days after your retirement, even if you are requesting a deferred effective date.

Coverage for individuals who are gaining Medicare will be effective the date Medicare Part B begins.

6. Can I or my Medicare enrolled dependent choose to be insured by IYC Medicare Advantage or Medicare Plus, and the non-Medicare individual choose a non-Medicare IYC Health Plan design under my family coverage?

Yes, you can be insured by two different health plans if you have a retiree contract where one or more family members have Medicare and one or more do not. This is called a Medicare Some contract. You may select from the following:

- Either IYC Medicare Advantage or Medicare Plus for the Medicare enrolled individuals
- One other IYC Health Plan design for the non-Medicare individuals

7. What is the health insurance marketplace and is it an option for me?

For individuals younger than age 65 and ineligible for Medicare, the Marketplace, established under the Affordable Care Act (ACA), allows you to shop for health insurance outside of our programs. Visit healthcare.gov for more information.

Grievances and Appeals

8. What if I have a complaint about my health plan, dental plan, or PBM?

Each of the plans and the PBM participating in the LAHP is required to have a complaint and grievance resolution procedure in place to help resolve a participant's problems. Contact your plan or the PBM to get information on how to initiate this process. You must exhaust all of your appeal rights through the plan or PBM first in order to pursue review through an External Review/Independent Review Organization (IRO) or through ETF and the Group Insurance Board. If the plan or PBM upholds its denial, it will state in its final decision letter your options if you wish to proceed further. If you continue to be dissatisfied with the outcome, you may contact ETF's Ombudsperson Services at 1-877-533-5020 or email ombudsperson@etf.wi.gov.

9. What if my health plan, dental plan, or PBM upholds a denial that is based on medical reasons, such as "medical necessity?"

Depending on the nature of your complaint, you may be given rights to request an external or independent review through an outside organization. This option becomes available when a plan or PBM has denied services as either not medically necessary or experimental, or due to a preexisting condition exclusion denial or rescission of coverage. For more information, you may contact ETF's Ombudsperson Services at 1-877-533-5020 or email ombudsperson@etf.wi.gov. Note: If you choose to have an IRO review the plan or PBM's decision, that decision is binding on both you and your plan or PBM except for any decision regarding a preexisting condition exclusion denial or the rescission of coverage. Apart from this exception, you have no further rights to a review through ETF or the courts once the IRO decision is rendered.

10. What if my health plan, dental plan, or PBM upholds a denial that is not eligible for IRO, such as a denial based on contract interpretation?

As a member of LAHP, you have the right to request an administrative review through ETF if your health plan or PBM has rendered a decision on your grievance and it is not eligible for IRO review as described above. For more information, you may contact ETF's Ombudsperson Services at 1-877-533-5020 or email ombudsperson@etf.wi.gov. To initiate an ETF review, you may call or send a letter to ETF and request an *ETF Insurance Complaint* (ET-2405) form. Complete the complaint form and attach all pertinent documentation, including the plan's response to your grievance.

Please note that ETF's review will not be initiated until you have completed the grievance process available to you through the plan or PBM. After your complaint is received, it will be acknowledged and information may be obtained from the plan or PBM. An ETF ombudsperson will review and investigate your complaint and attempt to resolve your dispute with your plan or PBM. If the ombudsperson is unable to resolve your complaint to your satisfaction, you will be notified of additional administrative review rights available through ETF.

Tax Implications

11. Are there tax implications for covering my non-tax dependent (who is an adult child)?

No. The Affordable Care Act (ACA) and 2011 Wisconsin Act 49 eliminated tax liability for the fair market value of health coverage for adult children through the month in which they turn age 26, if eligible. If the tax dependent status of your dependent over age 26 changes, please notify ETF.

Selecting a Health Plan

12. Can family members covered under one policy choose different health plans?

No, if all family members are eligible for Medicare, or none are. However, if your family contract includes at least one individual who has Medicare and at least one who does not, yes. See Question 6, "Can I or my Medicare enrolled dependent choose to be insured by IYC Medicare Advantage or Medicare Plus, and the non-Medicare individual choose a non-Medicare IYC Health Plan design under my family coverage?"

13. Can I receive medical care outside of my health plan network?

This can be a concern for members who travel and those with covered dependents living elsewhere, such as a college student living away from home. Consider the following when selecting a health plan:

If you enroll in a Local Health Plan HMO, you are required to obtain allowable care only from providers in the HMO's network. These HMOs will cover emergency care outside of their service areas, but you must get any follow-up care to the emergency from providers in the HMO's network. Do not expect to join a Local Health Plan HMO and get a referral to a non-HMO physician. An HMO generally refers outside its network only if it is unable to provide needed care within the HMO.

If you are covered under IYC Medicare Advantage, Medicare Plus or a Preferred Provider Organization (PPO) - the Local Access Plan or State Maintenance Plan (SMP), you have the flexibility to seek care anywhere. UHC's IYC Medicare Advantage-PPO offers nationwide coverage for participants with Medicare Parts A and B, with both in- and out-of-network benefits. Medicare Plus provides access to care nationwide from any provider who accepts Medicare, and worldwide through a foreign travel rider. For the PPOs, out-of-network care is subject to higher deductible and coinsurance amounts.

14. How can I get a listing of the physicians participating in each plan?

Contact the plan directly. ETF does not have this information. Medicare Plus and IYC Medicare Advantage permit use of any provider that accepts Medicare.

15. What steps should I follow to enroll in the health insurance program?

- Determine which plans have providers in your area.
- Contact the health plans directly for information regarding available physicians, medical facilities and services.
- Review the health plan rates in this guide.
- Also review the health plan pages available from ETF.
- Complete the *Health Insurance Application/ Change for Retirees* (ET-2331) form.

Other Enrollment Opportunities

16. Are there other enrollment opportunities available to me after my initial one expires?

You may be able to get health insurance coverage if you are otherwise eligible under specific circumstances as described below:

If you are currently enrolled in LAHP with individual coverage, because your dependents are insured under a group health insurance plan elsewhere, and eligibility for that coverage is lost or the employer's premium contribution for the other plan ends, you may take advantage of a special 30-day enrollment period to change from individual to family* coverage. Coverage will be effective on the date the other coverage or the employer's premium contribution ends.

If you are currently enrolled in LAHP with family coverage, you may request to provide coverage for your* eligible adult child who is not currently insured. You do this during the annual special enrollment period. Coverage for your dependents will be effective the following January 1.

If you are insured under LAHP* and have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may add dependents or change to family coverage if coverage is elected within 30 days of marriage or 60 days of the other events. Coverage is effective on the date of marriage, birth, adoption or placement for adoption.

*Survivors may not add new spouses or stepchildren.

17. Can I change health plans, cancel my insurance or change coverage levels when I or my dependent have a Medicare coverage change?

Yes. Covered retirees may change plans, cancel coverage or change coverage levels (for example, family to individual) when a covered individual has a change in their Medicare coverage, for example, when they turn age 65 and gain Medicare. You must file an application within 30 days of the Medicare enrollment. You can file it sooner, if you apply to enroll in Medicare up to three months before your 65th birthday. Coverage will be effective on the date the Medicare coverage begins.

Note: If you are eligible for Medicare, you must be enrolled in the hospital (Part A) and medical (Part B) portions of Medicare at the time of your retirement. If you are not enrolled for all available portions of Medicare, you will be responsible for the portion of your claims that Medicare would have paid beginning on the date Medicare coverage would have become effective except for under the IYC Medicare Advantage plan. If you are not enrolled in both Medicare Parts A and B, you are not eligible for IYC Medicare Advantage.

Annual Special Enrollment Period

The special enrollment period is the annual opportunity for retirees insured in LAHP to select one of the many health plans offered by LAHP. Following are some of the most commonly asked questions about the enrollment period.

18. What is the special enrollment period?

The special enrollment period is an opportunity to change plans, change from family to individual coverage, cancel your coverage or cancel the coverage for your adult dependent child (age 19 and older). It is offered only to currently insured retirees who are eligible under LAHP. Changes made become effective January 1 of the following year.

19. May I change from individual to family coverage during the special enrollment period?

Yes, coverage will be effective January 1 of the following year for all eligible dependents.

Making Changes During the Special Enrollment Period

20. How do I change health plans during the special enrollment period?

If you decide to change to a different plan, you may submit a *Health Insurance Application/Change for Retirees* (ET-2331) form to ETF. Applications received after the deadline will not be accepted.

21. What is the effective date of changes made during the special enrollment period?

Coverage changes are effective January 1 of the following year.

22. What if I change my mind about the health plan I selected during the special enrollment period?

You may submit or make changes anytime during the special enrollment period by filling out a paper application. After that time, you may withdraw your application (and keep your current coverage) by notifying ETF in writing before December 31.

Other rules apply when canceling coverage. For more information, see the Cancellation or Termination of Health Coverage section.

