

Chapter 2 — Health Plan and Program Information

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The Wisconsin Public Employers Group Health Insurance Program offers three types of plans to participating employees and annuitants: alternate health plans, the Standard Plan, and the State Maintenance Plan. Effective January 1, 2015, there are four different Program Options to choose from, including a High Deductible Health Plan (HDHP) option.

201 Alternate Health Plans (HMOs and PPOs such as WEA Trust)

Alternate health plans are health maintenance organizations (HMOs) and preferred provider organizations (PPOs) that provide Uniform Benefits at a lower cost, with slightly different benefits, than the Standard PPO Plans. Most employees select an alternate health plan.

All alternate health plans participating in the Group Health Insurance Program offer the same level of coverage, called Uniform Benefits, with the exception of dental coverage that may be offered at the discretion of the health plan. If dental coverage is offered, it is Uniform Dental Benefits.

Uniform Benefits, as detailed in the *It's Your Choice Reference Guide*, are designed to ease employee health plan selection and assist ETF's efforts to negotiate quality care at the lowest possible cost. Uniform Benefits permit employees to select a health plan based on cost, quality of services, and access to specific physicians or other health care providers.

While Uniform Benefit coverage levels are the same for alternate health plans, plans differ in other ways, namely premium amount, provider network, benefit determinations and administrative requirements. Uniform Benefits and premium amounts change on an annual basis, so the latest *It's Your Choice Decision Guide* (ET-2128d) and *Reference Guide* (ET-2128r) are the most reliable resources for details.

Note: Benefits generally differ for annuitants and their dependents enrolled in Medicare.

202 Standard PPO Plan

The Standard PPO Plan is a comprehensive self-insured Preferred Provider Organization (PPO) that is currently administered by WPS Health Insurance (WPS). Participants enrolled in the Standard Plan can see a provider of their choice without the network restrictions associated with an HMO. In exchange for this freedom to select the provider of their choice, the participants have different benefit levels depending on whether the provider selected is in-network (higher benefit level) or out-of-network (lesser benefit level). Participants can review the *Standard PPO Plan* brochure for more details regarding the differences between the benefits under the Standard Plan and the Uniform Benefits offered under the alternate health plans.

Four different Standard PPOs are available, based upon the Program Option (PO) an employer selects (refer to subchapter 204). Detail about them is available as follows:

PO 2: <http://etf.wi.gov/publications/et2131.pdf>

PO 6: <http://etf.wi.gov/publications/et2160.pdf>

PO 4: <http://etf.wi.gov/publications/et2162.pdf>

PO 7: <http://etf.wi.gov/publications/et2170.pdf>

Members who choose this plan typically want the freedom of choice to see any provider, anywhere. They tend to be higher utilizers of care and thus the cost of this plan is typically greater than an alternate plan.

203 State Maintenance Plan (SMP)

The State Maintenance Plan (SMP) offers the same Uniform Benefits package as the alternate health plans, but is available only in those counties that do not have a qualified Tier 1 alternate health plan as noted in the current *It's Your Choice Decision Guide*. The SMP is administered by WPS.

204 Three Health Insurance Premium Contribution Structures Available

Employers may not provide payments to employees in lieu of coverage under the WPE Group Health Insurance Program. Employer contributions toward health insurance coverage are limited to those described in Wis. Stat. § 40.51 (7) and Wisconsin Administrative Code ETF 40.10.

Under the law, participating employers potentially have three structures available for

establishing employer contribution toward premium. The 88% Calculation Method, which must also align with the 105% calculation, the Three-Tiered Premium Structure and the 105% Formula Method that is only available to those groups identified in the law following passage of 2011 Wisconsin Act 10. Contributions can vary by employee groups. A group can be defined by start dates, full-time equivalency, coverage type (single or family), collective bargaining agreements and/or geographic location. Contact ETF with questions.

1. The 88% Calculation Method must align with the 105% calculation. The 88% and 105% rate tables ETF provides indicate the maximum employer share. If a health plan's premium is equal to or less than the employer's share, the employer pays the entire premium. The employer may adjust the employer contribution downward to require employees who select low-cost plans to pay some amount. The employer must apply the same adjusted contribution rate equally to all employees within the same group, regardless of the plan they select.

