

**UW SYSTEM
ADMINISTRATION MANUAL
ANTHEM DENTALBLUE DENTAL INSURANCE**

May 2008

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**UW SYSTEM ADMINISTRATION MANUAL
NONREPRESENTED and UNCLASSIFIED
ANTHEM DENTALBLUE DENTAL INSURANCE
Group Number 83445
Revised April 2008**

The purpose of this manual is to provide administrative guidance and is not meant to replace the individual plan policies. If there is a conflict between this manual and the contract, the contract will take precedence.

This administrative manual provides the operating policies and procedures for the following Anthem DentalBlue dental plans offered to nonrepresented and unclassified employees. Use the same deduction codes for both the UWS- and OSER-sponsored plans:

- Dentacare 186 (also referred to as Dentacare HMO), Deduction Code 467
- Preferred – PPO Option VP 864, Deduction Code 478
- Supplemental plan, Deduction Code 479.

Note: The group number for the UWS-sponsored plan is 83445. For the OSER-sponsored plan, offered to represented UWS employees, the group number is 93881. Please check the correct box in the Employer section at the bottom of the application.

LEVELS OF COVERAGE

- Employee only
- Employee Plus 1 dependent
- Employee Plus 2 or more dependents

Levels of coverage vary widely between plans. Upon enrollment it is assumed the employee has examined and understands the benefits selected.

The Supplemental plan requires employee participation in a medical plan providing, at a minimum, diagnostic and preventive dental coverage. Neither the Standard Plan nor the other PPO plans offered under the State Group Health Insurance Program, provide basic dental coverage. Further, the Therefore, members of these plans are not eligible to enroll in the Supplemental plan.

Employees with health care coverage other than with the State of Wisconsin Group Health Insurance program, which includes dental coverage, are eligible for the Supplemental plan. The employer should ask to see an ID card for verification of the other dental coverage.

Note: Anthem Blue Cross and Blue Shield is the company that insures the Anthem DentalBlue-Dentacare products. Anthem DentalBlue refers to a portfolio of dental

products from Anthem Blue Cross and Blue Shield. Dentacare refers to the HMO plan offered by Anthem DentalBlue.

EMPLOYEE ELIGIBILITY

Participation in the UWS-sponsored plan is limited to non-represented classified employees, unclassified employees (faculty, academic staff, limited appointees), non-represented graduate assistants, employees-in-training, fellows and scholars eligible for immediate or future state share employer contribution towards the State of Wisconsin group health insurance program.

Eligibility for immediate or future state share employer contribution towards the State of Wisconsin group health insurance program is defined as follows:

An employee is not required to participate in the State of Wisconsin Group Health Insurance Program, only to be eligible for immediate or future state share contribution towards health insurance.

The Supplemental plan requires employee participation in a medical plan providing, at a minimum, diagnostic and preventive dental coverage.

In 2006, represented employees became eligible for an Anthem DentalBlue plan, sponsored by the Office of State Employment Relations (OSER). The OSER-sponsored and the UWS-sponsored plans have identical plan designs, offer the same three plan options with the same benefit levels and premium rates. Represented employees should be enrolled under group number 93881.

Limited Term Employees (LTE's) who are covered under the Wisconsin Retirement System and become eligible for state share contribution for health insurance, regardless of whether they take advantage of the health insurance benefit, are eligible to participate in this dental program. They get a new enrollment opportunity if they later become permanent employees with no break in service.

Rehired annuitants who are collecting a Wisconsin Retirement System annuity, are not eligible for state share employer contribution to the State of Wisconsin Group Health Insurance program, therefore, are ineligible to enroll as active employees. Employees who retire may continue participation in the dental plans upon completion of the Group Coverage Continuation Form (UWS-8). See Continuation of Coverage.

INITIAL ENROLLMENT OPPORTUNITIES

Eligible employees must submit a completed application to their benefits office within 30 days of their initial eligibility date. Coverage is effective on or after the first of the month following receipt of the approved application.

If the employee enrolls in Anthem DentalBlue prior to enrolling in the State Group Health Insurance program (e.g., a classified employee in the first six months of WRS participation; effective 7/1/08, after two months of WRS participation), the employee may select the Dentacare HMO or Preferred PPO plan. The employee may not change to the Supplemental plan until the next dental open enrollment or plan change opportunity upon or after enrollment in a health plan that offers routine preventive and diagnostic dental benefits.

