State of Wisconsin Supplemental Benefit Plans Administration Manual

For use with these insurance plans:

Dental with Delta Dental of Wisconsin (Delta or Delta Dental)

Vision with DeltaVision (with EyeMed Vision Care)Accident

Insurance Plan with Securian Financial

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I. Introduction

Supplemental benefit plans (supplemental plans) are types of insurance that are:

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

The Group Health Insurance Program (GHIP) is referenced occasionally in this manual, for reference or contrast. The Department of Employee Trust Funds has made efforts to align administrative policy and procedure for supplemental plans with those for GHIP, where feasible. Individuals do not have to be enrolled in the GHIP in order to be eligible for the supplemental plans.

II. Definitions

Beneficiary: Any individual identified as the recipient of benefits in the event of the subscriber's death (Beneficiary Designation (ET-2320)); generally, an employee's spouse, child(ren), and/or stepchild(ren).

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

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

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

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

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

Dependent: Means a subscriber's:

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

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

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

Employer: The employer's office of human resources, payroll and/or benefits, and the payroll center that serves that WRS-participating state agency or local entity.

ETF: Department of Employee Trust Funds.

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

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

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

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

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

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

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

Member: An individual enrolled in a supplemental plan.

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

Plan or Supplemental Plan: Supplemental plan approved by the Board as an optional employee-pay-all benefit, and/or benefit available to employees and/or retirees.

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

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

Retirees: A WRS member who has retired and is eligible for group health insurance plans under the WRS or is the surviving spouse of a retiree. Eligible retirees include those who meet at least one of the following criteria:

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

Note: This does *not* include beneficiaries who were not the spouse of the subscriber.

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

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

State: State of Wisconsin.

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

Subscriber: An active employee or retiree enrolled in a supplemental plan who is not enrolled as the dependent of another subscriber.

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

UWS: University of Wisconsin System, an employer with its own payroll system. Includes all University of Wisconsin institutions.

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

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

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

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

WRS: Wisconsin Retirement System.

III. Eligibility & Enrollment

Employee Eligibility

An active employee who is eligible for the GHIP, with or without employer contribution.

Employee Enrollment

Eligible employees may enroll within the first 30 days of their hire date. Coverage is effective on the first of the month that first occurs during the 30-day enrollment period. For example, if a new hire starts their employment on June 14, their coverage would become effective July 1. If an employee that was not eligible for the WRS becomes eligible, the employer has 30 days to notify the employee of eligibility for supplemental plans. The employee then has 30 days from the date of notification to enroll.

In addition, employees have the following enrollment opportunities:

- If previously eligible under the WRS, an employee may enroll if they have had more than a 30-day break in employment.
- If an employee previously eligible under the WRS has less than a 30-day break between state employers:
    - Treat the subscriber records as a transfer, as if employed by a new state agency.
    - Treat the subscriber records as a reinstatement with no break in coverage if the subscriber returns to the same agency within 30 days.

      Note: If the break in employment crosses the first of the month, that coverage is still continuous
- Under Wis. Stat. §40.52 (3), §40.02 (25) (b) 2 and §40.02 (25) (b) 2 g, a UWS employee eligible for the graduate assistant/short-term academic staff benefit package may enroll in supplemental benefits within 30 days of beginning their first eligible appointment; however
    - If this is not the employee's first eligible appointment, they may still be eligible for the "initial" 30-day enrollment period if they had a 30-day employment break between appointments.
- LTEs/University Staff-Temporary have an additional 30-day enrollment opportunity under the following conditions:
    - The hours of employment increase due to a change in the position appointment and the employee now qualifies for full share of employer contribution towards the GHIP; or

- The employee is appointed to a different position and newly qualifies for the full share of the employer contribution towards the GHIP.

- Local employees:
  - Local employees are eligible for supplemental plans if their employer opts into the program.
  - Local employers work directly with the vendor on payment of coverage.
  - If a local employer calls ETF with questions about supplemental plans, ETF will refer the local employer to the applicable vendor.

