

**State of Wisconsin and University of Wisconsin System Employees  
Dentacare HMO, Preferred PPO and Supplemental Plans  
Frequently Asked Questions  
Revised October 2009**

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

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

**1. Who is eligible for these plans?**

There are two identical plans. One is sponsored by the University of Wisconsin and the other is sponsored by the Office of Employment Relations (OSER).

For the OSER-sponsored plan, you must be an unclassified or non-represented classified employee working at a State agency (not the UW System) or a represented classified employee working for a State agency or the UW System.

For the University of Wisconsin System plan, you must be unclassified faculty, academic staff or short-term academic staff appointees, non-represented classified employees (including LTEs covered by the retirement system), non-represented graduate assistants, fellows and scholars and employees in-training are eligible.

For either plan:

- 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. You must be covered under a health insurance plan that provides preventive and diagnostic dental coverage to select the Supplemental Plan.
- c. If retiring, you may continue their coverage indefinitely with the same rights as an active employee.

**2. How do I contact Anthem DentalBlue if I have a question or a concern?**

You can contact Anthem DentalBlue by telephone or email, as well as by U.S. Mail. If you telephone Anthem DentalBlue about the Dentacare HMO or the Supplemental Plan, please call 1-800-627-0004. For issues relating to the Preferred PPO, please call 1-888-525-9296

Anthem DentalBlue has an Automatic Voice Response System (IVR) that will promptly direct you to the correct unit. When you call, have your Identification number handy. You will need this number as it is needed to direct your call based on the following options:

- Dial the appropriate customer service number
- Select Language: 1) English 2) Other
- Select who is calling: 1) Dental office; 2) Member; 3) Group Administrator; 4) Agent/Broker
- Speak or type in your Member ID number
- Options: You will be given options for the reason of your call. Select the most appropriate choice. You may not always need to speak to a customer service representative as the IVR was developed to answer simple inquiries.

If you prefer to email Anthem DentalBlue, there is an email address dedicated to UWS and State employees. The email address is [StateofWIEmpsDnService@anthem.com](mailto:StateofWIEmpsDnService@anthem.com).



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The mailing address for claims and correspondence for any of the three plans is:

Dental (Claims/Correspondence)  
P.O. Box 9211  
Oxnard, CA 93031-9211

The mailing address for enrollment information for any of the three plans is:

Anthem DentalBlue  
4361 Irwin Simpson Rd  
Mason, OH 45040

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You can also find additional information, by referencing the appropriate Dental Blue booklet for your selected plan, at the following link: <http://oser.state.wi.us/docview.asp?do>

**3. The dental plan is referred to as both DentalBlue and Dentacare but their materials also say Anthem. What is the difference?**

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.

**4. I am currently a represented employee enrolled in the OSER-sponsored dental plan and I will be moving to a non-represented position. Am I eligible to enroll in the UWS plan? What if I'm a non-represented employee moving to a represented position?**

Technically, there are two identical dental programs offered, one is offered through OSER to its employees and the other is offered through the University of WI System. If you are changing appointments and losing your eligibility for your current Anthem dental plan, this is considered a qualifying event and you may enroll in the other dental plan within 30 days of your new appointment start date. Any amount of an applicable waiting period previously satisfied will be applied to the waiting period under your new plan if there was no lapse in coverage.

**5. I just transferred to the UW from a state agency, or vice versa. Do I have enrollment opportunity for this plan?**

It depends. If you are first eligible for the UWS-sponsored or the OSER-sponsored plan, you have the same enrollment opportunity as any other new employee. If you are transferring between State agencies or upon transfer remain in either a represented or non-represented UWS appointment, your coverage will be transferred. You cannot change plans or add dependents until the next annual change opportunity. Any waiting period that has been met under one of these programs will be applied towards any waiting period under the new plan (provided there is less than a 30-day break between jobs). If you were already enrolled in the OSER plan and are still eligible for that plan after the transfer, you should still complete a new application to be sure that Anthem DentalBlue has your most current information.

**6. Am I eligible to enroll 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 may enroll in the Dentacare HMO or Preferred PPO when initially eligible or during an open enrollment. You may **NOT** 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.



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**7. 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.