The criteria for a local employer using either the 88% Calculation Method or the 105% Formula Method are as follows:

- Participating employers are allowed to pay up to 88% of the average premium cost of the qualified Tier One health plans within the service area of the employer (i.e., the county).
 - The 105% of the low-cost qualified health plan contribution method still applies. This method allows the employer to contribute toward the premium for any eligible employee an amount between 50% and 105% of the least costly qualified health plan within the county of the employer.
 - The minimum employer premium contribution for all local employees cannot be less than 50% for employees who work 1,044 hours or more per year or less than 25% for employees who work fewer than 1,044 hours.
2. The Three-Tiered Premium Structure is also available for employers to use in establishing the maximum employee contribution toward premium. Each year the Group Insurance Board and its consulting actuaries rank and assign each of the available health plans to one of three "tier" categories. An employee's premium contribution is determined by the tier ranking of the health plan selected.

The criteria for a local employer to implement tiering is as follows:

- The employee portion of the monthly premium will increase for plans in higher tiers by at least \$20 for single coverage and \$50 for family coverage for each successively higher tier.
- The employee's single or family premium contribution must be the same for all plans in a given tier.
- A number of provisions affect the amount an employer may contribute toward the employee cost of health insurance. 2011 Wisconsin Act 10 also requires that participating local employers not pay more than 88% of the average premium

cost of the qualified tier one health plans. If a collective bargaining agreement is in effect, the terms of that agreement regarding group health insurance apply. In addition, Administrative Code ETF 40.10 prohibits the employer from paying more than 105% of the least costly qualified health plan within the employer's county.

- The employer must pay at least 50% of the premium for employees who work 1,044 hours or more per year and can pay no less than 25% of the premium for employees who work fewer than 1,044 hours per year.
3. All employees of participating local employers are subject to the 88% maximum contribution method except those listed below. For these, the 105% formula applies or a tiering structure that aligns with the 105% formula may be used:
- Represented employees who are subject to a collective bargaining agreement that was in place before June 28, 2011.
 - Non-represented managerial law enforcement or managerial fire-fighting employees initially hired by a local employer before July 1, 2011. These employees are paid at the same percentage as represented law enforcement or fire-fighting personnel hired before July 1, 2011.
 - Represented law enforcement or fire-fighting employees initially hired before July 1, 2011 and who on or after July 1, 2011 became a non-represented law enforcement or fire-fighting managerial employee. These employees are paid at the same percentage as represented law enforcement or fire-fighting personnel hired before July 1, 2011.

In these cases, the 105% of the low-cost qualified health plan contribution method still applies.

Health plans must have providers in the geographic area serving the majority of the employees in order to be considered in the employers' contribution formula; however, this does not limit the employee's choice of plans. Employees may select any plan offered by this program, as long as they are willing to receive health care from its respective network providers.

Note: The State Maintenance Plan (SMP) will be designated as the low-cost qualified health plan in those counties where other plans do not meet the minimum provider qualification requirements. In those counties, the 88% formula is based on SMP rates.

For health plan premium rates, refer to the *It's Your Choice Decision Guide* (ET-2128d) or applicable addendums for the *Coinsurance* (ET-2168), *Deductible* (ET-2158) or *High Deductible Health Plan* (ET-2169) program options.

Premiums change annually on January 1.

205 Program Options (PO)

Local government employers have flexibility in choosing cost-sharing plan options under the WPE Group Health Insurance Program. Employers may offer up to four program options (POs) to different classes of employees (that is, collective bargaining units). Individual employees cannot choose between POs. Following the bulleted descriptions below, a grid briefly illustrates the differences between the POs.

Local employers may change POs or enroll under additional program options once a year, by submitting an *Existing Employer Option Selection Resolution* (etf.wi.gov/publications/et1152.docx) with ETF before October 1. It must be signed by your governing body. Employers having questions about changing, adding, or deleting program options may call the Employer Services Section at 1-877-533-5020 or 608-266-3285.

PO 2: Traditional or HMO-Standard PPO. Under this program option, subscribers select from:

- Traditional (no coinsurance or deductible) Uniform Benefits offered by the Alternate Health Plans (refer to subchapter 201).
- Standard PPO that allows participants to see their choice of provider with higher out-of-pocket costs for out-of-network providers. Detail is provided in the *It's Your Choice Guides*.

PO 6: Coinsurance HMO-Standard PPO. Subscribers select a health plan that offers Coinsurance Uniform Benefits or the Standard PPO. This program option offers Uniform Benefits premium rates that are approximately 5% lower than PO 2 rates.