A classified employee may also delay enrollment in any of the Anthem DentalBlue plans until the employer contribution for health insurance begins. This allows employees to enroll in the Supplemental plan without first having to enroll in the Dentacare HMO or Preferred PPO plans.

Effective Date Examples:

An employee hired July 7, submits an application on July 10.

- The Anthem DentalBlue plan coverage is effective August 1.

An employee hired July 7, submits an application on August 6.

- The Anthem DentalBlue plan coverage is effective September 1.

OTHER ENROLLMENT PERIODS

Open Enrollment

If an employee does not apply when first eligible, the employee must wait until the next Open Enrollment period to apply for Anthem DentalBlue insurance. Open Enrollments are periodically established through contract agreements between the University and the Dental administrator. There are no regularly scheduled Open Enrollment periods.

There are no provisions for applying through evidence of insurability.

Annual Change Opportunity

Participating employees will have an annual opportunity to change plans or dental centers and to add eligible dependents. This opportunity will coincide with the Health Insurance Dual Choice Enrollment Period, with changes being effective on the following January 1st.

During this annual period, covered employees may:

- Change from one plan to another. For example, if they are currently covered under the Dentacare HMO plans or Preferred PPO, they may choose to change to the Supplemental plan, or vice versa (note: they are eligible for the Supplemental plan *only* if their HMO provides preventive and diagnostic dental benefits).

- Increase their level of coverage to include some or all eligible dependents. For example, Employee Plus 1 coverage may be increased to Employee Plus 2 or more coverage.
- Subscribers of the Dentacare HMO may change their selected dental clinic.

If they change to the Preferred PPO or the Supplemental plan, any portion of the 90-day waiting period for basic and major services that has been completed will be credited towards the waiting period of the new plan, if any.

Loss of Other Coverage

Employees or dependents who involuntarily lose other dental coverage may, qualify for a special enrollment opportunity (HIPAA). The application for Anthem DentalBlue coverage must be submitted with 30 days of the qualifying event. A qualifying event is the involuntary loss of other coverage, such as due to termination of employment (unless due to gross misconduct) or loss of dependent eligibility. This provision also applies if the other employer discontinues its premium contributions.

Should the employee or dependent elect COBRA continuation coverage through the prior plan, he/she must exhaust the period for which he/she is eligible to continue coverage before this Loss of Other Coverage provision will apply.

ID CARDS

Employees who subscribe to an Anthem DentalBlue plan will receive an ID card with their name and Anthem DentalBlue ID number. This card should be presented to the provider when receiving treatment. In most cases, members will not be required to submit claims, however, the reverse side of the card contains information on filing claims.

BENEFIT HANDBOOKS

Employees should print a copy of the benefit handbook from the UWSA or UW Service Center web site. Printed copies are not available.

APPLICATION PROCESSING

Dental applications are provided on the UWSA and UWSC websites. Prior to processing the application, a minimum of three copies must be made.

Mail Original copy to: Anthem DentalBlue
 Attn: Enrollment
 4361 Irwin Simpson Road
 Mason, OH 45040

Or Fax to: 513-770-7360, Attn: Enrollment

Or email a scanned application to: christy.mathews@anthem.com

Mail Second copy to: UW Service Center for monthly reporting

Third Copy: Retain at the benefits office

Employees should be advised to make a copy for their records.

The date the benefits office receives the completed application should be indicated in the space provided at the bottom of the application. See the "For Office Use Only" section on the application.

EMPLOYEE PAYROLL DEDUCTIONS

Premiums are deducted monthly for unclassified faculty and academic staff and from each "A" biweekly payroll for classified employees. Premiums are deducted pre-tax for all eligible employees. However, the Internal Revenue Code does not extend this benefit to domestic partners or LTE's. Premiums pay for coverage one month in advance. A deduction taken in January pays for February coverage. The employee pays the total cost of the premium; there is no employer contribution to this plan.

Unclassified Employees with 9-Month Academic Year Appointments

Employees with recurring 9-month academic year appointments will automatically have multiple deductions taken from the May payroll check, typically paid on June 1, in order to provide continuous coverage during the summer interim period. Premium deduction will resume when the employee returns to pay status.