Re-Employed Retirees

23. How are my health benefits affected if I return to work for an employer not under the Wisconsin Retirement System?

If you return to work for a non-WRS participating employer after retirement, your WRS annuity and health benefits will not be affected.

24. How are my health benefits and premiums affected if I return to work for an employer who is under the WRS?

If you return to work for a WRS-participating employer, you may be eligible to once again become an active WRS employee. If you make this election and become an active WRS employee, your annuity will be suspended and you will no longer be eligible for health insurance as a retiree/annuitant. You will be eligible for health insurance as an active WRS employee through your WRS-participating employer if the employer is participating in an ETF health plan. Check with your employer to make sure you have other health insurance coverage available before you elect WRS participation.

You may also waive or terminate enrollment under Medicare until the first Medicare enrollment period after active WRS employment ceases. Your premium

rates, while covered through active employment, will be the active employee contribution rates for your plan, not the Medicare rates.

When you subsequently terminate employment and resume your annuity, your eligibility for coverage is once again dependent on you meeting the requirements for newly retired employees.

Dependent Eligibility

Individual coverage covers only you. Family coverage covers those described below. All eligible, listed dependents are covered under a family contract. A subscriber cannot choose to exclude any other eligible dependent from family coverage except as described in the question: "When does health coverage terminate for my dependents?"

25. Who is eligible as a dependent if I select family coverage?

- Your spouse.
- Your children who include:
  - Your natural children.
  - Stepchildren.
  - Adopted children and pre-adoption placements. Coverage will be effective on the date that a court makes a final order granting adoption by the subscriber or on the date the child is placed in the custody of the subscriber, whichever occurs first. These dates are defined by Wis. Stat. § 632.896. If the adoption of a child is not finalized, the insurer may terminate coverage of the child when the adoptive placement ends.
  - Legal wards that become your permanent ward before age 19. Coverage will be effective on the date that a court awards permanent guardianship to you (the subscriber or your spouse).
  - Your grandchildren born to your insured dependent children may be covered until the end of the month in which your insured dependent (your grandchild's parent) turns age 18. Your child's eligibility as a dependent is unaffected by the birth of the grandchild.

Dependents and subscribers may only be covered once under the Group Health Insurance Program. In the event it is determined that a dependent is covered by two separate subscribers, the subscribers will be notified and will have 30 days to determine which subscriber will remove coverage of the dependent and submit an application to remove the dependent. If the dependent(s) is to be newly covered by a subscriber that has individual coverage, the contract may be converted to a family contract. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.

Children may be covered until the end of the month in which they turn age 26. Their spouse and dependents are not eligible. Upon losing eligibility, they may be eligible for COBRA continuation. (See Question: Who is eligible for continuation?) Coverage may continue beyond turning age 26 when children:

1. Have a disability of long standing duration, are unmarried, dependent on you or the other parent for at least 50% of support and maintenance and are incapable of self-support; or
2. Are full-time students and were called to federal active duty when they were under age 27 and while they were attending, on a full-time basis, an institution of higher education. Note: The adult child must apply to an institution of higher education as a full-time student within 12 months from the date the adult child fulfilled their active duty obligation.

26. What are my coverage options if my spouse is also a state of Wisconsin or participating Wisconsin Public Employer (WPE) employee or retiree?

Note: If you are a retiree and cancel your LAHP insurance coverage, you will not be able to re-enroll in this program unless you meet the LAHP eligibility requirements. See question 4.

If premiums for family coverage are being deducted on a pre-tax basis (for most employees), coverage may only be changed to individual coverage effective at the beginning of the calendar year or when the last dependent becomes ineligible for coverage, or becomes eligible for and enrolled in other group coverage.

If both spouses are each enrolled for individual coverage and premiums are being deducted on a pre-tax basis, family coverage may only be elected effective at the beginning of the calendar year or when the employees have gained a dependent that necessitates family coverage.

If premiums are being deducted on a post-tax basis (for retirees), one of the individual contracts may be changed to a family plan at anytime without restriction and the other individual contract will be canceled (see "Note" above). Family coverage will be effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application.

If premiums are being deducted post-tax, one family policy can be split into two individual plans with the same carrier effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application from both spouses. For subscribers whose premiums are being deducted on a post-tax basis, coverage can be changed

at anytime.

Coverage will be effective on the beginning of the month following receipt of an electronic or paper application, or a later date specified on the application. (Note: Most LAHP enrolled retirees who terminate their coverage may not re-enroll.)

If at the time of marriage, two LAHP retirees each have family coverage or one has family coverage and the other has individual coverage, coverage must be changed to one of the options listed above within 30 days of marriage to be effective as of the date of marriage. Failure to comply with this requirement may result in denial of claims for eligible dependents. Note: Change from individual to family coverage due to marriage is effective the date of marriage if an electronic or paper application is received by ETF within 30 days of the marriage.

27. What if I have an adult child who is, or who becomes, physically or mentally disabled?

If your unmarried child has a physical or mental disability that is expected to be of long-continued or indefinite duration and is incapable of self-support, they may be eligible to be covered under your health insurance through our program. You must work with your health plan to determine if your child meets the disabled dependent eligibility criteria. If disabled dependent status is approved by the health plan, you will be contacted annually to verify the adult dependent's continued eligibility.

If your child loses eligibility for coverage due to age or loss of student status, but you are now indicating that the child meets the disabled dependent definition, eligibility as a disabled dependent must be established before coverage can be continued. If you are providing at least 50% support, you must file an application with ETF to initiate the disability review process by the health plan. Your dependent will be offered COBRA continuation*.

If your disabled dependent child, who has been covered due to disability, is determined by the health plan to no longer meet their disability criteria, the health plan will notify you in writing of their decision. They will inform you of the effective date of cancellation, usually the first of the month following notification, and your dependent will be offered COBRA continuation*. If you would like to appeal the plan's decision, you must first complete the plan's grievance procedure. If the plan continues to deny disabled dependent status for your child, you may appeal the plan's grievance decision to ETF by filing an *ETF Insurance Complaint* (ET-2405) form. Note: If you are changing health plans, see also the Changing Health Plans section.

** Electing COBRA continuation coverage should be considered while their eligibility is being verified. If it is determined that the individual is not eligible as a disabled dependent, there will not be another opportunity to elect COBRA. If it is later determined that the child was eligible for coverage as a disabled dependent, coverage will be retroactive to the date they were last covered, and premiums paid for COBRA continuation coverage will be refunded.*

28. What if I don't have custody of my children?

Even though custody of your children may have been transferred to the other parent, you may still insure the children if the other dependency requirements are met.

Note: Dependents may only be covered once under LAHP, the State of Wisconsin Group Health Insurance Program and the Wisconsin Public Employers Group Health Insurance Program. In the event it is determined that a dependent is covered by two separate subscribers, the subscribers will be notified and will have 30 days to determine which subscriber will remove coverage of the dependent and submit an application to remove the dependent. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.

29. When does health coverage terminate for my dependents?

Coverage for dependent children who are not physically or mentally disabled terminates on the earliest of the following dates:

The date eligibility for coverage ends for the subscriber.

The end of the month in which:

- The child turns age 26.
- Coverage for the grandchild ends when your child (parent of grandchild) ceases to be an eligible dependent or becomes age 18, whichever occurs first. The grandchild is then eligible for continuation coverage.
- Coverage for a spouse and stepchildren under your health plan terminates when there is an entry of judgment of divorce.
- The child was covered per Wis. Stat. § 632.885 (2) (b) and ceases to be a full-time student.
- The child becomes insured as an employee of a state agency, or an employer who participates in the State of Wisconsin Group Health Insurance Program.
- You terminate coverage for your adult dependent (age 19 and older) within 30 days of their eligibility for and enrollment in another group health insurance program. Termination will be effective the first of the month following receipt

of an electronic or paper application. You may also terminate coverage for your adult dependent during the annual special enrollment period to be effective January 1 of the following year.

Note: If it is determined that a dependent is covered by two separate subscribers, the subscribers will be notified and have 30 days to determine which will remove coverage of the dependent and submit an application to remove the dependent. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.

See the Continuation of Health Coverage section for information on continuing coverage after eligibility terminates.

Family Status Changes

30. Which changes need to be reported?

You need to file an application as notification for the following changes to ETF within 30 days of the change. Additional information may be required. Failure to report changes on time may result in loss of benefits or delay payment of claims.

- Change of name, address, telephone number and Social Security number, etc.
- Obtaining or losing other health insurance coverage, including any part of Medicare
- Addition of a dependent (within 60 days of birth, adoption or date legal guardianship is granted)
- Loss of dependent's eligibility, including Medicare eligibility
- Marriage
- Divorce
- Death (Contact ETF if dependent is your named survivor.)
- Eligibility/enrollment for Medicare

31. Who do I notify when a dependent loses eligibility for coverage?

You have the responsibility to inform ETF of any dependents losing eligibility for coverage under LAHP. Under federal law, if notification is not made within 60 days of the later of (1) the event that caused the loss of coverage, or (2) the end of the period of coverage, the right to COBRA/continuation coverage is lost. A voluntary change in coverage from a family plan to a single plan does not create a continuation opportunity.