- Coinsurance Uniform Benefits' offered by the Alternate Health Plans, includes a member coinsurance of 10% up to a maximum of \$500 individual/\$1000 family except for federally required preventive care. Such care is 100% covered. This program option mirrors the Uniform Benefits offered to state employees. Over time, if changes are made to the state Uniform Benefits plan, this plan will mirror those changes.
- The Standard PPO allows participants to see their choice of provider, with higher out-of-pocket costs for out-of-network providers. This program has larger deductible and coinsurance costs than the PO 2 Standard PPO allowing for greater premium savings.
- More detail is provided in the addendum at: <http://etf.wi.gov/members/IYC2015/et2168.pdf>.

PO 4: Deductible HMO--Standard PPO. Subscribers select a health plan that offers Deductible Uniform Benefits or the Standard PPO. Uniform Benefit premium rates in PO 4 are approximately 10% lower than PO 2 rates.

- Deductible Uniform Benefits, offered by the Alternate Health Plans, contains an up-front deductible on all medical services except for federally-required preventive

care. Such care is 100% covered. The deductible is \$500 individual/\$1000 family per calendar year. Once the deductible is met, benefits are administered generally without coinsurance.

- The Standard PPO allows participants to see their choice of providers, with higher out-of-pocket costs for out-of-network providers. This program has larger deductible and coinsurance costs than the Standard PPOs of PO 2 and PO 6 allowing for greater premium savings.
- More detail is provided in the addendum at: <http://etf.wi.gov/members/IYC2015/et2158.pdf>.

PO 7: High Deductible Health Plan (HDHP) HMO-Standard HDHP PPO. Subscribers select a health plan that offers an HDHP Uniform Benefits or the Standard PPO. This option will be compliant with Health Savings Accounts or Health Reimbursement Accounts. The employer may set up such plans as they wish.

- HDHP Uniform Benefits, offered by the Alternate Health Plans, contains a deductible of \$1,500 single, \$3,000 family except for federally required preventive care. Such care is covered at 100%. In a family plan, the entire \$3,000 deductible must be met before the coinsurance coverage begins. This deductible applies to all services (including prescription drugs and offered Uniform Dental). After the deductible, medical services are subject to a 10% member coinsurance and pharmacy benefits apply to the listed copays up to an overall out-of-pocket limit of \$2,500 individual, \$5,000 family. This program option mirrors the HDHP Uniform Benefits offered to state employees. If changes are made to the state HDHP, this plan will mirror those changes.
- The Standard HDHP PPO allows participants to see their choice of providers, with higher out-of-pocket costs for out-of-network providers.
- More detail is provided in the addendum at: <http://etf.wi.gov/members/IYC2015/et2169.pdf>.

Note: Please refer to the Non-Medicare Benefits - Program Options Table on the following page.