Employees who are not expected to return in the fall will have the premium taken from their June 1 payroll check for June coverage only. Retroactive premium deductions should never be taken if coverage is lost due to non payment of premiums. If coverage is lost, the employee must wait until the next Open Enrollment opportunity to enroll

EMPLOYMENT STATUS CHANGES

Reinstated Employees

If coverage ends due to termination of the employee's appointment, coverage can be reinstated upon the employee's return to eligible employment within 90 days of the appointment termination date. A new application for reinstated coverage must be completed within 30 days of the employee's return to an eligible active appointment. Reinstated coverage must be the same coverage in effect prior to termination. If a required plan waiting period had been met prior to termination no additional waiting

period is required. The new coverage effective date will be the first of the following month.

If the return to eligible employment occurs more than 90 days after the termination date, the application procedures and waiting periods, if applicable, for a new employee will apply.

Leave of Absence

Institutions should advise employees who go on a leave of absence (including military leave) of the following two options regarding the payment of premiums:

- 1.) Employees can prepay for coverage during their leave. Payments should be made at least quarterly to the institution's benefits office and be made payable to Anthem DentalBlue. When submitting the premium to the UW Service Center, the coverage months reflected by the payment should be noted on the check. If the premium is not prepaid, coverage will terminate after the prepaid period.
- 2.) Employees may allow their coverage to lapse during the leave of absence. The employee can re-enroll upon return from the leave by completing a new application within 30 days of return from the leave. The employee may change his/her level of coverage upon his/her return to work if there was a qualifying event (marriage or birth or adoption of a child) or an Annual Change Opportunity during the leave of absence.

If a qualifying event or Open Enrollment occurs while the employee is on leave, the employee may enroll by submitting an application to the benefits office within 30 days of return from leave.

Transfers to the UW System from Other State Employment

Employees who transfer to the UWS from other non-UWS state employment have the same enrollment opportunities as a new employee. If the employee was covered under the OSER-sponsored Anthem DentalBlue group coverage, he/she must complete a new application within 30 days of the transfer even if he/she was covered under the same group (Group number 93881) in the non-UWS state employment. This is because of the different payroll systems used by the UWS and the state agencies.

Any waiting period that has been met under the prior plan will be applied towards the waiting period under this plan. Unclassified and non-represented employees should be enrolled in the UWS sponsored dental plans. Eligible represented employees should be enrolled in the OSER sponsored plans.

Transfers between UW Institutions

Transfers between UWS institutions do not receive a new enrollment opportunity by virtue of the transfer. Employees who are enrolled in an Anthem DentalBlue plan and transfer to another institution should complete a new Anthem DentalBlue application to ensure continuous plan coverage and maintain correct home mailing information. Dental Centers may change as a result of relocation.

The employee has a new enrollment opportunity only if he/she is now eligible for the non-represented UWS Anthem DentalBlue plan or the OSER Anthem DentalBlue plan and he/she wasn't eligible for that plan prior to the transfer.

Exception: If, prior to the transfer to a new UW Institution, an employee participates in the Dentacare HMO or Preferred PPO plan and is enrolled in a health plan which does not offer dental benefits and is relocating for 3 months or more, the employee has the opportunity to change to the Supplemental plan if a new health plan offers dental benefits. Likewise, if an employee changes to a health plan that does not offer a dental benefit, the employee must change to the Dentacare HMO or Preferred PPO plan. An application to change dental plans must be submitted to the benefits office within 30 days of the transfer.

Transfers between Appointment Types

An employee previously in a classified represented position (even if the employee was covered under the OSER-sponsored Anthem DentalBlue program) who changes to a non-represented position is eligible to apply for the Anthem DentalBlue insurance. He/she may select any Anthem DentalBlue plan offered and any waiting period that has been met under the prior plan will be applied towards the waiting period under this plan. Application must be submitted within 30 days of the appointment change.

If an employee in a represented position also holds a concurrent active nonrepresented appointment, the nonrepresented appointment, regardless of its percentage, will make this individual eligible to enroll providing he/she is eligible, or will be eligible, for state share contribution to health insurance.

In the event a participating nonrepresented employee transfers to an ineligible represented position the employee should be notified by the benefits office that the employee has 60 days, starting with the effective date of the new position, to terminate coverage under this plan and/or seek other available coverage. In situations like this the employee may be guaranteed an enrollment opportunity in another plan, if available, under HIPAA and may also be eligible for COBRA continuation under this plan.

DEPENDENT ELIGIBILITY

If application is not made within the deadlines shown below, the employee must wait until the next group Open Enrollment period or the Annual Change Opportunity to

increase coverage or to add additional, uncovered family members to an existing dental plan.

