2018 SPECIAL ENROLLMENT

DENTAL WISCONSIN

Designed Exclusively for State of Wisconsin Members

DENTAL WISCONSIN PROGRAM			
2018 Plan Coverages	Preferred Provider Organization Plan (PPO)		Select Plan
	In-Network	Out-of Network	
Diagnostic/Preventive	100%	75%	No Coverage
Basic – includes oral surgery	75%	55%	75%
Major/Restore – includes implants	50%	25%	50%
Ortho – for children under the age of 19*	50%	50%	50%
Ortho Lifetime Maximum*	$1,000		$1,000
Annual Deductible	$25	$50	$50
Office Visit Copay	None		None
Annual Dental Maximums • First year of coverage (2018) • Second year of coverage (2019) • Third year of coverage (2020 and later)	**PPO** $600 $800 $1,250		**Select Plan** $600 $800 $1,250
Orthodontic Lifetime Maximum*	$1,000 per member		
Endodontic & Periodontic	Both Under Major/Restore		Both Under Major/Restore
Coverage Orthodontic*	Waiting Period 24 months		Waiting Period 24 months
Network	Dental PPO Providers	Any Dentist	Any Dentist
WI Providers	1,521	4,553	4,553

** For eligible children under 19. All appliances must be in place before the eligible child's 19th birthday. There is a 24-month waiting period from the dependent's effective date for benefits for orthodontic services and supplies.* ***Note: We'll pay secondary after your primary dental plan.***

MONTHLY RATES IN 2018		
Active Employees	**PPO Plan***	**Select Plan**
Employee	$22.38	$21.04
Employee + Spouse	$47.40	$43.24
Employee + Child(ren)	$52.98	$49.90
Family	$80.10	$73.36
Annuitants	**PPO Plan***	**Select Plan**
Insured	$35.62	$27.56
Insured + Spouse	$75.42	$56.68
Insured + Child(ren)	$84.34	$65.40
Family	$127.48	$96.20

** Rate reduced or not changed.*

ANY DENTIST

You may visit any dentist; you will recieve the best value when you choose a Delta Dental provider. **Since Delta's Contract with EPIC provides an extensive network of providers (93% of WI Dentists), it's easy to locate one near you.** However, If you choose to receive treatment from a provider not in the Delta network, you'll still be eligible for coverage. Any difference between EPIC's allowable amount and what the provider charges will be your responsibility.

FIND A PROVIDER

To find a provider, visit our website **EPICBenefits.com**, click on the "Employees of the State of Wisconsin" link, and click on the "Dental Wisconsin" tab. You will find links for Delta Dental PPO Providers and Premier Providers.

Not sure if your dentist is a Delta Dental provider? Call Delta Dental at **800-236-3712**, visit Delta Dental on the web at **deltadentalwi.com** or contact your dentist directly.

HOW TO ENROLL

Consult your payroll office for enrollment requirements. Enrollment must occur at the time of a qualifying event. Visit etf.wi.gov for more information on qualifying events. You must be eligible to enroll in a State of Wisconsin sponsored health plan to be eligible for this coverage.

Note: You are required to remain enrolled for the calender year unless your eligibility changes.

This general outline of benefits does not serve as a legal document. For complete list of benefits, limitations and exclusions, please see contract.

***Questions?** Call EPIC: 800-520-5750 | Delta Dental: 800-236-3712 | EpicBenefits.com | Enrollment Period: Oct 2-27, 2017 Effective 1/1/2018

Other Information

EPIC SPECIALTY BENEFITS

AUTOMATIC DEDUCTION

Premiums will be conveniently deducted from your paycheck on a pre-tax basis automatically when you enroll in this benefit. If you prefer to have your insurance premiums deducted post-tax, you must file an *Automatic Premium Conversion Waiver* (ET-2340) before your benefits begin or prior to the next plan year. You must continue the coverage for the entire year, unless you experience a valid change in status event that allows you to change or cancel coverage. Once you file a waiver, it will remain in effect until you revoke it. *NOTE: If you have coverage that includes a domestic partner, non-tax dependent or you are a limited term employee, your premiums will be deducted post-tax from your paycheck.*

The State of Wisconsin requires each employee to identify any family members who are not "tax dependents." A "tax dependent" is a person who qualifies as your dependent on your income tax for Internal Revenue Code purposes. Your family members, including adult children, do not need to be "tax dependents" to be eligible for coverage.