If your last dependent is losing eligibility, you must file an application to change to individual coverage.

32. If I do not change from individual to family coverage during the special enrollment period, will I have other opportunities to do so?

There are other limited opportunities for coverage to be changed from individual to family coverage without restrictions as described below:

If an application is received by ETF within 30 days of the following events, coverage becomes effective on the date of the following event:

- Marriage (survivors may not add spouses or stepchildren).
- Any of your eligible dependents involuntarily lose eligibility for other medical coverage or lose the employer contribution for the other coverage.
- An unmarried parent whose only eligible child becomes disabled and thus is again an eligible dependent. Coverage will be effective the date eligibility was regained.

If an application is received by ETF within 60 days of the following events, coverage becomes effective on the date of the following event:

- Birth or adoption of a child or placement for adoption (timely application prevents claim payment delays).
- Legal guardianship is granted.
- A single father declaring paternity. Children born outside of marriage become dependents of the father on the date of the court order declaring paternity, on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of the state of Wisconsin) or on the date of birth with a birth certificate listing the father's name. The effective date of coverage will be the birth date, if a statement of paternity is filed within 60 days of the birth. If filed more than 60 days after the birth, coverage will be effective on the first of the month following receipt of application.

If an application is received by ETF upon order of a federal court under a National Medical Support Notice, coverage will be effective on either:

- The first of the month following receipt of application by the employer; or
- The date specified on the Medical Support Notice.

Note: This can occur when a parent has been ordered to insure one or more children who are not currently covered.

33. What action do I need to take for the following personal events (marriage, birth, etc.)? What restrictions apply?

Note: You may view the Life Events Guide online at etf.wi.gov/insurance/life-events-guide or contact ETF for a copy. Family coverage must include all eligible dependents with the exception of adult child dependents (age 19 and older) who have other group health insurance coverage.

Marriage: You can change from individual to family coverage to include your spouse (and stepchildren if applicable) without restriction, provided your application is received within 30 days after your marriage, with family coverage being effective on the date of your marriage. This does not apply to survivors.

If you were enrolled in family coverage before your marriage, you need to complete an application as soon as possible to report your change in marital status, add your new spouse (and stepchildren) to the coverage, and if applicable, change your name. In most cases, coverage for the newly added dependent(s) will be effective as of the date of marriage.

Note: You may also change health plans when adding a dependent due to marriage. The subscriber will need to file an application within 30 days of the marriage with coverage effective with the new plan on the first day of the month on or following receipt of the application.

Birth/Adoption/Legal Guardianship/Dependent Becoming Eligible: If you already have family coverage, you need to submit a timely electronic or paper application to add the new dependent. Coverage is effective from the date of birth, adoption, when legal guardianship is granted, or when a dependent becomes eligible and otherwise satisfies the dependency requirements. Be prepared to submit documentation of guardianship, paternity, or other information. Go to the ETF website at etf.wi.gov to see the Life Change Events and Documentation Requirements.

If you have individual coverage, you can change to family coverage with your current health plan by submitting an application within 30 days of the date a dependent becomes eligible or within 60 days of birth, adoption or the date legal guardianship is granted.

Note: You may also change health plans if you, the subscriber, file an application within 30 days of a birth or adoption with coverage effective on the first day of the month on or following receipt of the application.

Single Mother or Father Establishing Paternity: A subscriber may cover their dependent child, effective with the child's birth or adoption, by submitting a timely electronic or paper application, changing from individual to family coverage.

Children born outside of marriage become dependents of the father on the date of the court order declaring paternity or on the date the "Voluntary Paternity Acknowledgment" (form DPH 5024) is filed with the Department of Health Services (or equivalent if the birth was outside the state 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 a statement of paternity is filed within 60 days of the birth. If more than 60 days after the birth, coverage is effective on the first of the month following receipt of the electronic or paper application.

A single mother may cover the child under her health plan effective with the birth by submitting an application changing from individual to family coverage.

Upon Order of a Federal Court Under a National Medical Support Notice: This can occur when a parent has been ordered to insure their eligible child(ren) who are not currently covered. You will need to submit an application to ETF with coverage becoming effective on either the first of the month following receipt of application by ETF, or the date specified on the National Medical Support Notice.

Divorce: Your ex-spouse (and stepchildren) can remain covered under your family plan only until the end of the month in which the marriage is terminated by divorce or annulment, or to the end of the month in which the *Continuation-Conversion Notice* (ET-2311) is provided to the divorced spouse, if family premium continued to be paid, whichever is later. (In Wisconsin, a legal separation is unlike divorce in that it does not affect coverage under LAHP.) Divorce is effective on the date of entry of judgement of divorce. This date is usually when the judge signs the divorce papers and the clerk of courts date stamps them.

You should notify ETF prior to the divorce hearing date and once the entry of judgment of divorce has occurred. You will need to contact the clerk of courts to learn the date of entry of judgment of divorce. If you fail to provide timely notice of divorce, you may be responsible for premiums or claims paid in error which covered your ineligible ex-spouse and stepchildren. Following divorce, your ex-spouse and stepchildren are eligible for COBRA/continuation coverage under a separate contract with the group plan for up to 36 additional months. Conversion coverage would then be available. You can keep your dependent children and adopted stepchildren on your family plan for as long as they are eligible (age, student status, etc.). (See Continuation of Health Coverage section for further information.)

You must file an application with ETF to change from family to individual coverage or to remove ineligible dependents from a family contract.

When both parties in the divorce are LAHP retirees, and each party is eligible for this health insurance in their own right and is insured under this program at the time of the divorce, each retains the right to continue this health insurance coverage, regardless of the divorce.

- The participant who is the subscriber of the

insurance coverage at the time of the divorce must submit an electronic or paper health application to remove the ex-spouse from their coverage and may also elect to change to individual coverage.

- The participant insured as a dependent under their ex-spouse's insurance must submit a health application to establish coverage in his or her own name. The ex-spouse must continue coverage with the same plan unless they move out of the service area (e.g., county). The electronic or paper application must be received by ETF within 30 days of the date of the divorce.
- Only one participant may cover any eligible dependent children (not former stepchildren) under a family contract. Coverage of the same dependents by both parents is not permitted.

Note for retirees: If you fail to enroll within 30 days of the date of divorce, you have no enrollment or continuation rights. You will not be able to re-enroll in this program.

Medicare Eligibility: Please refer to the Medicare information in this FAQ for details regarding Medicare eligibility and enrollment requirements.

Death & Surviving Dependents: If a LAHP retired employee with family coverage dies, the surviving insured dependents shall have the right to continue coverage for life under LAHP at group rates. The dependent children may continue coverage until eligibility ceases if they:

- Were enrolled at the time of death; or
- Were previously insured and regain eligibility; or
- Are a child of the employee and born after the death of the retiree.

Health insurance coverage will automatically continue for your covered surviving dependents. Continued coverage will be effective on the first of the month after your date of death. Surviving dependents may voluntarily terminate coverage by providing written notification to ETF and coverage will terminate on the last day of the month in which their written request is received by ETF.

If the surviving dependent(s) terminates coverage for any reason they may not re-enroll later.

Note: The survivors may not add persons to the policy who were not insured at the time of death.

If individual coverage was in force at the time of death, the monthly premiums collected for coverage months following the date of death will be refunded. No partial month's premium is refunded for the month of coverage in which the death occurred. Surviving dependents are not eligible for coverage.

34. I am a beneficiary (an insured survivor) who has remarried. Are my new spouse and stepchildren eligible for this program?

No. Eligibility is limited to the retired employee and their spouse or surviving spouse and their dependent children.

35. When can I change from family to individual coverage, or individual to family coverage?

If your premiums are deducted on a post-tax basis (for retirees), you may change from family to individual coverage at anytime. The change will be effective on the first day of the month on or following receipt of your paper application by ETF. Switching from family to individual coverage when you still have eligible dependents is deemed a voluntary cancellation of coverage for all covered dependents and is not considered a "qualifying event" for COBRA/ continuation coverage.

Changing from individual to family coverage is only allowed during the special enrollment period, or when you or an eligible dependent has a qualifying event that allows for family coverage. See Question 32: "If I do not change from individual to family coverage during the special enrollment period, will I have other opportunities to do so?"

36. If I'm covered by two health plans under a Medicare Some contract and me or my dependent newly gain Medicare, what happens to my coverage?

Family members who gain Medicare will automatically be enrolled in the Medicare plan in place for the Medicare individual(s) that is, either IYC Medicare Advantage or Medicare Plus. The effective date will be the same as the Medicare effective date. Make sure to let ETF know the Medicare dates by sending a copy of your Medicare card. For more information see the "Medicare Information" section.