Single coverage in a health plan with dental coverage does not eliminate eligibility to select dependent coverage under these plans.

Dependents eligible for Anthem DentalBlue coverage include:

- 1.) Legally married spouse of the employee or;
- 2.) Domestic partner of the employee as evidenced by an approved Affidavit of Domestic Partnership.
- 3.) Unmarried children of the employee, spouse or domestic partner through the end of the year they attain age 19. Eligibility may continue until the end of the calendar year in which the child attains age 25 if the unmarried dependent child remains a full time student and receives at least 50% support from the employee or other parent.
- 4.) Unmarried children, of any age, who are incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent on the employee or other parent for support and maintenance. The children must be disabled before otherwise losing eligibility.
- 5.) The child of a dependent child (grandchild) until that dependent child (not the grandchild) attains the age of 18 years.

For dependents to be covered under the dental plan they must be listed regardless of whether or not family coverage is in effect. In other words, upon the birth of a child, an application form must be filed with the child listed as a dependent even if family coverage is already in effect. Failure to do so will result in the employee having to wait for the next Open Enrollment or the Annual Change Opportunity to add the dependent.

Note: In cases where both spouses/domestic partners are UW System non-represented employees, one of the employees can enroll in a single plan and the other can select a family plan or both employees can enroll in single plans if there are no dependents that they wish to insure. If one employee is covered under this plan and the other is covered under the OSER-sponsored plan, each may enroll for family coverage (and cover any dependent children) as these are considered to be two different dental plans.

FAMILY STATUS CHANGES

Coverage may be reduced from Employee Plus 2 or more to Employee Plus 1 or Employee only at any time. There does not need to be a family status change. The

reduced coverage will be effective on the first of the month for which the new premium is deducted.

When coverage is increased due to a family status change, the full month's premium is due if the effective date of the change falls between the 1st and the 15th of the month. If the change occurs on or after the 16th of the month, no premium is due for that month. Do not prorate premiums. Any newly added dependents are subject to the 90-day waiting period if the coverage is the Preferred PPO or the Supplemental plan.

Marriage

If an employee has Employee-only or Employee Plus 1 dependent coverage, and there is a change in status which would make the employee eligible for Employee Plus 1 or Employee Plus 2 or more dependents coverage, an application to add the additional family member(s) must be submitted within 30 days of FIRST becoming eligible for increased coverage due to marriage. The new coverage is effective as of the date of marriage.

If the employee has coverage under this plan and his/her spouse is covered under the OSER-sponsored plan, they could each add their spouse to their respective Anthem DentalBlue plans as their dependent and would receive the benefits of both plans. The plan that covers the individual as an employee pays before the plan that covers the individual as a dependent. If the employee also has Epic Excess Major Medical and Dental plan, Epic will always be the last payer.

Adding Dependent Children

Newborns: If an employee has coverage in effect, a newborn dependent child may be added within 60 days of childbirth. A new application must be filed with the benefits office and forwarded to Anthem DentalBlue, even if other dependent children are already covered under the plan.

Coverage is effective as of the date of birth or, if paternity is later established, on the date of the court order declaring paternity or the date that "Voluntary Paternity Acknowledgement" (form HCF 5024) is filed with the Department of Health and Family Services.

Adoption: If an employee adopts a child, an application to add the child must be filed within 60 days of the date of adoption. Coverage is effective as of the date of adoption.

Legal Guardianship: If an employee receives legal guardianship of a child, a new application adding the child must be filed within 30 days of the date of the court order appointing legal guardianship. Coverage is effective on the date that the legal guardianship is effective.

Return to Eligible Dependent Status: If an employee has an otherwise ineligible dependent child who returns to school as a full-time student and again meets the criteria for an eligible dependent, a new application must be filed within 30 days of again being eligible, such as starting school. Coverage is effective as of the first day of classes.

SPOUSE TO SPOUSE TRANSFER

A spouse to spouse transfer may also be accomplished if both participants are UWS employees and the primary subscriber terminates employment. Domestic partners qualify for spouse-to-spouse transfers. However, a spouse to spouse transfer is possible **only** if both spouses are covered under the same plan (i.e., DentaCare HMO, Preferred PPO or Supplemental plan) and group (Group # 83445). A spouse to spouse transfer is **not** possible between a State employee and a UWS employee since they are enrolled in different groups and have different risk pools.