Declining Enrollment

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

State Transfers

If an employee transfers to a different state agency under the same payroll center (for example in STAR a transfer from Department of Corrections to Department of Justice and UWS (for example UW-Whitewater to UW-Stevens Point), coverage is continuous. If the transfer occurs across different payroll centers, a new application must be submitted.

An employee is eligible to enroll in supplemental plans after a transfer only if the plan was *not* offered at the prior agency. The employee is not eligible to enroll if the plan was available at the previous employer, but they waived coverage.

When transferring payroll centers, employees enrolled in a supplemental plan are not able to change the coverage level. For example, an employee enrolled in single coverage with UW that transfers to a STAR agency cannot change to family coverage, or vice versa.

Retiree Eligibility

Any retiree who is eligible for the GHIP is also eligible for the supplemental vision and dental programs. Retirees who did not have the Securian Accident Plan as an active employee are not eligible for that coverage.

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

Employees of local employers that don't participate in the supplemental dental and/or vision programs can enroll at retirement as a loss of other coverage life event if the following apply:

- The employee was enrolled in the supplemental dental and/or vision plan offered by their local employer as an active employee *and*,
- Their local employer does not offer retiree coverage for supplemental dental/and or vision.

Otherwise, those retirees are eligible to enroll during open enrollment to be effective the following calendar year.

DeltaVision and Delta Dental require a completed retiree enrollment form within 60 days

of retirement (see the Continuation section) in order to continue coverage. **Note**: Accident Plancoverage is portable and available to any employee who had the plan as an active state employee until that employee turns 70 years old. Securian Financial requires a completedportability form within 31 days of retirement.

Re-hired retirees may enroll in supplemental plans if they have suspended their annuity and are eligible to enroll in the GHIP as an active employee. The employer is responsible to offer enrollment to an eligible re-hired retirees. A member remains in retiree status if the retiree:

- Does not have a qualifying event.
- Is receiving an annuity while employed.
- Does not use payroll deduction but continues to pay the vendor directly.

Dependent Eligibility

Eligible children cease to be dependents on a supplemental plan at the end of the month in which they turn age 26, except in the following circumstances:

- A grandchild ceases to be a dependent at the end of the month in which the covered dependent child (parent) turns age 18.
- A spouse and stepchild(ren) cease to be dependents at the end of the month in which a marriage is terminated by divorce or annulment or the date that the Continuation or Portability Notice for each plan is provided to the divorced spouse.
- Full-time students called to active duty prior to age 27.
    - After turning age 26, as required by Wis. Stat.§ 632.885(2)(b), a dependent includes a child who is a full-time student, regardless of age, who was called to federal active duty when the child was under age 27 and while the child was attending, on a full-time basis, an institution of higher education.
    - The adult child must apply to an institution of higher education within 12 months after completing his/her active duty obligation.
    - The employer will verify this status to enroll the dependent. Vendors will enroll dependents based on the employer's approval.
    - For a retiree subscriber whose adult child fits this situation, the vendor may require that the subscriber submit verification.
- Adult disabled dependents:
    - An unmarried dependent child who is incapable of self-support because of a physical or mental disability that began prior to age 26 and can be expected to be of long-continued or indefinite duration of at least one year, is an eligible dependent, regardless of age.
    - The child remains a disabled dependent as long as at least 50% of the child's support and maintenance is provided by the subscriber and/or the subscriber's spouse, as demonstrated by the IRS Pub. 501.
    - The GHIP will monitor eligibility annually of members and dependents that receive insurance in the GHIP and will notify the employer and ETF when terminating coverage prospectively upon determining the dependent is no longer disabled and/or no longer meets the support requirement. The employer will notify their Employer Services Section (ESS) contact at ETF of any support requirement changes.