Please Note: If there are differences in this document and the Group Policy Contract, the Group Policy Contract is the governing document. This insurance plan has been authorized by the Group Insurance Board (Board) for the purpose of permitting premium collection through payroll deductions under authority granted by § 40.03 (6) (b) and pursuant to §20.921 (1) (a) 3. State Statutes. The standards used by the Board include, but are not limited to: documentation of financial stability, demonstration of a reasonable ratio of claims paid to the premium level, authority to conduct business in the State of Wisconsin, agreeing to conditions for the rate-making process, value to state employees and other administrative conditions. Department of Employee Trust Funds (ETF) staff and the Board's actuary review proposals for participation prior to Board approval. However, the Board does not require competitive bids nor a benefit comparison with similar products from other vendors.

Exclusions

The following aren't covered under the policy. The policy provides no benefits for: Dental services for any illness or injury covered by Worker's Compensation or similar laws, even if a member doesn't choose to claim such benefits. • Dental services furnished by the U.S. Veterans Administration, except for such dental services for which under the policy we are the primary payor and the U. S. Veterans Administration is the secondary payor under applicable federal law. • Dental services furnished by any federal or state agency or a local political subdivision when the member is not liable for the costs in the absence of insurance, unless coverage under the policy is required by any state or federal law. • Dental services covered by Medicare, if a member has or is eligible for Medicare, to the extent benefits are or would be available from Medicare. • Dental services for any injury or illness caused by: (1) atomic or thermonuclear explosion or resulting radiation; or (2) any type of military action, friendly or hostile. • Dental services for cosmetic purposes, unless necessitated as a result of injuries sustained while the member is covered under the policy. • Dental services which aren't dentally necessary or which aren't appropriate to the treatment of an illness or injury as determined by us. • Dental services provided by members of a member's immediate family or anyone else living with him/her • Dental services which are experimental or investigative. • Dental services not specifically identified as being covered under the policy. • Dental services when not provided by a dentist, physician or a licensed dental professional performing a related service requested by a dentist or physician. • Dental services provided when a member's coverage was not effective under the policy. This includes care provided either prior to the member's effective date of coverage or after his/her coverage terminated under the policy. • Dental services in connection with any illness or injury caused by a member's commission of, or attempt to commit, an assault, battery, felony, or act of aggression, insurrection, rebellion, participation in a riot or engaging in an illegal occupation. • Dental services for replacement of a lost or stolen prosthesis or for a replacement or second prosthesis. • Dental services for oral hygiene, dietary, or plaque control instructions and programs. • Athletic mouth guards. • Any amount billed by a dentist, physician or licensed dental professional because of the patient's failure to appear for a scheduled appointment. • Dental services received from the dental or medical department of any employer, union, employee benefit association, trustee, or for services of a dentist or clinic contracted for or by any such organization. • Dental services for dentures, crowns, inlays, onlays, bridgework or appliances for altering vertical dimensions. • Dental services for denture or bridgework adjustments provided to a member within six months of the placement of a denture or bridgework with that member. • That portion of the amount billed for a porcelain-veneer crown or pontic on or replacing a tooth or teeth posterior to the second bicuspid, which exceeds our determination of the charge for a full-cast metal crown or pontic. • Dental services for a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the reasonable charge for the permanent denture or bridge. • Dental services provided, for, or in connection with, precision or semi precision attachments, denture duplication or other customized attachments. • Drugs and medicines, other than injectable antibiotics administered by a dentist or physician as a result of dental treatment. • Orthodontia services except as specifically provided by the policy. • Dental services or that portion thereof, for which the member has no legal obligation to pay. • Dental services, including, but not limited to, oral surgical services, or that portion thereof, which are covered expenses under the member's EPIC group health coverage or any other medical coverage that he/she has, or for which benefits are paid under such EPIC coverage or other coverage. • Dental services provided during any waiting periods. • Dental services provided in connection with the treatment of the temporomandibular joint, except for oral surgical services. • That portion of the amount billed for the dental service covered under the policy that exceeds our determination of the charge for such dental service. • Orthodontia services for other than malocclusion of natural teeth. • Crowns for the purpose of periodontal splinting.

General Information - This brochure is only a general outline of benefits, limitations, and exclusions. You can find a more detailed description of coverage in the applicable certificate of insurance. A certificate will be issued to each employee who becomes insured under the plan. The words "charge" and "charges" as used in this brochure mean an amount we determine as reasonable, considering factors such as the amount providers charge for similar services and supplies provided in the same geographic area. Coverage is subject to all terms and conditions of the policy, which is your contract of insurance. The policy consists of the group master policy, including the application and all policy riders and endorsements.