A new application is required and there will be no interruption in coverage. Two employee-only plans for a husband, wife or domestic partner who maintain eligibility in the same Anthem DentalBlue plan (e.g., both have the Supplemental plan) may be combined:

- 1.) At any time, if no other persons are to be added to the membership, by submitting an Anthem DentalBlue application, with coverage effective as of the first payroll deduction to reflect the combined family coverage.
- 2.) Within 30 days following the date one spouse becomes ineligible for coverage, by submitting an application to the benefits office, with coverage effective as of the date of the spouse's termination of coverage due to ineligibility.
- 3.) During an Annual Change Opportunity or an Open Enrollment.

The spouse to spouse change does not allow the members to add dependents (unless a qualifying event has occurred) or to elect a different Anthem DentalBlue plan, nor will it effect the member's waiting period under the Preferred PPO or the Supplemental plan.

NAME CHANGE AND/OR ADDRESS CHANGE

A change must be reported by completion of an application form. Name changes will be reflected in the payroll processing reports. Mail the original copy to Anthem DentalBlue Enrollment and retain a copy of the form in the employee file. The UW Service Center does not need a 'report copy' if the form is used only for the reporting of name and/or address change.

If the employee is relocating for 90 days or more, he/she should select a new Dental Center within 30 days of the move if they have the Dentacare HMO or the Preferred PPO coverage. If their eligibility for the Supplemental plan changes that should also be noted to the employee as a plan change will be necessary.

EMERGENCY SERVICES

If emergency treatment is required and the member is 50 miles or more away from his/her selected Dentacare Center, the member should call the nearest Dentacare Center. The member is responsible for co-payments according to the schedule of benefits. If another Dentacare Center is not available, the member should arrange for treatment, obtain an itemized bill for the required services, and submit the bill to their selected Dentacare Center. The member will be reimbursed up to \$50.00 for emergency charges provided by a non-Dentacare provider.

Emergency is defined as a condition that needs to be treated immediately due to swelling, pain, and/or infection.

DENTAL CENTERS

Selection

Dentacare HMO members are required to select a Dentacare Center. The subscriber and covered dependents must receive their dental care from the same designated dental center; however, each person may choose any dentist associated with that dental center. Upon enrollment, if the employee fails to select a Dentacare Center, Anthem DentalBlue will assign one within the employee's service area.

If treatment is required that is not available at the selected Dentacare Center, the employee may receive treatment from a specialist outside of the Dentacare Network upon written referral from the Dentacare dentist.

Preferred PPO members, while not required to use a Preferred PPO Provider, will have lower out-of-pocket costs if a Preferred PPO Provider is selected.

Supplemental plan members may receive dental services from any licensed dentist.

Changing Centers

Employees and their dependents are allowed to change Dentacare Centers prospectively twice per calendar year regardless of the reason. A new application must be completed and submitted to the benefits office for processing. The requested effective date of the clinic change should be noted.

If the employee is relocating for 90 days or more, he/she should select a new DentaCare Center within 30 days of the move. If their eligibility for the Supplemental plan changes that should be noted to the employee as they must select the Dentacare

HMO or Preferred PPO. The effective date of the center change will be the later of the first of the month following the move or receipt of the application by the benefits office.

For additional changes the employee should submit a request to change Dentacare Centers directly to Anthem DentalBlue. Each case is reviewed through an appeals process and decided on a case-by-case basis.

Plan and Dentacare Center changes may also be done during an Annual Change Opportunity or an Open Enrollment. Changes in the Dentacare Center at these times will not count as one of two times per year that the employee may change Centers.

TERMINATION GUIDELINES

Cancellation

Voluntary cancellation will result in coverage termination at the end of the month for which the last premium payment has been made. The employee must complete an application indicating cancellation. Premiums are paid one month in advance.

The Plan does not provide refunds as a result of termination of coverage. Cancellation effective dates are always the end of the month. Refunds will not be prorated for partial months nor will refunds be processed for past coverage.

Loss of Eligibility

Employees: Employees who cease to be eligible for coverage due to termination of their appointment or premium non-payment will have their coverage terminated at the end of the coverage month for which the last premium payment was made.

Supplemental plan subscribers who change to a medical plan with no dental coverage will no longer meet the plan's minimum eligibility requirements. The subscriber will have 30 days from the date the new medical plan's effective date to enroll in either the Dentacare 186/HMO or the Preferred PPO Plan. Coverage under the Supplemental plan must be terminated.