Employers are not required to transmit disability status of dependents with enrollment records, but are responsible to provide the designation and/or verification as follows:

- **Delta Dental and Delta Vision:** If the employer indicates the dependent is permanently disabled on electronic enrollment via an Electronic Data Interchange (EDI) transmission or online enrollment, no further verification is needed. If dependent becomes permanently disabled after enrollment or is not reported as previously stated, a form will be provided to the subscriber for completion by a physician for verification.
- **Securian Financial:** Does not need to be notified that the dependent is an adult disabled dependent. Securian Financial will verify status when a claim is filed on the adult disabled dependent.

Additional Eligibility Rules

Child born outside of marriage

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

  DeltaVision, Delta Dental, and Securian Financial do not need copies of the documentation if the employer has seen the documentation and is satisfied the above requirements were met. However, the supplemental providers do reserve the right to ask for a copy of the documentation at a later date if the need arises.

Foreign nationals

- An eligible foreign national member who is:

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

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

Note: An employee or retiree may cancel their enrollment in any supplemental plan up until December 31 for the subsequent year; this is not considered a late change. The cancellation will not be effective until the first day of the following calendar year. If the employee's paycheck or retiree's annuity is deducted for coverage beginning January 1 and the member cancels the coverage before January 1, the vendor must return the premium payment.

Employees

If an employee or eligible subscriber failed to enroll or make a change during their eligibility period or open enrollment, they may request a review from the employer, which may need subsequent approval by ETF.

The review process for active employees is as follows:

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

5. ETF will advise the employee and employer of a decision within 30 days. If a late enrollment or change is allowed, premiums will be adjusted back to January 1 or the missed effective date.

Retirees

1. If a retiree failed to submit enrollment or changes during open enrollment, they must submit their request for review directly to ETF. ETF in consultation with the vendor, if needed, has the final decision, based on standards set forth in the *State of Wisconsin Supplemental Benefit Plans Administration Manual* (ET-1158). If a late enrollment or change is allowed, premiums will be adjusted back to January 1 or the missed effective date.

V. Changing Coverage

Specific qualifying events trigger opportunities for a subscriber to enroll, cancel, or change supplemental coverage. They include:

- Marriage,
- Birth or adoption,
- Permanent placement of a legal ward,
- Dependent child turning age 26,
- Divorce or annulment,
- Leave of absence, and
- Eligibility for or loss of comparable coverage.

Refer to the Life Event Change Guide for a complete list of qualifying events: etf.wi.gov/its-your-choice/2022/state-employee-retiree-health-plan/how-choose-enroll-your-benefits/life-events-guide

Notification of Change - Employees

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

Notification of Change - Retirees

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

Adding Dependents to Existing Coverage

Absent a qualifying event, a dependent can be added only during an enrollment period designated for such action. The newly added dependent will be subject to coverage limits applied to new enrollees if a plan includes coverage limits.

Note: Unlike State Group Health Insurance, a subscriber may elect which eligible dependents to cover under supplemental plans.

Changing Coverage Upon Marriage

A covered employee must complete and sign an enrollment application within 30 days of the date of marriage if the employee wishes to insure the spouse and any eligible dependents of the employee or spouse.

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

The subscriber must complete, sign, and submit an enrollment application to the employer within 60 days of the date of birth, adoption, or legal guardianship or within 30 days of the other qualifying events that makes the dependent eligible.

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

Process When a Covered Employee Gets a Divorce or an Annulment

Refer to the Continuation Coverage section to determine if or how continuation must be offered to the former spouse and their dependents. If the covered employee is removing dependents from coverage, the employee must submit an enrollment application(s) to the employer.

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

Delta Dental: Allows dual coverage for a child but will not pay more than 100% of the covered amount for a service or item. DeltaVision does not coordinate benefits with multiple plans.

Securian Financial: An individual may only be covered once under the accident plan. If both parents are eligible employees for the accident plan, only one parent may cover the child(ren). If the vendor becomes aware of dual coverage issues, the vendor will report the issue to the employer and coordinate a correction.