Health Plan Information

37. When and how must I notify ETF of various changes?

All changes in coverage like those listed below are accomplished by completing an approved electronic or paper application within 30 days after the change occurs. Retirees should file with ETF. Failure to report changes on time may result in loss of benefits or delay payment of claims. (See Question 30: Which changes need to be reported?):

- Change in plan (for example, from Local Health Plan Medicare to IYC Medicare Advantage)
- Change in plan coverage (for example, from individual to family)
- Name change
- Change of address or telephone number

- Addition/deletion of a dependent to an existing family plan

Exception: If you change your primary care provider (PCP) or primary care clinic (PCC), you must contact your health plan for details.

38. How do I receive health care benefits and services?

You will receive identification cards from the health plan you select. You will receive separate identification cards from Navitus Health Solutions, the pharmacy benefit manager. If you lose these cards or need additional cards for other family members, you may request them directly from the health plan.

Health plans are not required to provide you with a certificate describing your benefits. ETF provides the Local Health Plan, Local Access Plan, Medicare Plus, and the Uniform Pharmacy Benefits Certificate of Coverage online. ETF also provides the IYC Medicare Advantage Evidence of Coverage online. You may also request a paper copy from ETF.

Present your identification card to the hospital, physician, or pharmacist who is providing the service. Identification numbers are necessary for any claim to be processed or service provided.

Most of the health plans require that non-emergency hospitalizations be prior authorized and contact be made if there is an emergency admission. Prior authorizations may be required for high-tech radiology (for example, MRI, PET, CT scans) and for low back surgeries. Check with your plan, and make sure you understand any requirements.

39. Will a Local Health Plan HMO (plans other than the Local Access Plan, IYC Medicare Advantage and Medicare Plus) cover dependent children who are living away from home?

Only if the HMO has providers in the community in which the child resides. Emergency or urgent care services are covered wherever they occur. However, non-emergency treatment must be received at a facility approved by the health plan. Outpatient mental health services and treatment of alcohol or drug abuse may be covered. Refer to the Certificate of Coverage online. Contact your health plan for more information.

40. How do I file claims?

Most of the services provided by health plans do not require filing of claim forms. However, you may be required to file claims for some items or services. All health plans require claims be filed within 12 months of the date of service or, if later, as soon as reasonably possible.

If you are enrolled in IYC Medicare Advantage, when you visit your provider, you must show your health plan's card. You do not need to show your Medicare card, but you should keep it in a safe place. Your provider will submit your claims directly to UHC.

41. How are my benefits coordinated with other health insurance coverage?

When you are covered under two or more group health insurance policies at the same time and both contain coordination of benefit provisions, insurance regulations require the primary carrier be determined by an established sequence. This means that the primary carrier will pay its full benefits first (such as Medicare); then the secondary carrier would consider the remaining expenses. (See the Coordination of Benefits Provision found in the Local Health Plan, Local Access Plan or Medicare Plus Certificate of Coverage online. The IYC Medicare Advantage Evidence of Coverage is also online.) Note that with coordination of benefits, the secondary carrier may not always cover all of your expenses that were not covered by the primary carrier.

42. If I meet my plan's out-of-pocket limit (OOPL), do I have to continue to pay copayments?

Once you reach your OOPL, you no longer have to pay most copayments. You will continue to pay copayments for certain level 3 and level 4 prescription drugs, and any other essential health benefit services that do not accumulate to the OOPL.

There is a federal maximum out-of-pocket (MOOP) of $9,450/$18,900 which is the maximum you will pay for essential health benefits. Please see your Certificate of Coverage for information on which services apply to the OOPL and MOOP.

43. If my family is covered by two health plans under a Medicare Some contract, how will medical out-of-pocket costs accumulate for the Medicare and non-Medicare individuals on different plans?

As it works for Medicare Some contracts now, medical claims paid for the Medicare members accumulate to the Medicare out-of-pocket costs while the non-Medicare claims accumulate to the non-Medicare out-of-pocket costs.

For example, a Medicare individual could pay $500 for durable medical equipment and have the rest of their medical claims paid at 100%, while the non-Medicare individual could pay claims up to the annual out-of-pocket limit (OOPL) for their IYC Health Plan design. Navitus claims will accumulate to one family out-of-pocket for all individuals. For more information, see the "Medicare Information" section.

Provider Information

44. Does a Local Health Plan HMO cover care from physicians who are not affiliated with the health plan?

Most Local Health Plans will pay nothing when non-emergency treatment is provided by physicians outside of the plan unless there is an authorized referral or prior authorization. Contact the health plans directly regarding their policies.

For emergency or urgent care, plans are required to pay for care received outside of the network, but it may be subject to usual and customary charges. This means the plan may not pay the entire bill and try to negotiate lower fees. However, ultimately the plan must hold you harmless from collection efforts by the provider. (See the definition of Emergency Care in the Certificate of Coverage online.)

45. How do I choose a primary care provider (PCP), primary care clinic (PCC) or pharmacy that is right for me?

Check your health plan's or Navitus's website for helpful information on selecting a provider. You can also call and inquire. If you do not select a medical PCP or PCC, the health plan will select one for you and notify you.

If you're not sure a provider holds the same beliefs as you do, call the clinic or pharmacy and ask about your concerns. For example, you may want to ask about the provider's opinion about dispensing a prescription for oral contraceptives.

46. How do I know which providers are in-network?

You may contact any health plan directly to receive a printed copy of their provider directory. ETF does not maintain a current list of this information.

47. Can I change my primary care provider (PCP) or primary care clinic (PCC)?

Contact your health plan to find out their requirements to make this change and when your change will become effective.

48. If my PCP or other health care professional is listed with a Local Health Plan, can I continue seeing him or her if I newly enroll in that Local Health Plan?

If you want to continue seeing a particular physician (or psychologist, dentist, optometrist, etc.), contact that physician to see if they will be available to you under the Local Health Plan you are considering enrolling in. Confirm this with the plan's provider directory. Even though your current physician may join an Local Health Plan, they may not be available as your PCP just because you join that Local Health Plan.

49. What happens if my provider leaves the plan midyear?

If you are enrolled in a Local Health Plan HMO, you will need to find an in-network provider for your care unless you are a participant who is in her second or third trimester of pregnancy. Then you may continue to have access to your provider until the completion of postpartum care for yourself and the infant. If you are enrolled in a Preferred Provider Organization (PPO) such as the Local Access Plan and you continue to see this provider, your claims will be paid at the out-of-network benefit level.

If a provider contract terminates during the year (excluding normal attrition or formal disciplinary action), and you are a participant in your second or third trimester of pregnancy, the plan is required to pay charges for covered services from these providers on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the member is held harmless.

Health plans will individually notify members of terminating providers (prior to the special enrollment period) and will allow them an opportunity to select another provider within the plan's network. Your provider leaving the plan does not give you an opportunity to change plans midyear.

50. What if I need medical care that my primary care provider (PCP) or primary care clinic (PCC) cannot provide?

All participants must designate a PCP or PCC. Your primary PCP or PCC is responsible for managing your health care. Under most circumstances, they may refer you to other medical specialists within the health plan's provider network as they feel is appropriate. However, referrals outside of the network are strictly regulated for most health plans. Check with your health plan for their referral or prior authorization requirements.

Premium contribution

51. How often will premium rates change?

All group premium rates change at the same time: January 1 of each year. The monthly cost of all health plans will be announced during the annual special enrollment period.

52. How will I be billed for premiums under LAHP?

As long as you are receiving a monthly annuity that is large enough to cover the cost of the health insurance premiums, your premiums will be deducted from your annuity. If your annuity is too small to cover the cost of the insurance premiums, you will be billed directly by the health plan.

Deductible/Copayment/Coinsurance/ Out-of-Pocket Limit

53. What are preventive services?

Preventive services are routine health care that includes check-ups, patient counseling and screenings to prevent illness, disease and other health-related problems. Federal law requires that specific preventive services performed by in-network providers be offered at no cost to you. You may contact ETF for a list of these preventive services.

54. What is a copayment?

A copayment is a fixed amount you pay, for example for prescription drugs, usually due at the time you receive the service. Members will also have copayments that apply to certain covered health care services.

55. What is coinsurance?

Coinsurance is your share of the costs of certain covered health care services or prescription drugs, calculated as a percent of the amount for the service or cost of the drug.

Non-Medicare member example: If a diagnostic test costs $100 and you have met your deductible, your coinsurance payment of 10% would be $10 (10% of $100). The health plan pays the rest of the cost ($90).

56. What is an out-of-pocket Limit (OOPL) and maximum out-of-pocket (MOOP) limit?

An out-of-pocket limit (OOPL) is a plan provision that limits a member's cost sharing. The OOPL is the maximum amount that a member will pay for in-network, covered services during a plan year (same as calendar year).