**8. What if I'm a new classified employee and defer enrollment in group health insurance until the state contribution begins?**

If you are a new classified employee deferring health insurance enrollment until the state contribution begins, you may select the Dentacare HMO or Preferred PPO plan immediately or you may defer enrollment until you are eligible for the state share of health insurance premium. You may then enroll in any of the offered Anthem DentalBlue plans or change to the Supplemental plan within 30 days of your enrollment in a health insurance plan that offers diagnostic and preventive dental services.

If you do not enroll in a dental plan at one of the opportunities described above, you will not have another opportunity until a subsequent open enrollment. [See Questions 10 - 12 for enrollment deadlines.]

**9. If I carry health insurance under the Standard Plan, am I eligible to enroll in 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 enroll 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.

**10. Who are eligible dependents? How do I enroll my domestic partner?**

Eligible dependents include:

- Legally married spouse of the employee
- Domestic partner of the employee as evidenced by an approved "Affidavit of Domestic Partnership" (see next paragraph). For coverage effective on or after January 1, 2010, please use the ETF Affidavit, form ET-2371. <http://etf.wi.gov/publications/et2371.pdf>
- Unmarried children of the employee, spouse or domestic partner, through the end of the year in which the child attains age 19.
- Unmarried children may continue to be covered as your dependent until the end of the month in which the child attains age 27. 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. 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. 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.
- 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.
- Coverage ceases at the end of the month a dependent marries regardless of age.



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As mentioned above, domestic partners and their dependent children are eligible dependents under this dental program. To enroll a domestic partner, an Affidavit of Domestic Partnership must be filed with your application (ET-2371 <http://etf.wi.gov/publications/et2371.pdf>). There are strict time frames that must be met. If the domestic partnership later terminates, two forms must be submitted to your payroll office: 1) an Affidavit of Termination of the Domestic Partnership (ET-2372 <http://etf.wi.gov/publications/et2372.pdf>) and 2) a new application removing the domestic partner and his/her dependent(s) from coverage.

**11. 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 Affidavit of Domestic Partnership ((ET-2371 <http://etf.wi.gov/publications/et2371.pdf> 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.

**12. What is my enrollment deadline?**

If you want coverage in the dental plan to begin as soon as possible, 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 provides 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).

If you want to wait to enroll in the dental plan until you are eligible to enroll in the Supplemental Plan (i.e., delaying until the employer first contributes towards health insurance premiums), you must submit your application within 30 days from the first of the month following the month in which you complete your first two months as a State or University employee in the Wisconsin Retirement System (WRS). You may then elect the Supplemental Plan (provided your health plan provides preventive and diagnostic dental benefits), the Dentacare HMO, or the Preferred PPO.

This plan does not offer enrollment through Evidence of Insurability, therefore, if you do not enroll when initially eligible, you will have to wait for an open enrollment opportunity. Open enrollments will be periodically established through contract agreements.

**13. 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.

**14. 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. <http://www.uwsa.edu/hr/benefits/ins/dentcomp.pdf>

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



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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 at <http://www.uwsa.edu/hr/benefits/ins/dentblue.htm> 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 as a dependent student) or travel frequently. With the Supplemental plan, you may also see lower out-of-pocket costs by using a provider in the Preferred PPO directory but you may see the dentist of your choice.

### **15. 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.

### **16. How do I choose a clinic or dentist?**

Refer to the provider directories at <http://www.uwsa.edu/hr/benefits/ins/dentblue.htm> or <http://oser.state.wi.us/subcategory.asp?linksubcatid=1151>. 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 the provider's fees may be lower.

### **17. What happens if I enroll for the Dentacare HMO but forget to select a clinic or dentist when completing my application?**

The only plan that requires that you select a clinic is the Dentacare HMO. If you don't select a clinic, the dental administrator will select one for you and will send you an identification card that will indicate the name of that provider. To change the provider, complete a new application indicating your selection and return it to your staff benefits office. Refer to the HMO provider directory at <http://www.uwsa.edu/hr/benefits/ins/dentblue.htm> or <http://oser.state.wi.us/subcategory.asp?linksubcatid=1151>. **Important:** You may only change providers twice in a calendar year. This would count toward that limit.

### **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. 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.



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**20. Is the Dental and Excess Medical plan + EyeMed (EPIC) deductible satisfied by charges paid under the Anthem DentalBlue plan?**

No. While the EPIC plan does provide dental coverage in addition to excess medical coverage, it is in no way associated with Anthem DentalBlue. If you have coverage under both EPIC and an Anthem DentalBlue plan, the EPIC will always be the last plan to pay. You must still meet the \$75 per person deductible for benefits to be payable by EPIC.