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

Pre-Tax Deductions

Eligible subscribers (LTEs/University Staff-Temporary are not eligible) may have premiums for the DeltaVision and Delta Dental supplemental plans deducted from their paychecks before federal, state, and Social Security taxes are calculated.

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

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

Post-Tax Deductions

If a subscriber does not wish to have their premiums taken on a pre-tax basis, they must complete an Automatic Premium Conversion Waiver/Revocation of Waiver (ET-2340) form. If the application reflects enrollment of at least one dependent whose coverage is not tax deductible under IRA Publication 501, the full premium must be deducted post-tax even if the dubscriber does not complete an ERA Automatic Premium Conversion Waiver.

Premiums for LTEs must always be deducted post-tax.

Note: Accident plan premiums are only deducted post-tax.

VII. Naming a Beneficiary

Beneficiary Records

The Securian Financial Accident Plan is the only supplemental plan that has a death benefit. The following provisions for naming a beneficiary are for the Securian Financial Accident Plan only:

- Members should fill out the beneficiary forms found on ETF's website at etf.wi.gov/resource/beneficiary-designation
- The member, not the employer should submit the form to ETF via the contact information found on the form.
- Securian Financial will collect a new beneficiary form if a member chooses to port their policy.
- If the subscriber dies without a named beneficiary, the standard sequence applies as outlined in Wis. Stat. § 40.02(8)(a)2.

Benefits Payable After Death of the Subscriber

For any supplemental plan under contract with ETF, if a subscriber dies before receiving a benefit owed by the vendor, ETF may release the contact information for the Chapter 40 beneficiary to the vendor, upon request of the vendor, per Wis. Stat. § 40.07(1m).

VIII. Both Parents or Spouses Employed by a State Employer

1. **May two married, covered subscribers (employees and/or retirees) each subscribe to family coverage for the same supplemental plan?**

   DeltaVision does not coordinate benefits with multiple plans.

   Delta Dental allows a person to be a subscriber on one plan and a dependent on another in the Select and Select Plus plans only. Duplicate coverage is not allowed under the Preventive Plan.

   If a member is covered by more than one dental supplemental plan and has duplicate coverage, Delta Dental will allow coverage for two separate sets of service, or "stacking," wherein both plans pay for one set of services

   The Securian Financial Accident Plan does not allow stacking.

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

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

   For the AD&D portion of the accident plan, the subscriber is covered at a higher level than the employee who is designated as a spouse, the other portions of the plan are at the same level.

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

   If spouses are both subscribers, work for the same or different employer, and each carries single coverage, one spouse can change to family coverage or employee + spouse coverage if they experience a qualifying event and apply within 30 days of the event. This new family or employee + spouse coverage could include both spouses if one of the adults drops their individual plan.

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

   If there is no qualifying event, these changes can only be made during the plan's open enrollment and will be effective the following January 1.

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

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

- The employee designated as the subscriber terminates. The change will be effective on the first day of the month following the date of termination or retirement of the subscriber.
- The employee designated as the subscriber goes on an unpaid or military leave of absence. The change will be effective on the first day of the calendar month following the first date of the subscriber's unpaid or military leave of absence.
- The employee may also make the change during the open enrollment period, which will be effective the following January 1.

Delta Dental and DeltaVision's Summary of Benefits for 2022 can be found at: etf.wi.gov/its-your-choice/2022/state-employee-retiree-health-plan/supplemental-benefits

IX. Leave of Absence

Leave of Absence (LOA) Procedures

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

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

- The subscriber must pay the employer, on terms determined by the employer. The employer must make timely payments to the vendor to maintain coverage.
  - Employers may arrange to collect payments in advance for up to three months of premiums, using payroll deduction (to preserve the pre-tax opportunity).
    - If an employer sends a lump-sum payment to the vendor in advance of premium due dates, the employer must clearly identify the months of coverage the lump-sum payment represents.
    - If the payroll center's payment system allows, the employer holds the personal checks and applies them to the remittance to the vendor in the month due.