Dependent Children: Unmarried children have coverage through the end of the year they attain age 19. Eligibility may continue until the end of the year the child attains age 25 if the unmarried dependent child remains a full time student who receive at least 50% support from the employee or other parent. Coverage ceases at the end of the year in which the unmarried dependent ends full time student status or reaches the limiting age. Coverage ends at the month in which the child marries or is no longer receiving 50% of support from a parent.

Unmarried children, of any age, who are incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent on the parent(s) for support and maintenance may remain covered indefinitely. However, they cannot be

added back to the plan if their coverage has previously been terminated due to reaching the limiting age.

Example: A dependent child's coverage ends at age 22, at the end of the year in which the child graduates from college (loss of student status). At age 26, the child is severely injured in a car accident. The child is not eligible to be added back on the employee's plan as a dependent.

However, if the child is in an accident at age 21 while still a covered dependent, he/she can remain a covered dependent as long as he/she is unmarried and meets the criteria for a totally disabled dependent.

If a dependent child marries or is no longer dependent upon a parent for at least half of their support and maintenance, they lose eligibility for dependent coverage at the end of the month in which they were married or the support and maintenance ends.

The child of a dependent unmarried child (i.e., a grandchild) has coverage through the end of the month in which the dependent child (not the grandchild) turns age 18.

Former Spouse/Domestic Partner:

A divorced spouse has coverage through the end of the month in which the divorce is final. Coverage for the divorced spouse's dependents will also end unless otherwise required by the divorce decree.

The domestic partner of an employee has coverage through the end of the month in which the "Termination of Domestic Partnership" form is filed. Coverage for his or her dependents will also cease.

In cases resulting from a termination of a relationship, a premium refund may be due if the deduction was already taken for prospective coverage. In all cases a new application should be completed.

If no dependents remain covered subsequent to the termination of dependent coverage, an application should be submitted to change to single coverage.

CONTINUATION of COVERAGE UNDER COBRA OR BY CONTRACT

Eligible employees and/or eligible dependents that participate in an Anthem DentalBlue plan and retire, terminate or lose coverage through an involuntary loss of eligibility are eligible to apply for continuation. If a required plan waiting period has not been met prior to application for continuation the waiting period met-to-date will be applied towards the waiting period for the continuation coverage. Continuants have the same premiums, benefits, rights and responsibilities as all other members.

(Exception: An employee who is terminated due to gross misconduct on the job is not eligible for COBRA.)

Eligible members can continue for the following time periods:

<u>Member</u>	<u>Duration</u>	<u>Coverage Provided Under:</u>
Employee	18 months*	COBRA
Divorced/Surviving Spouse	36 months*	COBRA
Domestic Partner (+ children)	36 months	By Contract
Dependent Child	36 months*	COBRA
Retiree	Indefinite	By Contract

* Under the 1985 federal COBRA legislation.

The benefits office should provide a continuation form/request to the member within 5 days of notice of loss of eligibility, regardless of whether the member is eligible to continue coverage (if the member is not eligible to continue coverage, state the reason why in the space provided at the top of the form). Newly ineligible dependents must also complete an Anthem DentalBlue application to establish themselves as the primary subscriber.

If the loss of eligibility is for a dependent, the employee must notify the benefits office within 30 days of the qualifying event in order for the dependent to be eligible for continuation unless the benefits office was previously made aware of the event, in which case the benefits office should take the initiative to issue the notice.

Individuals who are eligible to continue must submit the completed Continuation notice to Anthem DentalBlue within 60 days from either the coverage termination date or the date of the continuation notice, whichever is later, or the right to coverage continuation is lost.

The continuing individual should submit the continuation form and application (if necessary), to:

Anthem DentalBlue
4361 Irwin Simpson Road
Mason, OH 45040

Anthem DentalBlue will bill the individual. The benefits office is not required to collect advanced premiums.

There is no conversion plan available to terminating members.

Non-Covered Retirees

WRS retirees who were not covered as an active employee and/or declined to continue coverage, may be offered open enrollment opportunities, (to coincide with Dual-Choice)

to enroll through the Wisconsin Retired Educators' Association. Information is available from the Wisconsin Retired Educators' Association at 608-831-5115 (email: wrea@wrea.net) or on the OSER website at <http://oser.state.wi.us/docview.asp?docid=6114> (scroll to the bottom of the web page).

EMPLOYER ERROR PROVISION

In limited circumstances employer errors may be corrected.