LAHP has OOPLs in place that apply to certain medical and prescription drug out-of-pocket costs. The federal government also enforces Maximum Out-of-Pocket (MOOP) limits that are much higher than the OOPLs of LAHP. For any essential health benefit costs that do not stop at the program OOPL, the federal MOOP limits provide a safety net that does not allow you to incur any out-of-pocket expenses more than $9,450 individual or $18,900 family.

Note: For the group health insurance program, this typically applies to Level 3 and Level 4 non-preferred prescription drugs.

Pharmacy Benefit Manager (PBM)

57. What is a PBM?

A PBM is a third-party administrator of a prescription drug program that is primarily responsible for processing and paying prescription drug claims. In addition, it typically negotiates discounts and rebates with drug manufacturers, contracts with pharmacies and develops and maintains the drug formulary.

A PBM also provides programs designed to help members maintain or improve their overall health by working closely with the member and their doctor to ensure the drugs members take are safe and effective.

Navitus Health Solutions is the PBM for LAHP.

58. What is a formulary? How is it developed? How will I know if my prescription drug is on it?

A formulary is a list of prescription drugs that are determined to be both medically effective and cost-effective by a committee of physicians and pharmacists.

Drugs are evaluated by the committee based on their effectiveness, side effects, drug interactions and then cost. Drugs are reviewed on a continuous basis to make sure the formulary is kept up-to-date and that patient needs are being met.

The Navitus MedicareRx plan (Medicare Part D) formulary is established by the Centers for Medicare & Medicaid Services (CMS), a federal agency within the United States Department of Health and Human Services.

You can access the Navitus MedicareRx plan formulary on Navitus's public facing website (https://etf.benefits.navitus.com) (no login required), through the "Members" section on the Navitus MedicareRx web site, https://medicarerx.navitus.com or call the Navitus MedicareRx team at 1-866-270-3877.

59. How does my four-tier drug benefit work?

Your drug benefit has four different tiers, Levels 1 through 4. Drugs are divided between those tiers and you will pay different amounts for a drug based on its tier. The lower the tier, the less you pay.

Your plan encourages you to use preferred formulary drugs by having a lower copayment or coinsurance for Level 1 and Level 2 drugs. Drugs listed at Level 3 have a coinsurance and are considered non-preferred drugs. These drugs are still covered, but will cost you more money. Level 4 drugs are specialty drugs, and have the largest amount of cost-sharing.

Copayments and coinsurance for Level 1 and Level 2 drugs count toward your annual Level 1/Level 2 out-of-pocket limit (OOPL). Coinsurance for Level 3 and Level 4 drugs do not count toward the OOPL; they only count toward the federal maximum out-of-pocket limit (MOOP).

For non-Medicare members: Level 4 drugs must be filled through either Lumicera Specialty Pharmacy or UW Specialty Pharmacy. With the exception of certain limited distribution drugs, specialty drugs will not be covered at other pharmacies.

For Medicare members: You may use Lumicera Specialty Pharmacy or UW Health Specialty Pharmacy,

or you may use a different specialty pharmacy. If you use Lumicera or UW Specialty, your costs will be lower, and will apply to your annual OOPL for specialty drugs.

Please note that some drugs are not covered on the same level on the non-Medicare formularies and the MedicareRx plan formulary. Some drugs may require prior authorization or quantity limits on the MedicareRX plan formulary. Please check with your provider or contact Navitus to learn more.

60. How does the prescription drug benefit work for specialty medications?

For non-Medicare members, preferred specialty prescription drugs are classified as Level 4 drugs when they are filled through Lumicera or UW Specialty pharmacies. These drugs have a $50 copayment each time you fill the prescription, and will count torwards your MOOP. Getting your drugs through Lumicera or UW Specialty will also give you access to programs that can help you manage your medications. Call Navitus at at 1-844-268-9789 for more details.

Specialty drugs that are non-preferred, or specialty drugs filled outside of Lumicera or UW Specialty, will not be covered.

For Medicare members, specialty drugs are classified as Level 4 drugs. If you fill your prescriptions for preferred specialty drugs at Lumicera or UW Specialty, you will have a $50 copayment each time you fill the prescription, and that copayment counts toward your Level 4 OOPL.

If you receive a non-preferred drug, or fill your prescription at a network pharmacy other than Lumicera or UW Specialty, you will have a non-preferred coinsurance of 40% (up to a maximum of $200), and that coinsurance will not count towards the Level 4 OOPL, only the federal MOOP. Call Navitus at 1-866-270-3877 for more details.

61. Will I have to use a different ID card when I go to the pharmacy?

Yes. You will have two identification cards: one from your health plan and one from either (a) Navitus Health Solutions or (b) the Navitus MedicareRx (PDP) plan (for eligible retirees enrolled in Medicare) for pharmacy benefits. When filling prescriptions, you must present your Navitus pharmacy benefits ID card to the pharmacist.

62. What will my prescription drugs cost?

The cost of prescription drugs can change frequently, sometimes even month-to-month. Navitus has a tool on their website that will tell you how much your drugs will cost at the specific pharmacy you go to.

Go to https://members.navitus.com and set up an account for the Navitus Portal. Then click on Cost Compare to check the price of your drugs.

You can also view the most up-to-date formulary at Navitus's ETF Benefit website. No need to log in, just select your health insurance plan and view the formulary. The formulary lists every drug that is covered by your pharmacy benefit and which tier the drug is on.

63. Why did I get a generic drug instead of a brand name drug?

To provide you with the best value, the uniform pharmacy benefits requires that higher cost brand name drugs be replaced by lower cost generic equivalent or alternative drugs that have been proven to work like the brand name drug. In most cases the brand name drug will not be a preferred drug on the formulary. If you cannot take the generic drug for medical reasons, your doctor will have to request an exception to coverage from Navitus.

Some doctors write prescriptions as "DAW-1," or "dispense as written." This means the pharmacist will fill the brand name drug as written on the prescription and will not substitute an available generic equivalent. You will pay more for "DAW-1" brand name Level 3 drugs unless you cannot take the generic equivalent drug due to a medical need. If you have a medical need, your doctor must submit an FDA MedWatch form for the prescription. Your doctor can contact Navitus for the form. Without the form, you will pay the 40% coinsurance plus the cost difference between the brand name drug and its generic equivalent. With the form, you will pay a 40% coinsurance (with a limit of $150).

You can find examples of Level 3 cost sharing on drugs at etf.wi.gov/files/level-3-cost-sharing-handoutpdf.

Medicare Information

If you are eligible for Medicare, you must be enrolled in the hospital (Part A) and medical (Part B) portions of Medicare at the time of your retirement. If you are not enrolled for all available portions of Medicare (A and B) upon retirement, you will be liable for the portion of your claims that Medicare would have paid beginning on the date Medicare coverage would have become effective.

For all health plans, prescription drugs will continue to be covered through Navitus, the Pharmacy Benefit Manager (PBM). This is your Part D plan.

Because all health plans that participate in LAHP have coverage options that are coordinated with Medicare, you will remain covered by the health plan you have selected even after you enroll in Medicare. Premium rates will be lower if you or a dependent are eligible for Medicare. Medical coverage under the Local Health Plans (health plans that offer Uniform Benefits) does

not change. The IYC Medicare Advantage plan also offers Uniform Benefits. However, if enrolled in the Local Access Plan or SMP, your coverage will change to Medicare Plus, a Medicare supplement, when you enroll in Medicare Parts A and B. Health plan coverage does not duplicate benefits paid by Medicare.

For information about Medicare benefits, eligibility and how to enroll, contact your local Social Security Administration office or call 1-800-772-1213. In addition, the State Health Insurance Assistance Program (SHIP) has counselors in every state and several territories who are available to provide free one-on-one help with your Medicare questions or problems. The Wisconsin SHIP can be reached at 1-800-242-1060. Additional information and assistance can be found at www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm.

64. What do I need to do when my spouse or I become eligible for Medicare?

Important: When you receive your Medicare card, please send a photocopy to ETF immediately or your Medicare coordinated coverage may be delayed. Contact ETF for more information.

At the time of your retirement, you and your dependents who are eligible for Medicare must enroll for the Part A (hospital) portion and Part B (medical) portion of Medicare. When you and/or your dependents are eligible for Medicare Parts A and B, your group health insurance coverage will be integrated with Medicare and the monthly premium will be reduced.

In general, enrollment in Medicare Part D (prescription drug coverage) is voluntary; however, you may pay a penalty if you do not enroll when you are first eligible or are not covered by what Medicare considers creditable coverage. Regardless, Medicare Part D coverage is provided by LAHP 's PBM, Navitus. Additional information about all parts of Medicare can be found in the following questions and answers.

Also see Question 17: "Can I change health plans, cancel my insurance or change coverage levels when I or my dependent have a Medicare coverage change?"