If the subscriber's payments to the employer lapse, the employer will notify the vendorto lapse coverage. Vendors should only lapse coverage if instructed by the employer and/or noted in enrollment/change files from a payroll center, and not on the basis of non-payment on remittance reports.If the subscriber intends to let coverage lapse, the employer must notify the vendor that thesubscriber is on an approved LOA.

- For active employee on a biweekly payroll schedule, monthly premiums are deducted over two pay periods. If an employee goes on leave of absence mid-month and does not continue coverage, the employer will notify the vendor to lapse coverage effective at the end of the month for which full payment had been collected. Any partial month payroll deductions should be refunded to the employee.

Best Practice Note: Employers should advise employees *not to cancel* coverage during LOA, but instead choose to have *it lapse to preserve their rights to re-enroll when they return to work*.

If the subscriber lets coverage lapse while on LOA, within 30 days of their return to work, they may re-enroll in the same level of coverage that was in force prior to the lapse of coverage. Coverage is effective the first of the month on or following return to work.

If an open enrollment period occurred while the subscriber was on LOA, they may make any changes that were allowed during the open enrollment period.

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

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

Military Leave Procedure

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

- Premium(s) for plan coverage(s) must be paid through the employer. The vendor will not bill the subscriber directly.
- Employers that collect premiums in advance may collect up to one year of premium prior to deployment.
- The employer will contact the subscriber at least one month before prepaid coverage will lapse, to request notification from the subscriber to extend or let the coverage lapse.
- The subscriber provides documentation of military leave to the employer for other human resources purposes, but it is not necessary to send documentation of the military leave to the vendor.

The vendor does not terminate the coverage of a subscriber and dependents upon notification of active military status. Enrollment will remain active until the subscriber or employer notifies the vendor to terminate coverage, using electronic enrollment file or paper enrollment/change form.

The employer must notify the vendor that the subscriber is on military leave if the subscriber intends to let coverage lapse. If the subscriber allows coverage to lapse while on military leave, they may re-enroll in the same level of coverage that was in force prior to the lapse of coverage, if they do so within 30 days of their return to work. Coverage is effective the first of the month on or following return to work.

If an open enrollment period occurred while the employee was on military leave, they may change the level of coverage or make any other changes that were allowed during the enrollment period.

Retirees

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

X. Cancellation/Termination

Once enrolled, subscribers must remain in the plan for the full calendar year unless there is a qualifying event as described below. Non-payment of premiums will lead to cancellation of the policy at the end of the last month for which payment was received and a lapse of coverage may limit future re-enrollment opportunities. Reinstatement after termination for non-payment will be the decision of the vendor. See further detail on timing and process at etf.wi.gov/its-your-choice/2022/state-employee-retiree-health-plan/how-choose-enroll-your-benefits/life-events-guide

State Transfer

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

Adult Child Turning Age 26

The employer must terminate a dependent's plan enrollment at the end of the month in which they turn age 26. The employer must issue a Continuation Coverage election form for DeltaVision and Delta Dental coverage to the dependent losing eligibility, and adjust the records accordingly so that there is no excess premium deducted from the subscriber's payroll. An adult child turning age 26 can choose to port their accident plan coverage. The portability form and instructions can be found at https://web1.lifebenefits.com/content/dam/form/grp/accident-portability-state-of-wi_88433.pdf

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

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

Dependent Coverage Terminations

Absent a qualifying event, the subscriber may only elect to remove covered dependents during the annual open enrollment period. Coverage ends on December 31.

When the dependent is removed, they may not be re-enrolled except during a designated enrollment period. There are no mid-year opportunities to remove a dependent from coverage, except due to a qualifying event.

