

**University of Wisconsin System Employees
Dentacare HMO, Preferred PPO and Supplemental Plans
Frequently Asked Questions
Revised September 2011**

Please be aware that you must remain covered under this plan
for the entire calendar year unless your employment terminates.

Enrollment is closed for 2012. To maintain coverage in 2012 you must be a UW System classified employee represented by a union and enrolled in the plan as of December 1, 2011. This plan will not be offered in 2013.

In this document, “you” means a State of Wisconsin or University of Wisconsin employee.

1. Who is eligible for these plans?

You must be a permanent represented classified employee; and:

- a. You must be eligible to enroll in the State of Wisconsin group health insurance program with either an immediate or future state share contribution. Rehired annuitants are not eligible unless they stop their WRS annuity and resume participation in the Wisconsin Retirement System (WRS).
- b. To elect the Supplemental Plan, you must be covered under a health insurance plan that provides preventive and diagnostic dental coverage.
- c. You must have coverage in force by December 1, 2011 to be eligible to remain covered in 2012.

2. What is my enrollment deadline?

For currently enrolled members, applications to make coverage changes for 2012 are due by 4:30 p.m. on October 28, 2011.

If you wish to cancel your coverage for 2012, an application must be submitted by December 1, 2011.

If your effective date of coverage is December 1, 2011 or earlier, you must submit an application to your payroll/benefits office no later than 30 calendar days from the begin date of your appointment. You may only elect the Dentacare HMO or Preferred PPO (not the Supplemental Plan) unless you have health insurance that provides some level of diagnostic and preventive dental benefits. You may subsequently change to, or enroll in, the Supplemental Plan when the employer begins to contribute towards your health insurance coverage, again, provided you carry health insurance that includes preventive and diagnostic dental benefits (this does not apply to faculty or academic staff as they do not need to be in the WRS for two full months before the employer contribution begins).

3. How do I decide which plan to choose?

Review the [Plan Summary](#) for details about the benefits and out-of-pocket costs, including premiums, office visit co-pays and coinsurance.

If your group health plan provides some diagnostic and preventive dental services, you may want to select the Supplemental Plan which was designed to “wrap-around” the dental benefits most of the participating health plans provide. With the Supplemental plan you may see the dentist of your choice.

If your health plan does not cover any diagnostic and preventive dental services, you may **NOT** select the Supplemental Plan. You should consider the Dentacare HMO or Preferred PPO. Check the [Provider Directories](#) to see if your dentist is listed as a Dentacare HMO or Preferred PPO provider. If you select the HMO, you must use a Dentacare provider. If you select the PPO, you will receive a higher level of benefits when you use a Preferred PPO provider but you can see any dental provider. This may be a better choice for you if you have covered family members living in another area (such



**Dentacare HMO, Preferred PPO and Supplemental Plans
Frequently Asked Questions
Revised September 2011**

as a dependent student) or travel frequently. With the Supplemental plan, you may see the dentist of your choice but you will see lower out-of-pocket costs by using a provider in the Preferred PPO directory. These providers cannot bill you for charges in excess of the amount approved by Anthem.

4. Who are eligible dependents?

Eligible dependents include:

- a) Legally married spouse of the employee
- b) Domestic partner of the employee as evidenced by an approved "Affidavit of Domestic Partnership". Please use a qualified [ETF Affidavit of Domestic Partnership](#) or [UWS Affidavit of Domestic Partnership](#).
- c) Unmarried children of the employee, spouse or domestic partner, through the end of the year in which the child attains age 19.
- d) Married or unmarried children may continue to be covered as your dependent until the end of the month in which the child attains age 26 (in 2011, unmarried adult children are eligible until the end of the month in which they turn age 27).
 - i. If the child is not eligible to be your dependent according to IRS guidelines it is important to indicate that on the application or notify your payroll/benefits office as soon as possible.
 - ii. If the child is not tax-eligible dependent, your premiums will be deducted on a post-tax basis to avoid imputed income on the value of the coverage. Imputed income would increase the amount you "earn" and the amount on which you are taxed.
- e) Unmarried children of any age who are incapable of self-sustaining employment by reason of mental or physical disability and are chiefly dependent on the employee or other parent for support and maintenance.
- f) The child of a dependent child (grandchild) until the end of the month in which the dependent child attains age 18. The dependent's coverage is unaffected.

5. As a represented classified UWS employee, can I carry both Anthem DentalBlue and Dental Wisconsin?

Yes, you are eligible for both plans. The plan that has covered you for a longer period of time will be the primary payer of your claims. After it processes your claim, the other insurer will process your claim under coordination of benefits. However, you will be required to satisfy the waiting periods of the Dental Wisconsin plan if you maintain your Anthem DentalBlue coverage.