65. When must I apply for Medicare?

Medicare Part A: Most people become eligible for Medicare upon reaching age 65. Individuals who have been determined to be disabled by the Social Security Administration (SSA), become eligible after a 24-month waiting period.

If you or your spouse are actively working when you become eligible, you may want to consider enrolling in Medicare Part A, as it may cover hospital services if your health plan denies them. There is no premium for Medicare Part A.

Medicare Part B: The requirement to enroll in Medicare Part B coverage is deferred for active employees and their dependents until termination of employment, through which active employee health insurance coverage is provided.

If you have terminated employment, or are a surviving dependent and are eligible for coverage under Medicare, you must immediately enroll in both Part A and Part B of Medicare unless you are otherwise employed and have health insurance coverage through that employment. ***If you do not enroll for all available portions of Medicare upon retirement, you will be liable for the portions of your claims that Medicare would have paid beginning on the date Medicare coverage would have become effective.***

If you or your insured spouse are employed, enrollment in Medicare may be deferred until retirement from that job.

For subscribers and their dependents with End Stage Renal Disease (ESRD): You will want to contact your local Social Security office, health plan, provider and Medicare to make sure you enroll in Medicare Part A and Part B at the appropriate time. You will want to decide if it would be beneficial to enroll in Part B during your initial or general enrollment opportunities to avoid later delayed Medicare enrollment and potential premium penalties after your 30-month coordination period ends.

Medicare Part D: U.S. resident retired members and their spouses and/or dependents who are Medicare enrolled and who participate in LAHP will automatically be enrolled in the Navitus MedicareRx (PDP) plan, which is underwritten by Dean Health Insurance Inc., a federally-qualified Medicare contracting prescription drug plan. The prescription drug coverage under this program is Medicare Part D coverage that includes all 50 states and Puerto Rico. The services area excludes most U.S. Territories, such as the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. It is not available outside of this service area. Your monthly health insurance premium includes a portion that applies to this program's coverage.

Before Navitus can report your enrollment in Medicare Part D to Medicare, they need to have your Medicare Beneficiary Identifier (MBI) number and Parts A and B effective dates. In most cases, ETF will request this information from you two to three months in advance of your 65th birthday by sending you a *Medicare Eligibility Statement* (ET-4307). ETF will then provide the information to Navitus. Please complete and return this form as soon as possible to ensure you receive the benefits you are eligible for and your claims are paid properly.

If you do not receive the *Medicare Eligibility Statement* (ET-4307) at least one month before your 65th birthday please contact ETF. The form is also available online.

If you are retired and cover a Medicare-eligible spouse or disabled dependent on your health plan, please notify ETF and provide your dependent's Medicare information.

Individuals may choose to enroll in another Medicare Part D prescription drug plan; however, it is not recommended or required for your continued coverage under LAHP.

If you choose to enroll in a different Medicare Part D plan, your health insurance premium for LAHP does not change, but your supplemental, wrap-around pharmacy coverage will be secondary to the other Medicare Part D plan. For more information, see Question 74: "Does Medicare Part D affect my prescription drug coverage? Should I enroll?" and Question 76: "Will my health insurance premium go down if I enroll in a different Medicare Part D prescription drug plan?"

66. If Medicare coverage is in effect, how do I file Medical, Part B and Pharmacy claims?

If Medicare is the primary insurance, your provider must submit claims to Medicare first. Once Medicare processes the claim(s), Medicare will send you a quarterly Medicare Summary Notice (MSN).

Health Plan Medicare (health plans that offer Uniform Benefits for medical coverage): Many of the health plans have an automated procedure after Medicare processes the claim, where the provider then submits it to the health plan for processing. However, some health plans require members to submit a copy of the MSN and, in certain circumstances, a copy of the provider's bill. You should discuss with your provider if they will bill Medicare and your health plan on your behalf. Contact your health plan for additional information.

Medicare Plus: Your responsibilities in the claims process will depend on the policies and practices of the medical facility from which you receive care. You may be required to submit the claims to Medicare and then submit the proper forms to UHC for supplemental payments. Refer to the Medicare Plus Certificate of Coverage available online or contact ETF for more information, and contact your health care provider or facility regarding their particular Medicare claims procedures. Care is allowable worldwide. For services outside of the U.S. you will have to pay the provider, then have the claim(s) translated into English and converted into U.S. currency. Then submit them to UHC.

IYC Medicare Advantage: Allows members to use any health care provider in the United States or U.S. territories and is offered by UHC. The benefits are the same in- or out-of-network. When you visit your provider, you must show your health plan's card. Your provider will typically submit your claims directly to UHC. To request reimbursement for a covered service charge that you paid, get a Direct Member Reimbursement form from UHC and send it and your receipt (noting on it your name and your member ID) with a copy of your card to the address on the back of that card.

You must be enrolled in Medicare Parts A and B to be eligible for the IYC Medicare Advantage plan. You should keep your Medicare card in a safe place, but you should not show it when you receive health care services, as the the IYC Medicare Advantage plan will be primary for your service. See Question 67: "If I have Medicare as my primary coverage, how are my benefits coordinated?"

Pharmacy Benefit Manager: As long as you maintain the Navitus MedicareRx (PDP) plan as your Medicare Part D PDP, Navitus will process your claims for both Part D and the supplemental wrap coverage that is included.

However, if you choose to enroll in a Medicare Part D plan other than the Navitus MedicareRx (PDP) plan, your supplemental wrap coverage, which is part of LAHP's pharmacy benefits, will be considered secondary. You should be prepared to file the secondary claims manually through Navitus. Contact Navitus for more information on filing manual claims. Refer to the Medicare Part D Information section of the FAQs for more details.

Medicare Part B pharmacy claims are covered under the supplemental wrap benefit. For specific information on Medicare Part B pharmacy coverage and Part B claims processing, see the plan description page for Navitus™ Health Solutions.

67. If I have Medicare as my primary coverage, how are my benefits coordinated?

Since all health plans have coverage options that are coordinated with Medicare, you will remain covered by the health plan you selected after you are enrolled in Medicare, even though Medicare is the primary payor of your claims.

Exceptions:

1. If you are enrolled in IYC Medicare Advantage, UHC will pay your claims.
2. If you are enrolled in the Local Access Plan or SMP, your coverage will be changed to Medicare Plus.

   There are some differences in benefits between these health plans. Medicare Plus is designed to supplement the benefits you receive under

Medicare. For purposes of paying benefits, Medicare is the primary plan and Medicare Plus is the secondary plan. This means Medicare benefits apply first and then the Medicare Plus plan reviews the claims to determine if there is anything else that is payable.

3. If you are enrolled in one of the Local Health Plans Medicare, your health coverage will remain substantially the same as before Medicare coverage became effective. For purposes of paying benefits, Medicare is the primary plan and LAHP is the secondary plan. This means Medicare benefits apply first and then the health plan reviews the claims to determine if there is anything else that is payable. Because of this coordination with Medicare benefits, your monthly premiums for your LAHP will be less.

Note: For some benefits under the Health Plan Medicare and IYC Medicare Advantage, such as durable medical equipment, Medicare Part B and the health plan both have a 20% coinsurance that you are responsible to pay.

68. What is the Social Security income-related monthly adjusted amount (IRMAA) and does it affect me?

If you are enrolled in Medicare and your modified adjusted gross income exceeds certain limits established by federal law, you may be required to pay an adjustment to your monthly Medicare Part B (medical) and Medicare Part D (prescription drug, i.e. Navitus MedicareRx (PDP) plan) coverage premiums. The additional premium amount you will pay for Medicare Part B and Medicare prescription drug coverage is called the income-related monthly adjustment amount or IRMAA. Since Medicare beneficiaries enrolled in LAHP are required to have Medicare Parts A, B and D, the IRMAA may impact you if you have higher income.

To determine if you will pay the additional premiums, Social Security uses the most recent federal tax return that the IRS provides and reviews your modified adjusted gross income. Your modified adjusted gross income is the total of your adjusted gross income and tax-exempt interest income.

Social Security notifies you in November about any additional premium amounts that will be due for coverage in the next year because of the IRMAA. You must pay the additional premium amount, which will be deducted from your Social Security check if it's large enough. Failure to pay may result in Medicare terminating your coverage. The IRMAA is paid to Social Security, not the Local Annuitant Health Program. It is not included in your LAHP premium.

Additional information can be found in SSA information at https://secure.ssa.gov/poms.nsf/lnx/0601101031 or by calling the Social Security Administration toll-free at 1-800-772-1213.

IYC Medicare Advantage

69. Who is eligible for the It's Your Choice (IYC) Medicare Advantage Plan and which vendor administers it?

Individuals who are enrolled in both Medicare Part A and Part B and are insured under a retiree contract are eligible to enroll in IYC Medicare Advantage.

The Group Insurance Board selected UHC to administer the IYC Medicare Advantage plan under LAHP.