Dependents of employees:

- Coverage can only be canceled mid-year if a qualifying event makes the dependent ineligible for coverage or the dependent gains access to comparable coverage. The subscriber may submit an application/change request to the employer by December 31 to remove the dependent for the following calendar year in absence of a qualifying event.
- To remove a dependent due to a qualifying event, the subscriber must indicate the date of and reason for the loss of eligibility in the “Remove a Spouse or Dependent(s)” section of the enrollment application.
- Even if family coverage will remain in force, a change form must be submitted indicating which dependent is being canceled, the reason for the cancellation, as well as the date of the cancellation.

Dependents of retirees:

- Retirees and their dependents are committed to be enrolled for a full year, absent a qualifying event. Retirees can obtain a change form on ETF’s website or by contacting the vendor and requesting the form be mailed to them. Retirees must submit it directly to the vendor at the address provided on the form (not to ETF).

Cancellation Rights

All supplemental plans require that once a subscriber is enrolled for the calendar year, they must stay enrolled unless there is a qualifying event.

A subscriber who wishes to cancel coverage for the following calendar year may do so without a qualifying event during open enrollment. However, any valid cancellation notice filed with the employer (or with the vendor, for retirees) by December 31 will be honored effective January 1 of the following year.

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

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

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

Any subscriber may cancel or move from family, individual+child(ren), or individual+spouse to single coverage during the annual open enrollment period, even if the plan is not offering an enrollment opportunity.

XI. Continuation Coverage

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

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

If a retiree initially enrolls as a continuant (COBRA), it is up to the retiring subscriber to register during an open enrollment period **before the 18 months of continuing coverage has expired to change their supplemental coverage from continuation coverage to retiree**. If the retiree's continuation coverage expires before the next open enrollment period, the retiree will go without coverage and must wait until the next open enrollment period to re-register for supplemental insurance.

Accident Plan: Does not offer continuation coverage since the accident plan is a portable benefit. Any subscriber who has the Securian Financial Accident Plan as an active employee can maintain the coverage until age 70 currently at the same rate as active employees.

The portability form and instructions can be found at
https://web1.lifebenefits.com/content/dam/form/grp/accident-portability-state-of-wi_88433.pdf

Continuation Coverage Requirements

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

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

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

Dependent Loss of Eligibility

The subscriber is responsible for notifying the employer of an event that makes a dependent ineligible for coverage. Each covered member has an independent right to elect to continue coverage.

- The employer must ask the employee for each dependent's current address. If a dependent's address is not available, send the notice to the last known address for the dependent. If the last known address for a covered dependent is different, even for a minor, send the notice to that minor's known address.

- If the individuals who are eligible to continue coverage live together in a common household, one notice to all eligible individuals is acceptable.

If a spouse or child loses eligibility, the subscriber must notify their employer within 60 days of the event (such as divorce). Failure to notify the employer in that period may make the dependent ineligible to continue coverage. However, a continuation election form must still be issued by the employer. The employer must provide the qualified beneficiary with the vendor's appropriate continuation form, or in the case of the accident plan, information on contacting Securian Financial about porting the policy.

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

Continuation/Portability Form Timeline

An employee or retiree has 60 days from the date they were notified of their Continuation Rights or the date that their coverage as an active employee ends, whichever is later, to submit the retiree enrollment form to Delta Dental/Delta Vision.

An employee or retiree has 31 days from the date they were notified of their Continuation Rights or date that their coverage as an active employee ends, whichever is later, to submit a portability form, call, or email Securian Financial.

Vision Insurance and Dental Insurance will have continuation forms, while the accident plan will have portability forms.

Premium Due Dates

Once the subscriber has submitted the continuation application, the vendor bills the subscriber directly based on their selection indicated on the application.

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

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

Notification of Changes

If the Board approves a change to retiree rates, the vendor will send a letter to covered retirees/surviving dependents at least 60 days prior to the new premium effective date with the

new premium amount. The letter is not a billing statement. The letter advises subscribers that the increase will show as an adjustment on their first billing statement following the date of change.