6. If I keep this coverage for 2012, will I be eligible for any dental insurance in 2013?

Yes, you will be eligible to enroll in either the Dental Wisconsin PPO or Select plan due to loss of eligibility for other coverage. Dental Wisconsin will honor any waiting period that was met under Anthem DentalBlue.

7. Is there a waiting period before services are covered?

There is a waiting period of 90 days for new members before basic services (e.g., fillings) or major services (e.g., crowns, bridges, dentures) are covered under the Preferred PPO or the Supplemental Plan. The Dentacare HMO has no waiting periods for coverage. If you cancel your coverage and later re-enroll, you are considered to be a new member and the waiting periods will apply.

8. If I am already enrolled in Anthem DentalBlue and now enroll in Dental Wisconsin, will I have to satisfy the waiting periods under Dental Wisconsin?

You will have to satisfy the waiting periods under Dental Wisconsin if you also maintain your Anthem DentalBlue coverage. If you cancel your Anthem DentalBlue coverage by December 1 waiting periods satisfied under that plan will be applied to the waiting periods under Dental Wisconsin.



**Dentacare HMO, Preferred PPO and Supplemental Plans
Frequently Asked Questions
Revised September 2011**

9. I just transferred to the UW from a state agency. Do I have enrollment opportunity for this plan?

Probably not. New enrollments in this plan are not allowed as of January 1, 2012.

10. I am transferring from a represented classified appointment to an unclassified or non-represented classified position. Can I keep my Anthem DentalBlue coverage?

If you transfer from a represented classified appointment to an unclassified or non-represented classified appointment and you have Anthem DentalBlue coverage in force, you will lose eligibility for that coverage. The loss of eligibility creates a special enrollment opportunity to elect Dental Wisconsin within 30 days of your appointment change. Any waiting periods already satisfied under the Anthem DentalBlue coverage will apply to the Dental Wisconsin waiting periods.

The effective date of any dental coverage for which you are newly eligible due to the transfer will be the first of the month on or after your payroll/benefits office receives your completed application.

11. Can I have Anthem DentalBlue coverage if I do not carry health insurance through the State of Wisconsin?

If you are eligible to enroll in health insurance but do not carry it, you are eligible for the Dentacare HMO or Preferred PPO. You are **NOT** eligible to enroll in the Supplemental Plan unless you are covered under your own or a spouse's qualifying group medical plan. A qualifying group medical plan is one that includes diagnostic and preventive dental services (such as cleanings, x-rays and fillings) for all participants.

12. Does "Medical Plan" mean only the State Group Health insurance plan or can it mean the plan my spouse has with another employer?

You or your spouse/domestic partner must be eligible for the State Group Health insurance to be eligible to enroll. For the Supplemental Plan, you must be covered under a qualifying medical plan. A qualifying medical plan is one that offers diagnostic and preventive dental services to all participants.

13. If I carry health insurance under the Standard Plan, am I eligible for the Anthem DentalBlue Supplemental Plan?

No. You are not eligible to enroll in the Supplemental Plan because the Standard Plan does not offer dental benefits. The eligibility criteria for the Supplemental Plan require that the employee be enrolled in a qualifying health plan that provides diagnostic and preventive dental benefits. If you mistakenly enrolled in the Supplemental Plan you must file a new application to enroll in the Dentacare HMO or Preferred PPO plan instead. The original receipt date of the first application will be honored on the new application. All of the offered health plans under the State Group Health Insurance Program include coverage for diagnostic and preventive dental services with the exception of the Standard Plan and SMP.

14. If I obtain a dependent, can I add the dependent to my coverage during the calendar year?

Yes, if you marry or file a qualified [ETF Affidavit of Domestic Partnership](#) or [UWS Affidavit of Domestic Partnership](#) you may add your spouse or partner, and their dependent children, by filling an [application](#) with your payroll/benefits office within 30 days of the event. A newborn or adopted child must be added within 60 days of eligibility. Coverage is effective as of the date of eligibility. If the coverage change takes place mid-month, no premium is due. If the change occurs on or after the 16th of the month, the full premium reflecting the changed coverage is due for the month.

15. How do I add a domestic partner?

You must file a qualified [ETF Affidavit of Domestic Partnership](#) or [UWS Affidavit of Domestic Partnership](#). You may then add your spouse or partner, and their dependent children, by filling an



Dentacare HMO, Preferred PPO and Supplemental Plans Frequently Asked Questions Revised September 2011

[application](#) with your payroll/benefits office within 30 days of the date the affidavit is formally acknowledged. Please see [Domestic Partner Benefits for University of Wisconsin Employees](#) for more details.