**21. If I have some dental coverage through my health plan and one of the Anthem DentalBlue plans and am also enrolled in the Dental and Excess Medical +EyeMed plan (EPIC), 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 is: (1) the health plan, (2) the Anthem DentalBlue plan and (3) the EPIC plan. EPIC will always be the last to pay.

**Example Using the 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 Dental Blue 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 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 for covered dental services, is deducted from the \$1800 claim, leaving a balance of \$1725. EPIC pays 50%, up to an annual maximum of \$1,000. Fifty percent of \$1725 balance is \$862.50; however, in this example EPIC’s payment is limited to \$675 so as not to exceed the actual amount of the claim.

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

Then they calculate EPIC’s payment as if it were the primary payer.

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



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**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% 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 will be an annual change opportunity each October for subscribers to *change* plans for the following contract year, effective January 1st. This does not necessarily mean, however, there will be an opportunity to enroll, i.e., an open enrollment period, each year.

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 1<sup>st</sup>. If your effective date is after October 1<sup>st</sup>, 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 eligible for Anthem dental insurance. Can we both enroll in 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. I am going on leave and have employee only coverage. I am letting my coverage lapse while on leave. If an Anthem DentalBlue open enrollment occurs during the time I am on leave, will I be eligible for open enrollment when I return? If I am eligible for open enrollment, can I enroll in any plan as well as any level of coverage (e.g. employee, employee & 1 or employee & 2+)?**

You will be eligible for open enrollment when you return from leave provided you re-enroll within 30 days of your return to UW employment. You will be eligible to choose any level of coverage; however, if your health insurance plan does not cover any diagnostic and preventive dental services, you may NOT select the Supplemental Plan. If you terminate employment without returning to work, you do not have any rights to continue the coverage if you let coverage lapse.



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**28. I am moving and am changing from an HMO to the Standard Plan health insurance. May I continue to have coverage under the Supplemental Plan?**

No. If you change to a medical plan that does not offer diagnostic and preventive 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 within 30 days of the date your Standard Plan coverage begins. If you later move back and re-enroll in an HMO, you may not change back to the Supplemental Plan until the next annual change opportunity or an open enrollment period.

**29. 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.

**30. I carry health insurance through an HMO and the Anthem DentalBlue Supplemental Plan. When I retire later this year I will change to the Standard Plan for health insurance because I am moving from Wisconsin. Will I have the opportunity to change to the Dentacare 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 PPO Plan because you are moving out of the service area 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 as there won't be network providers available to you.

**31. Can I continue coverage if I terminate employment?**

Yes. Coverage may be continued by completing a continuation form, UWS-8 ([www.uwsa.edu/hr/benefits/ins/uws8.pdf](http://www.uwsa.edu/hr/benefits/ins/uws8.pdf)) or OSER-DCLR-216a (<http://oser.state.wi.us/docview.asp?docid=5449>).

Coverage may be continued for 18 months in the event of termination of employment or, for dependents, up to 36 months if coverage is lost due to death of the employee, divorce or legal separation or loss of eligibility for a dependent. If dependents lose coverage due to divorce or legal separation or loss of eligibility for a dependent, the payroll/benefits office must be notified within 60 days of the event or the right to continue coverage is lost.

**32. How long may I continue the dental plan at retirement?**

Indefinitely, as long as you are terminating employment **due to retirement** and you submit the continuation form (<http://www.uwsa.edu/hr/benefits/ins/uws8.pdf> or <http://oser.state.wi.us/docview.asp?docid=5449>) within the required time period. Should you die, your insured surviving spouse may continue coverage indefinitely.

**33. Will I be able to enroll for Anthem DentalBlue coverage if my health insurance plan drops dental benefits?**

Yes. You would have a 30-day enrollment opportunity after the date the other coverage is lost. You will be asked to provide evidence that other coverage ended.

**34. 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 or an open enrollment. Complete a new application and return it to your staff benefits office.



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**35. 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

**36. 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](mailto:StateofWIEmpsDnService@anthem.com).

Written correspondence should be sent to:

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

See question 2. for additional information please contact Anthem DentalBlue.