All changes to premiums or benefits take place at the same time for active employees, retirees, and continuation coverage subscribers. Premium change is usually effective as of January 1 for all subscribers.

Duration of Continuation Coverage

The duration of coverage is as follows:

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

Indefinite Continuation Coverage

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

- Surviving spouse may continue coverage indefinitely.
- Surviving dependent children may continue coverage until they otherwise lose eligibility.
- Retirees and their dependent(s) may continue coverage indefinitely until they otherwise lose eligibility for coverage.
- Subscribers who are approved for disability retirement under Wis. Stat. § 40.63 or a duty disability under Wis. Stat. § 40.65 must be offered Continuation Coverage or may stay continuously covered. They must be offered the option to reinstate coverage even if no coverage was in effect while no earnings were being received or the employee elected to discontinue coverage.
- The accident plan is a portable benefit. Any subscriber who has the Securian Financial Accident Plan as an active employee can maintain the coverage until age 70 currently at the same rate as active employees pay.

XII. Retirement, Disability, or Long-Term Disability

Retirement Continuation

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

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

Continuation Forms are located at etf.wi.gov/publications/employer

Subscribers who have the Securian Financial Accident Plan at retirement may maintain that coverage until age 70, making payments directly to the vendor.

Retirement and Continuation Billing

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

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

Re-hired Retirees

A retiree who returns to work for a state agency but continues to collect a WRS annuity is *not* eligible to enroll in supplemental plans at the time of hire. They can enroll as a retiree at the next open enrollment period and will pay premiums directly to the vendor. If the retiree is enrolled in the plan(s) during retirement, they may continue coverage by paying premiums directly to the vendor.

If a retiree suspends his/her annuity upon return to work for a state agency, they are eligible to enroll in the plans as an active employee.

XIII. Death of a Subscriber or Dependent

Procedures Outline

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

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

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

If a dependent dies, follow the process for a qualifying event if appropriate to change coverage level.

Notification of Death

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

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

Continuation Coverage

Survivors of a deceased subscriber have 60 days after the date of the Continuation Coverage notice to submit a Continuation Coverage to Delta Dental and DeltaVision to request continuation and 31 days to submit portability coverage to Securian Financial (see Continuation Coverage section).

- If a covered retiree dies, the surviving dependent(s) must contact the vendor. The vendor will provide the appropriate forms to apply to remain covered or see forms at etf.wi.gov and follow links to the plan page.
- **DeltaVision process**: For subscribers with an annuity deduction, ETF staff advise DeltaVision of retiree deaths. ETF does not automatically re-enroll dependents. The surviving dependent(s) must contact the vendor. The vendor will provide the appropriate forms to apply to remain covered or see forms at etf.wi.gov and follow links to the plan page. If dependent survivor(s) qualify as a retiree, the premium may be set up as an annuity deduction.

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

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

Once coverage begins, new dependents may be added if there is a qualifying event.

Important: If a death of the employee (or retiree) or one of the covered dependents is due to an accident, the employer or ETF may need to assist the survivor beneficiaries to submit a claim to the vendor if there is accident Insurance coverage. Claim forms are located on the vendor's website.

XIV. Employer Error

The following situations will constitute an employer error:

- A monthly premium taken after a subscriber has filed a cancellation notice with the benefits office: Payroll center must refund premiums and make adjustment of up to 60

days of premium cost in the next remittance to the vendor.

- Enrolling an employee who is in an ineligible position: Employer must refund premiums if taken.
- **In no event, will premium refunds exceeding two months of premium be approved by the vendor**: Premium refund requests more than three months should be submitted to the employer's risk management department.
- Failure of the employer to advise an employee of his/her initial program eligibility, eligibility as a result of a change to an eligible position, or eligibility change if employee makes employer aware of a qualifying event.
- An employee submitted an application, but the employer did not deduct premiums.
- The coverage effective date may be retroactive only in the case of employer error. For billing purposes, premiums must be collected based on the effective date of coverage.