70. What is the difference between the IYC Medicare Advantage plan and an individual Medicare Advantage plan (that I can get somewhere else on my own)?

The IYC Medicare Advantage Plan is a group insurance plan; most plans that are advertised on TV or in magazines are individual plans. Group insurance plans are purchased by an organization on behalf of a group. Individual plans are purchased by individuals for themselves or their family, either through an insurance company or a broker.

With a group Medicare Advantage plan, the state can negotiate plan enhancements that are not available with individual Medicare Advantage plans. The IYC Medicare Advantage plan provides Uniform Benefits, set by the Group Insurance Board each year. The prescription drug benefits will continue to be offered through Navitus.

71. How is the IYC Medicare Advantage plan different from the other options offered through the Group Health Insurance Program?

The IYC Medicare Advantage plan covers the same uniform set of benefits as most of the other Medicare-coordinated plans ETF offers. However, UHC offers some specialized services such as optional in-home preventive visits and Renew Active, a gym membership program.

IYC Medicare Advantage allows you to see any doctor nationwide who accepts Medicare and is willing to treat you and bill UHC.

72. If I choose the IYC Medicare Advantage plan, can I choose one of the other plan options in subsequent years?

As long as you are enrolled in LAHP, you have an opportunity to change plans each fall during the special enrollment period.

Note that Medicare permits a 12 month Medicare Advantage trial period. If you are enrolled in a Medicare Advantage plan for more than 12 months in your lifetime, once you leave LAHP, you will likely be limited to enrollment in a Medicare Advantage plan. If you

want to enroll in a Medigap or Medicare Supplement plan after your 12 month trial period, you may need to submit to medical underwriting and learn if your new plan accepts you.

Medicare Part D Information

73. Which Medicare Part D prescription drug coverage is provided under LAHP?

Medicare related prescription drug coverage will be provided by Navitus Health Solutions (Navitus) through a self-funded, Medicare Part D Employer Group Waiver Plan (EGWP) called the Navitus MedicareRx (PDP) plan. This plan is underwritten by Dean Health Insurance Inc. a federally-qualified Medicare contracting prescription drug plan. This affects Medicare-eligible participants covered under a retiree contract enrolled in LAHP. As required by Uniform Pharmacy Benefits and Medicare Plus, a supplemental wrap benefit is also included to mainly provide full coverage to LAHP members when Medicare Part D coverage does not during the Medicare Part D Deductible Phase or Coverage Gap Phase.

Your group health insurance premium already includes the cost of this benefit. There is no separate premium that needs to be paid for this Medicare Part D coverage. It is important that you read and understand the information presented on the Navitus MedicareRx plan description page. It is available online at https://medicarerx.navitus.com/ or on paper by calling Navitus.

74. Does Medicare Part D affect my prescription drug coverage? Should I enroll?

A Medicare Part D prescription drug plan (PDP) provides primary coverage of prescription benefits through Medicare. While enrollment in a PDP is voluntary, if you do not enroll when you are first eligible and do not have what Medicare considers creditable coverage, you may have to pay a penalty in the form of a higher PDP premium once you do enroll.

Under LAHP, after you become eligible for Medicare Part D, the following will happen:

1. You will be automatically enrolled in the Navitus MedicareRx (PDP) plan. Medicare-eligible spouses and/or dependents will also be enrolled. This is Medicare Part D coverage. Your group health insurance premium already includes the costs of this Medicare Part D coverage.
2. You will also be automatically enrolled for supplemental wrap coverage to ensure your prescription drugs are covered when Medicare Part D coverage does not during the Medicare Part D Deductible Phase or Coverage Gap Phase. Your health insurance premium already includes the cost of this supplemental wrap coverage.

When you are enrolled in the Navitus MedicareRx (PDP) *plan, you will be issued a new ID card that you will be required to use.*

75. What should I do if I have LAHP and a separate Medicare Part D plan?

You may want to cancel your other Part D program to avoid double coverage with your Navitus Part D plan. If you intend to keep that other Part D plan as well, notify ETF immediately.

76. Will my health insurance premium go down if I enroll in a different Medicare Part D prescription drug plan?

No. Your health insurance premium includes both medical and prescription drug coverage. If you choose to enroll in a different Medicare Part D plan, you will be dropped from the Navitus MedicareRx (PDP) plan and you will have to pay an additional premium to the other plan you enroll in. However, you will still have secondary coverage with the supplemental wrap benefits under LAHP. There is no partial refund of the LAHP premium if you choose to enroll in a different PDP. Navitus will coordinate coverage with Medicare and pay secondary claims after Medicare processes your prescription claims from the other Medicare Part D plan, minus the applicable copayments and coinsurance that are your responsibility. If you enroll in another Medicare Part D plan and you intend to stay in that program, notify ETF immediately. If ETF enrolls you in Navitus MedicareRx, you will be automatically disenrolled from your other plan by CMS.

Wellness

77. What is the Well Wisconsin Program?

The Well Wisconsin Program is available to eligible retirees and their spouses enrolled in the group health insurance program. It provides services and resources through WebMD and rewards participants with a $150 incentive after completion of the WebMD health assessment, health check, and a well-being activity. Members enrolled in IYC Medicare Advantage are not eligible for the $150 incentive, as UHC offers other financial incentives.

78. Who is WebMD and how do I earn the incentive?

WebMD manages all aspects of the Well Wisconsin Program. You can complete the Well Wisconsin Program activities using the secure WebMD wellness portal or by contacting WebMD. WebMD will issue the $150 incentive if eligible members complete the program activities by the wellness program year deadline. Visit webmdhealth.com/wellwisconsin or call 1-800-821-6591 to learn more.

79. Is the information I provide to WebMD confidential?

Yes. All of the information you provide to WebMD will

be kept strictly confidential as required by federal law. Only aggregate de-identified information will be shared with the group health insurance program or large employer groups. See the Equal Employment Opportunity Commission (EEOC) Notice Regarding Wellness Program and the WebMD privacy statement for more information.

80. Do any health plans offer additional wellness services?

The IYC Medicare Advantage plan offers different incentives and gym memberships through Renew Active. Medicare Plus also offers gym memberships through Renew Active. Contact UHC for more information.

81. Are wellness incentives taxable?

Yes, the Internal Revenue Service considers all incentives issued to you or your enrolled family members to be a fringe benefit of employment. Incentive payment information from WebMD and UHC will be provided to ETF to be reported as taxable income. No personal health information is shared with ETF, only the incentive payment amount. Retirees will see taxes removed from their Well Wisconsin prepaid card amount and will receive a W-2 from the WRS for incentive payments made by either WebMD or UHC.

82. Where can I find more information about the Well Wisconsin Program and WebMD?

Visit etf.wi.gov/well-wisconsin-members for additional FAQs about the Well Wisconsin Program and WebMD resources.

Changing Health Plans

83. Can I change from one plan to another during the year?

Yes, but only if you, the subscriber, file an electronic or paper application within 30 days for the following events with coverage effective on the first day of the month on or following receipt of the application:

- Move from your plan's service area (for example, out of the county) for a period of at least three months. Your new coverage will be effective subsequent to your move. You may again change plans when you return for three months by submitting another application within 30 days after your return. (See Question 85: "What if I have a temporary or permanent move from the service area?")
- You add one or more dependents due to marriage (except for survivors), birth, adoption or placement for adoption.

Note: If your premiums are being deducted post-tax, you may cancel coverage at anytime. You will not be able to re-enroll in LAHP. You may request the Life Event Guide from ETF for more information.

Otherwise, you can only change health plans without restriction during each special enrollment period and coverage will be effective the following January 1.

84. If I change plans, what happens to any out-of-pocket maximums that may apply to services I've received?

When you change plans for any reason (for example, during the special enrollment period or for a move from a health plan's service area), any annual health insurance out-of-pocket maximums under Uniform Benefits (such as durable medical equipment) will start over at $0 with your new plan, even if you change plans mid-year, with the exception of the prescription annual out-of-pocket maximum.

85. What if I have a temporary or permanent move from the service area?

A subscriber who moves out of a service area (for example, out of the county), either permanently or temporarily for three months or more, will be permitted to enroll in the IYC Medicare Advantage, Medicare Plus, Local Access Plan or an available Local Health Plan that offers in-network providers near you, provided an application for such plan is submitted within 30 days after relocation. You will be required to document the fact that your application is being submitted due to a change of residence out of a service area.

If your relocation is temporary but for longer than three months, you may again change plans by submitting an application within 30 days after your return.

It is important that you submit your application to change coverage as soon as possible and no later than 30 days after the change of residence to maintain coverage for non-emergency services. The change in plans will be effective on the first day of the month after ETF receives your application. File your application within the 30-days before or after your move. See Question 16: "Are there other enrollment opportunities available to me after my initial one expires?"