The following situations will constitute an employer error:

- 1.) A monthly premium taken **after** an employee has filed a cancellation notice with the benefits office. Refund may be requested.
- 2.) Failure of the benefits office to advise an employee of his/her initial program eligibility or eligibility as a result of a change to an eligible position. Contact UWS Plan Administrator, Beth Ritchie
- 3.) Enrolling an employee who is in an ineligible position. Refund premiums if taken. This may require switching the employee to the OSER plan.
- 4.) Refunds greater than one month of premium requires approval of UWS, HR plan administrator, Beth Ritchie. In no event will premium refunds exceeding three months of premium be approved. Premium refunds in excess of three months should be submitted to your risk management department.

Even in the case of employer error, the coverage effective date is always prospective, never retroactive.

The UWS HR Plan Administrator must be contacted in all cases involving employer error.

The following situations do not constitute an employer error:

- 1.) Initial Enrollment: Failure of the employee to submit a completed application to the benefits office within contractual deadlines if advised of his/her plan eligibility prior to the filing deadline.
- 2.) 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. These situations will not result in the refund of past premiums.

- 3.) Open Enrollment: Failure on the employee's part to submit a completed application where notice has been given to the general populous institution-wide. If necessary, the benefits office may wish to consider giving employees who work off-site advance knowledge of upcoming Open Enrollments to ensure sufficient time to receive new enrollment applications.
- 4.) An employee misunderstanding of benefits. The exception to this rule is if the benefits office misinformed an employee as to the level of benefits available under a specific plan. The benefits office should contact the UWS Plan Administrator, Beth Ritchie, prior to counseling an employee if they have questions relating to the plans.

GRIEVANCE APPEAL PROCESS

A plan member who is not satisfied with Anthem DentalBlue's decision regarding benefit payment, denial of a claim or customer service can use the grievance appeal process. After the member has contacted Anthem DentalBlue Customer Service Department, in an effort to resolve the issue informally, the grievance appeal process involves filing a personal letter. The letter should include the employee's name (and name of family member involved), Anthem DentalBlue ID number, home address, subscriber number and daytime telephone number. The explanation of the complaint should be specific and include dates of service and contact with the dental provider. Anthem DentalBlue must receive the letter within 60 days of notification of the denial of benefits. The letter and any supporting documentation should be sent to:

Anthem Blue Cross and Blue Shield
Attention: Grievance and Appeals Unit
P.O. Box 33200
Louisville, KY. 40233-3200

The employee has the right to represent their concerns in person at the grievance review, and will be notified of the time and place of the review at least 7 days in advance. Anthem DentalBlue will provide a written decision, including the rationale for the decision, within 30 days of receipt of the grievance. If special circumstances exist which require an extensive review, the decision will be made within 60 days of the grievance receipt.

AGE DISCRIMINATION IN EMPLOYMENT ACT

The Age Discrimination in Employment Act (ADEA) prohibits discrimination against employees age 70 and over. The Anthem DentalBlue plans offered have no age limitation and, therefore, are in compliance with the ADEA.

Instructions to complete the Anthem DentalBlue application:

The instructions below are intended to assist you in the completion of the applications for the Anthem DentalBlue dental plans.

- 1) **Enrollment Type:** The employee should indicate what type of enrollment the application is being completed for.
 - a. **New Hire:** Check this box if this application is for a first enrollment opportunity.
 - b. **Open Enrollment:** Check this box if the application is being completed during an approved Open Enrollment.
 - c. **Cancel:** Check this box if the application is being completed to cancel existing dental plan coverage.
 - d. **HIPAA:** Check this box if the application is being completed as a result of a qualifying HIPAA event. For example, an involuntary loss of other dental coverage.
 - e. **Change/Move:** Check this box if the application is being completed to change existing coverage. For example, single to Employee Plus 1 coverage or a change in dental center selected. If the employee has the Dentacare HMO plan and relocates to an area that is not served by the designated clinic, the employee may change to the Preferred PPO or the Supplemental plan (if eligible) within 30 days of the move.