**Wisconsin Public Employees
 Non-Medicare Benefits
 Program Options Effective January 1, 2015**

NON-MEDICARE BENEFITS		Program Option 2	Program Option 4	Program Option 6	Program Option 7	
		'Traditional'	'Deductible'	'Coinsurance'	'High Deductible - HDHP'	
UNIFORM BENEFITS	(For HMOs and some PPOs: benefits described for services at plan providers only)	Traditional Uniform Benefits (No deductible or coinsurance.)	\$500 Single / \$1,000 Family deductible except as required by federal law. After deductible is met, Uniform Benefits apply	90%/10% coinsurance to \$500 Single / \$1,000 Family out-of-pocket limit, except as required by federal law. After coinsurance is met, Uniform Benefits apply	\$1,500 Single / \$3,000 Family deductible and 90%/10% coinsurance (most services) to \$2,500 Single / \$5,000 Family out-of-pocket limit, applies to allowable medical, prescription drug and applicable dental services except as required by federal law. After coinsurance is met, Uniform Benefits apply.	
STANDARD PPO BENEFITS		Freedom of Choice type Benefit:	Standard PPO	Standard PPO	Standard PPO	Standard PPO HDHP
	Deductible (Unless otherwise noted, it is an overall deductible)	<i>In-Network:</i> \$100 Single / \$200 Family <i>Out-of-Network:</i> \$500 Single / \$1,000 Family	<i>In-Network:</i> \$500 Single / \$1000 Family <i>Out-of-Network:</i> \$1,000 Single / \$2,000 Family	<i>In-Network:</i> \$250 Single / \$500 Family <i>Out-of-Network:</i> \$500 Single / \$1,000 Family	<i>For allowable medical, dental (if available) and prescription drug claims:</i> <i>In-Network:</i> \$1,700 Single / \$3,400 Family <i>Out-of-Network:</i> \$2,000 Single / \$4,000 Family	
	Coinsurance	<i>In-Network:</i> 100% / 0% <i>Out-of-Network:</i> 80% / 20%	<i>In-Network:</i> 80% / 20% <i>Out-of-Network:</i> 70% / 30%	<i>In-Network:</i> 90% / 10% <i>Out-of-Network:</i> 70% / 30%	<i>In-Network:</i> 90% / 10% <i>Out-of-Network:</i> 70% / 30%	
	Annual out-of-pocket limit (Includes deductible & coinsurance)	<i>In-Network:</i> \$100 Single / \$200 Family <i>Out-of-Network:</i> \$2,000 Single / \$4,000 Family	<i>In-Network:</i> \$2,000 Single / \$4,000 Family <i>Out-of-Network:</i> \$4,000 Single / \$8,000 Family	<i>In-Network:</i> \$1,000 Single / \$2,000 Family <i>Out-of-Network:</i> \$2,000 Single / \$4,000 Family	<i>For allowable medical, dental (if available) and prescription drug claims:</i> <i>In-Network:</i> \$3,500 Single / \$7,000 Family <i>Out-of-Network:</i> \$3,800 Single / \$7,600 Family	

The WPE Group Health Insurance Program provides two different plan options:

- **Uniform Benefits** option (denoted in green in the chart).
- **Standard PPO Benefits** option (denoted in orange in the chart).

Note: Most employees opt for the Uniform Benefit option (denoted in green in the chart).

206 Pharmacy Benefit Manager (PBM) - Navitus

A pharmacy benefit manager (PBM) is the third party administrator of the prescription drug program and is primarily responsible for processing and paying prescription drug claims. All participants in the Group Health Insurance Program receive their pharmacy benefits through the PBM, Navitus Health Solutions, regardless of the health plan they have chosen.

Medicare eligible retirees enrolled in the Group Health Insurance Program will be automatically enrolled in the Navitus MedicareRx (PDP) plan, which is underwritten by Dean Health Insurance Inc., a federally-qualified Medicare Part D prescription drug plan. In addition, these retirees will also have supplemental “Wrap” coverage that pays secondary to the Navitus MedicareRx (PDP) plan.

Retirees may choose to be enrolled in another Medicare Part D plan, but it is neither recommended nor required. Retirees who choose to enroll in another Medicare Part D plan will be disenrolled from the Navitus MedicareRx (PDP) plan. However, they will still maintain the supplemental “Wrap” coverage, which will be secondary to the other Medicare Part D plan. There is no partial premium refund for enrolling in another Medicare Part D plan.

Pharmacy ID Cards

Subscribers receive separate ID cards from Navitus and must present that ID card to their pharmacist when filling a prescription. Please contact Navitus (refer to subchapter 106) for questions pertaining to the pharmacy benefit. In addition, retirees who maintain their enrollment in the Navitus MedicareRx (PDP) plan will receive a separate ID card specifically for the Navitus MedicareRx (PDP) plan.

207 Health Plan Contacts

Health plan addresses and phone numbers are listed on the inside back cover of the *It's Your Choice: Decision Guide* (ET-2128d). Your employees are encouraged to contact health plans using the resources listed on this page with specific questions regarding such topics as referral policies, benefits, filing of claims and/or provider networks.

Refer to <http://etf.wi.gov/publications/et1728.pdf>, which can be found under the Employer Forms and Brochures sections. Employers may use the contacts on this form to get answers to questions on membership, claims, grievances, supplies (and other information) etc. This form should not be shared with employees.

208 Coordination of Benefits (COB)

For a variety of reasons, some individuals are covered under more than one group health insurance plan. When this occurs, insurance regulations are used to “coordinate” or determine the order in which the benefits are paid. The plan that pays first is called the “primary plan” and the plan that pays next is the “secondary plan.” The insurance regulations for determining the order in which plans will pay benefits are described in the Uniform Benefits section of the *It’s Your Choice Reference Guide* (ET-2128r).

Questions regarding COB should be directed to the health plans.