If your relocation is for three months or more, you may again change plans by submitting an application within 30 days after your return. The change will be effective on the first of the month on or after your application is received by ETF, but not prior to your return.

86. What if I change plans but am hospitalized before the date the new coverage becomes effective and am confined as an inpatient on the date the change occurs (such as January 1)?

If you are confined as an inpatient (in a hospital, a skilled nursing facility or, in some cases, an Alcohol and Other Drug Abuse (AODA) residential center) or require

24-hour home care on the effective date of coverage with the new plan, you will begin to receive benefits from your new plan unless the facility you are confined in is not in your new plan's network. If you are confined in such a facility, your claims will continue to be processed by your prior plan as provided by contract until that confinement ends and you are discharged from the non-network hospital or other facility, or 12 months have passed. If you are transferred or discharged to another facility for continued treatment of the same or related condition, it is considered one confinement.

In all other instances, the new plan assumes liability immediately on the effective date of your coverage, such as January 1.

87. What if I have an adult child who is disabled and I am changing health plans during It's Your Choice enrollment?

Each health plan has the responsibility to determine whether or not a newly enrolled disabled dependent continues to meet the contractual definition of disabled dependent. (See the Dependent Eligibility Information section of this FAQ.)

Cancellation or Termination of Health Coverage

88. How do I cancel coverage? How might this impact me if I later want to re-enroll?

If you are a retiree, you may cancel at anytime, however, once your coverage is canceled, neither you nor your surviving dependents may re-enroll in this program. Contact ETF for more information. You must provide written, signed notification of cancellation to ETF.

If your adult dependent child (age 19 and older) becomes eligible for and enrolled in other group health insurance coverage, and you want to drop coverage for him/her, you must submit an application to ETF within 30 days of the effective date of other coverage. In addition, you must submit proof of enrollment such as an ID card from that coverage. If this is your last dependent and you want to change to individual coverage, you must note that on your application.

If your spouse becomes eligible for and enrolled in other group health insurance coverage and you want to change to individual coverage or cancel your family coverage, you must submit an application to ETF within 30 days of the effective date of other coverage. In addition, you must submit proof of enrollment such as an ID card that lists all individuals covered under that plan. (Retirees, please see the first paragraph in this Frequently Asked Question section for important information.)

Be aware that voluntary cancellation of coverage does not provide an opportunity to continue coverage for previously covered dependents. Cancellation affects both medical and prescription drug coverage.

No refunds are made for premiums paid in advance unless ETF receives your written, signed request on or before the last day of the month preceding the month for which you request the refund. Under no circumstances are partial month's premiums refunded. Once coverage terminates, you will be responsible for any claims inadvertently paid beyond your coverage effective dates.

89. When can my health insurance coverage be terminated?

Your coverage can only be terminated because:

- Premiums are not paid by the due date.
- Coverage is voluntarily canceled.
- Eligibility for coverage ceases (for example, a child loses coverage the end of the month in which they turn age 26).
- Death of the subscriber.
- Fraud is committed in obtaining benefits or there is an inability to establish a physician/patient relationship. Termination of coverage for this second reason requires Group Insurance Board approval.

Retirees only: Your coverage can be terminated because you:

- IYC Medicare Advantage enrollees only: You dropped Medicare Part B. Your coverage will change to Medicare Plus. You may also change health plans. (See Question 17.)
- Became ineligible for coverage as a retiree because of becoming an active WRS employee. (See Question 23.)

Contact ETF for the date coverage will end.

Continuation of Health Coverage

90. Who is eligible for continuation?

Your COBRA continuation rights are described in the Federal/State Notifications online. Both you and your dependents should take the time to read that section carefully. This section provides additional information about continuation coverage.

You do not have to provide evidence of insurability to enroll in continuation coverage. However, coverage is limited to the plan you had as an eligible retiree or covered dependent. (For example, if you change plans January 1 and your dependent loses eligibility December 31, that dependent would be eligible for COBRA from the plan you were enrolled in on December 31. An exception is made when the participant resides in a county that does not include a primary care physician for the subscriber's plan

at the time continuation is elected. In that case, the participant may elect a different plan that is offered in the county where the participant resides.) You may select another plan during the special enrollment period or if you move from the service area. If family coverage is in effect when continuation is first offered, each dependent may independently elect individual continuation coverage. A family of two may select two individual contracts at a lower cost than the premium for a family contract. The health plan will bill you directly.

There can be no lapse in coverage, so multiple premiums may be required.

A second qualifying event while on continuation will not serve to extend your period of continuation. Coverage will be limited to the original time period. The only exception is if you are found to be disabled by the Social Security Administration (SSA). Then, you may be able to extend your coverage from 18 up to 29 months. You must notify ETF within 60 days of the date SSA issues their decision. At the end of the continuation period you will be allowed to enroll in a Marketplace or an individual conversion plan through the health plan.

91. When my dependent loses eligibility, are they eligible for COBRA? What do I need to do to ensure COBRA coverage is offered?

You need to report this change to ETF within 60 days of the dependent losing their eligibility to ensure COBRA coverage is offered. Your dependent will be entitled to 36 months of continuation coverage.

92. Does my coverage change under continuation?

No, continuation coverage is identical to LAHP. Events such as death of retiree, divorce or the loss of eligibility for a dependent child entitles the dependent to 36 months of coverage. You are allowed to change plans during the annual special enrollment period or if the subscriber moves from the service area. However, your continuation coverage may be cut short for any of the following reasons:

- The premium for your continuation coverage is not paid when due.
- You or a covered family member become covered under another group health plan that does not have a preexisting conditions clause that applies to you or your covered family member.
- You were divorced from an insured retiree, and you subsequently remarry and are insured through your new spouse's group health plan.
- You or a covered family member become entitled to Medicare benefits.

If you or your covered dependent becomes eligible for Medicare, you may need to enroll in Medicare as soon as you are eligible. (See Question 65: "When Must I Apply for Medicare?")

93. Will my premium change under continuation?

It may change annually on January 1.

94. How do I cancel continuation coverage?

To cancel continuation coverage, send a signed, written notice to ETF. Include your name, Social Security number, birth date and address. ETF will forward your request to the health plan. Your coverage will be canceled at the end of the month in which ETF receives the request to cancel coverage.

95. How is my continuation coverage affected if I move from the service area?

If you move out of the service area (either permanently or temporarily for three months or more), you are eligible to change plans. (See Question 85: "What if I have a temporary or permanent move from the service area?")

Your application to change plans must be postmarked within 30 days before or after your move. Because you are on continuation coverage, call ETF at 1-877-533-5020 or go online to obtain a *Health Insurance Application/Change for Retirees* (ET-2331) form. Complete and submit the application to ETF.

96. When is Marketplace or conversion coverage available?

As required by law, non-Medicare retirees are eligible to apply for Marketplace or conversion coverage when group continuation coverage expires as this is considered an involuntary loss of coverage. (Termination due to non-payment of premium is considered voluntary cancellation and may not permit you to join the Marketplace.). Contact the plan directly to make application for coverage. Marketplace or conversion coverage is available without a waiting period for preexisting conditions. The coverage and premium amount may vary greatly from plan to plan.

If the health plan automatically bills you for coverage that you do not want, simply do not pay the premium for the coverage.

If you reside outside of the Local Health Plan service area at the time you apply for Marketplace or conversion coverage, you may only be eligible for an out-of-area policy through another insurance carrier. The benefits and rates of the plan are subject to the regulations in effect in the state in which you reside.

The Marketplace or conversion privilege is also available to dependents when they cease to be eligible under the subscriber's family contract. The request for Marketplace or conversion coverage must be received by the plan within 30 days after termination of group coverage. If you have questions, write or call the plan in which you are enrolled.

Dental

97. Am I eligible for Supplemental Dental Benefits?

All WRS participating local retirees are eligible for Supplemental Dental Benefits.

Three plans are available. The preventive plan offers coverage for basic procedures such as cleanings, fluoride treatment, fillings and orthodontics. The Select plan and Select Plus plan cover items such as crowns, bridges, dentures, implants and root canals.

98. How do I enroll on a Supplemental Dental Plan?

Local retirees should visit www.deltadentalwi.com/state-of-wi to view different options on how to sign up for coverage during open enrollment.

99. How do I find out which specific benefits and services are covered under the Uniform Dental Benefit and Supplemental Dental Plans?

For specific benefit details, view each plan's Certificate of Coverage. You may visit Delta Dental's website at www.deltadentalwi.com/state-of-wi or call Delta Dental directly at 1-844-337-8383.

100. How do I find a list of dental providers?

Contact Delta Dental directly at 1-844-337-8383 or visit www.deltadentalwi.com/state-of-wi to view the provider directories. Delta Dental PPO and Delta Dental Premier providers are all considered in-network for the Uniform Dental Benefit, Preventive Plan, and Select Plus Plan. Only Delta Dental PPO providers are considered in-network for the Select Plan.