Note: If a represented employee is eligible for the OSER plan but is mistakenly enrolled in this plan (or vice versa), the employee does not need to complete a new application for the correct plan.
 - f. **Waive:** Check this box if the employee elects not to enroll at the time of his or her initial eligibility.
 - g. Check this box for a spouse-to-spouse transfer. Both employees must work for UW System and be enrolled in the same Anthem DentalBlue coverage plan.
 - h. Check this box if the employee transfers from other state employment, another UW System institution or from a represented appointment to a non-represented appointment (or vice versa).
 - i. There is a specific box to check if the individual is a WRS retiree.
- 2) **Employee Name:** Provide the last and first name and middle initial.
- 3) **Sex:** Indicate the employee's sex.
- 4) **Birth date:** Indicate the employee's birth date.
- 5) **Social Security Number:** Indicate the employee's Social Security Number.
- 6) **Street Address:** Indicate the employee's home mailing address.
- 7) **Telephone Number:** Indicate the employee's home telephone number.

- 8) **Marital Status:** Indicate the employee's marital status.
- 9) **Original Hire date:** This is needed to determine if the employee is enrolling during an established enrollment opportunity.
- 10) **Domestic Partners:** If the employee is enrolling a domestic partner, verify that a Domestic Partner Affidavit is on file at UWSA or request that the employee complete one.
- 11) **Agency/Campus:** Identify your Institution's Name.
- 12) **Plan:** Check the box that indicates which dental plan is being selected. If the Dentacare HMO is selected, the employee should indicate the selected Dentacare Center or one will be assigned by Anthem DentalBlue.
- 13) **Dental Center Selected:** If the employee selected the Dentacare 186/HMO (see #12) please provide the Dental Center's number, found in the 186/HMO Provider Directory. If the employee selected the Preferred PPO indicate the PPO Dental Center selected from the PPO Provider Directory. For the Preferred PPO plan selection of an approved provider is optional in order to receive higher coverage rates. For the Supplemental plan this box does not require completion.
- 14) **Coverage Desired:** Check the box that indicates the level of coverage being requested.
- 15) **Family Coverage Section:** If family coverage has been selected, indicate all parties eligible and enrolling for dental coverage.
- 16) **Change Section:** If the employee is requesting a change in coverage the employee should provide their name and subscriber number in the space provided.

If the employee is requesting a change from employee (single) to employee Plus 1 dependent or employee Plus 2 or more dependents coverage please indicate the reason for the change in the space provided.

If the employee is requesting a change from employee & 1 dependent or employee Plus 2 or more dependents coverage to employee coverage please indicate the reason for the change in the space provided. You will need to issue COBRA continuation notices to the dependents that are losing coverage. You have 5 days from the date you are notified of the change to issue the COBRA continuation notice.

- 17) **Other Coverage Section:** If the employee has other dental coverage, for example through a spouse's plan, the employee should provide the name the coverage is under in addition to other requested information. Coverage provided under the employee's health insurance or the Epic Dental and Excess Major Medical does not need to be reported.
- 18) **Employee Signature:** The employee should sign and date application.
- 19) **For Office Use Only:** The benefits office must complete prior to entering the deduction into the payroll system.
- a. **Employer Contact Name:** List the name of the person Anthem DentalBlue or the UWSC should contact if there is a question.
 - b. **Employer Contact Address:** Provide the address for the employer contact.
 - c. **Employer Contact Phone Number:** List the name of the person Anthem DentalBlue or the UWSC should contact if there is a question.
 - d. **Date Received:** Indicate the date the application was received in the benefits office.
 - e. **Coverage Effective Date:** Indicate the first of the month on or after you receive the application or January 1 if enrolling during an open enrollment
 - f. **If Applicable – Region 1 or Region 2:** If the employee elects the Dentacare HMO, indicate if he/she resides in Region 1 or Region 2.
 - g. **Deduction Code:** Indicate the appropriate deduction code.
 - h. **Premium Amount:** Indicate the premium for the plan and level of coverage elected
 - i. **Agency/Campus Code:** Indicate the alphabetical code for your institution.
 - j. **Group Number:** Indicate which group number applies to the employee (faculty and academic staff and non-represented classified are in Group 83445 and represented employees are in Group 93881).

Group Coverage Continuation Form

COBRA Final Rules require that even when COBRA is not available to an employee, spouse or dependent, the employer must provide an otherwise qualified beneficiary with a written explanation of why he or she is not entitled to continuation coverage. In the italicized paragraph at the top of the continuation form, HRIS-1603, please circle whether or not the member is eligible for continuation.

If the member is not eligible, indicate reason. For example, if a dependent child is not eligible to continue coverage because the employee did not notify the benefit office within 60 days of the loss of eligibility, include a statement, such as "Notice of loss of eligibility was not provided within the required time period".