16. Are premiums taken pre-tax?

Yes, unless you are covering a domestic partner or you have indicated on your application that you are covering an adult child between the ages of 19 and 27 who you cannot claim as a dependent on your federal taxes. The Internal Revenue Code, Section 152 allows premiums for an employer-sponsored dental program to be taken pre-tax for qualified participants. However, the Internal Revenue Code does not extend this benefit to LTEs, employees enrolling with domestic partners as dependents or non-tax adult dependents.

17. How do I change a clinic or dentist?

Refer to the [provider directories](#). The HMO and the PPO have separate directories. There is no provider directory for the Supplemental Plan as you can see the dentist of your choice. However, if you use a dental provider listed in the PPO directory you may see lower out-of-pocket costs as these providers cannot bill you for charges in excess of the amount approved by Anthem.

18. What if my dentist leaves the plan during the year?

It depends on which plan you have selected. If you have selected the Dentacare HMO, you must use a dentist listed in the current Dentacare Provider Directory in order to receive benefits. With the Preferred PPO, you may continue to see your dentist; however, you will incur higher out-of-pocket costs under the out-of-network level of coverage. The Supplemental Plan has no provider restrictions so this situation should have no impact.

19. Why is the Dentacare HMO less expensive in the Milwaukee area?

Dentacare is better able to negotiate lower fees with providers in the Milwaukee area than they are in other areas of the state and that is reflected in the premium. The Dentacare HMO premiums for the Milwaukee area are shown on the Plan Summary as Region 1. The rates for the Preferred PPO and Supplemental Plan are the same statewide.

The "Milwaukee area" includes Milwaukee, Waukesha, Ozaukee, Washington, Racine and Kenosha counties. Region 2 includes all other counties/locations. The premium you pay is determined by the county in which you, the employee, live.

20. Is the EPIC Benefits+ deductible satisfied by charges paid under the Anthem DentalBlue plan?

No, you must still meet the \$75 per person deductible for benefits to be payable by EPIC Benefits+. If you have coverage under both EPIC Benefits+ and an Anthem DentalBlue plan, EPIC Benefits+ will always be the last plan to pay.

21. If I have some dental coverage through my health plan and one of the Anthem DentalBlue plans and am also enrolled in EPIC Benefits+, in what order will the plans pay my claims?

The "order of benefit" determination (which plan pays first) is uniform in the insurance industry. In the following example, there are three plans and the order of benefit determination is: (1) the health plan, (2) the Anthem DentalBlue plan and (3) EPIC Benefits+ plan. EPIC Benefits+ will always be the last to pay.



**Dentacare HMO, Preferred PPO and Supplemental Plans
Frequently Asked Questions
Revised September 2011**

Example Using the Anthem DentalBlue Supplemental Plan:

You receive 2 crowns at \$900 each. Total charges are \$1800.

- The HMO denies benefits because the plan does not provide coverage for crowns. The balance remaining is \$1800.
- You pay the \$50 deductible of the Supplemental Plan, leaving a balance of \$1750.
- The Supplemental plan pays 50% of the cost of a covered crown, subject to annual maximum of \$1,000. The Supplemental Plan pays half of the balance remaining of \$1750, for a total of \$875. You still have \$125 available to apply towards other covered services during the same calendar year.
- EPIC Benefits+ then determines its payment as if it was the primary plan (i.e., the first plan to pay on a claim) even though it will be the last plan to pay on the claim. That amount is then applied to the balance of the claim but will not to exceed the total amount billed and is subject to the annual maximum benefit.
- The annual \$75 deductible, applied by EPIC Benefits+ for covered dental services, is deducted from the \$1800 claim, leaving a balance of \$1725.
- EPIC Benefits+ pays 50%, up to an annual maximum of \$1,000. Fifty percent of \$1725 balance is \$862.50; however, in this example the EPIC Benefits+ payment is limited to \$675 so as not to exceed the actual amount of the claim.

Summary:	Total Claim=	\$1800
	Health plan pays=	\$ 0
	The annual Supplemental Plan deductible=	\$ 50
	Dental Blue plan pays 50%=	<u>\$ 875</u>
	Balance Remaining=	\$ 875

Then the EPIC Benefits+ payment is determined as if it were the primary payer.

Total Claim=	\$1800
EPIC Benefits+ annual deductible=	<u>\$ 75</u>
	\$1725
EPIC Benefits+ plan pays 50%=	\$ 862.50
Health Plan payment	\$0
Anthem DentalBlue payment	\$875.00
EPIC Benefits+ payment if primary	<u>+\$862.50</u>
	= \$1737.50
Your responsibility (\$1800 – \$1737.50)	= \$ 62.50

22. If my health plan provides coverage for crowns, will Anthem DentalBlue pay their percentage of benefits based on the original claim or the outstanding balance?