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

Not Considered an Employer Error

The following situations will not constitute an employer error:

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

Correcting Errors

If an employer error prevented timely enrollment, an application can be approved with the following procedures:

1. The employer furnishes sufficient information to ETF indicating one of the employer error criteria has been met.

2. The employee files an application which must be received by the employer within 30 days after the employee first becomes aware of the error, and
3. ETF finds that employee was denied coverage because of employer error.
4. Coverage is effective the first of the month following receipt of the new application. The application must be received within 30 days of the date the employer notifies the employee of the error.

XV. Subscriber Grievance

A member has the right to file a complaint or grievance against any supplemental plan vendor. This may include issues like incorrectly denied claims, coverage termination, or poor customer service.

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

In general, if a member or subscriber receives a negative notice from a supplemental plan vendor, they have the right to first question the action by contacting the vendor. The vendor is required to respond to all subscriber grievances by stating the reasoning why the vendor made the determination, and a detailed outline of the formal complaint process a subscriber must take to appeal the vendor's decision.

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

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

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

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

XVI. ETF Resource Links

Member or Employer Resource

etf.wi.gov/its-your-choice/2022/state-employee-retiree-health-plan/how-choose-enroll-your-benefits/life-events-guide

Resolving Member Issues

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

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

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

State employer or payroll center has an issue specific to a subscriber's enrollment status, premiums owed, ID card, etc. should contact the vendor directly using the contact list below.

Retirees

For supplemental plans, ETF's Retiree Insurance Staff may refer retirees to the designated vendor contact for enrollment or premium issues. See contact information in the next section.

XVII. Vendor Resource Links

The following vendors have contracts to provide supplemental plans in 2022.

Dental Claims and Benefits

DELTA DENTAL®

Phone: 1-844-337-8383
Call Center Open Monday - Friday
7:30 a.m. to 5:00 p.m. Central Standard Time

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

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

Accident Plan

securian FINANCIAL

Phone: 1-866-295-8690
email: madisonbranch@securian.com

Website:
www.LifeBenefits.com/plandesign/WIETF

To File a Claim:
www.securian.com/benefits

Address:
Securian Financial
P.O. Box 259708
Madison, WI 53725-9708

Vision Benefit

DELTA DENTAL®
DeltaVision®

Address:
DeltaVision
Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481

www.deltadentalwi.com/state-of-wi-vision

Phone:
For eligibility or billing inquiries: 1-844-337-8383 Monday - Friday: 7:30 a.m. to 5:00 p.m. Central Standard Time.

For benefits or claims inquiries: 1-855-544-6035 Monday - Friday: 6:30 a.m. to 10:00 p.m., Saturday - Sunday: 10:00 a.m. to 7:00 p.m. Central Standard Time

Nondiscrimination and Language Access

42 U.S. Code § 18116

ETF complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and others). ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact ETF at 1-877-533-5020; TTY: 711.If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

ETF Office of Policy, Privacy & Compliance
P.O. Box 7931
Madison, WI 53707-7931

1-877-533-5020; TTY: 711
Fax: 608-267-4549
Email: ETFSMBPrivacyOfficer@etf.wi.gov

If you need help filing a grievance, ETF's Office of Policy, Privacy & Compliance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at crportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019; 1-800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

The Wisconsin Department of Employee Trust Funds is a state agency that administers the Wisconsin Retirement System pension, health insurance and other benefits offered to eligible government employees, former employees and retirees.

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

Hmong – LUS CEEV: Yog tias koj xav tau kev pab txhais lus. Peb pab koj tau, peb pab koj dawb xwb, thov hu rau 1-877-533-5020 (TTY: 711)

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

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

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

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

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

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

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

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

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

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

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

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

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