Anthem DentalBlue will determine benefits based on the original claim as if there was no other insurance plan. Then Anthem DentalBlue will “coordinate benefits” with the health plan as described in the answer to question 21.

23. What is the orthodontic benefit?

The Orthodontic Savings Plan is available under all three Anthem DentalBlue plans. The plans do not pay a benefit but if you use an Anthem DentalBlue Preferred Orthodontist, you will receive a 20%



**Dentacare HMO, Preferred PPO and Supplemental Plans
Frequently Asked Questions
Revised September 2011**

discount off of billed charges, subject to a lifetime maximum of \$1000. There is no waiting period or age limit for the orthodontic benefit.

24. May I change from one of the offered plans to another?

There is an annual change opportunity each October for subscribers to *change* plans for the following contract year, effective January 1st. This plan will not be offered in 2013.

During this annual change period, you may:

- *Change from one plan to another.* For example, if you are *currently covered* under the Dentacare HMO or Preferred PPO, you may choose to change to the Supplemental Plan, or vice versa. (Note: you are eligible for the Supplemental Plan *only* if your health plan provides preventive and diagnostic dental benefits).
- *Increase your level of coverage* to include some or all of your dependents, e.g., Employee + 1 coverage may be increased to Employee & 2 or more coverage.
- Subscribers of the Dentacare HMO may change their selected dental clinic.

If you elect to change to the Preferred PPO or the Supplemental Plan, the 90-day waiting period for basic and major services is completed if you had Dentacare coverage on October 1st. If your effective date is after October 1st, any portion of the waiting period that you have already satisfied will be counted towards satisfying the waiting period of the plan you change to.

25. My spouse/domestic partner is also eligible for this plan. Can we do a “spouse-to-spouse” transfer of the Anthem DentalBlue coverage?

Yes. A spouse-to-spouse transfer is allowable if both spouses’ or domestic partners’ appointments are eligible for the Anthem DentalBlue coverage and both of you are covered under the same plan (i.e., HMO, PPO or Supplemental). A spouse-to-spouse transfer does not allow you to change Anthem DentalBlue plans.

26. My spouse/domestic partner and I are both enrolled for Anthem dental insurance. Can we both carry family coverage?

No, Anthem DentalBlue does not allow enrollment in two family plans. You can each enroll in a single plan or you may have one family plan if there are dependent children that you wish to insure.

27. May I remain in the Supplemental Plan if I switch to the Standard Plan during Dual-Choice?

No. If you change to a medical plan that does not offer preventive and diagnostic dental services you will no longer meet the eligibility criteria for the Supplemental Plan. You do, however, have an opportunity to change to the Dentacare HMO or Preferred PPO during Dual-Choice or within 30 days of the date your new medical plan begins.

28. I currently carry health insurance through an HMO and the Anthem DentalBlue Supplemental Plan. I am relocating and I will change to the Standard Plan for health. Will I have the opportunity to change to the Dentacare HMO or Preferred PPO at that time?

Yes. In fact, you must change as you will not be eligible for the Supplemental plan when you are covered under the Standard Plan. You are eligible to change to the HMO or PPO plan if you are moving for a minimum of 90 days and the Department of Employee Trust Funds (ETF) allows you to make a health plan change when this happens. You would not want to elect the Dentacare HMO if you leave the state as there won’t be network providers available to you.

29. Can I continue coverage if I terminate employment?

Yes. Coverage may be continued by completing a [continuation form](#) that you will receive from your employer.



**Dentacare HMO, Preferred PPO and Supplemental Plans
Frequently Asked Questions
Revised September 2011**

30. How often can I change my Dentacare HMO selected clinic?

You may change the Dentacare center twice per calendar year, not counting a change made during the annual change opportunity. Complete a new application and return it to your staff benefits office.

31. Where should claims submitted?

In most cases, the provider of dental services will submit the claims for you. If you do need to submit a claim, it should be sent to:

Dental (Claims/Correspondence)
PO Box 9211
Oxnard, CA 93031-9211

32. Who should I contact if I have a complaint?

In most cases, Anthem DentalBlue should be able to assist you. To telephone Anthem DentalBlue about the Dentacare HMO or the Supplemental Plans, call 1-800-627-0004. For complaints regarding the Preferred PPO, call 1-888-525-9296.

If you prefer to email Anthem DentalBlue, they have an email address that is dedicated to UWS and State employees. The email address is StateofWIEmpsDnService@anthem.com.

Written correspondence should be sent to:

Dental (Claims/Correspondence)
PO Box 9211
Oxnard, CA 93031-9211