

State of Wisconsin Group Health Insurance Program for
State of Wisconsin Employees
Retired State of Wisconsin Employees (Annuitants)
Members with Continuation Coverage (Continuants)
UW Graduate Assistants

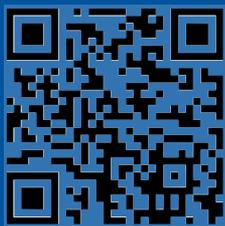


It's Your Choice 2015 Decision Guide

To Help You Choose Your Group Health Insurance Plan

Enrollment Period

October 6 to 31, 2014



Scan to read online.

Turn The Page
To Explore Your Options
For Health Insurance
Coverage

New Health Insurance Program for 2015

HDHP/HSA Highlights

All health plans will offer a High Deductible Health Plan (HDHP) option. If you choose to enroll in an HDHP, you will also enroll in a new Health Savings Account (HSA) and your employer will deposit funds in your account for you to use for qualified health care expenses.

What is an HDHP?

It is a health plan that, under federal law, has a minimum annual deductible and a maximum annual out-of-pocket limit set by the IRS. An HDHP does not pay any health care costs until the annual deductible has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The plan is designed to offer a lower monthly premium in return for more shared health care costs by the member.

HDHP Quick Facts

- The HDHP has a deductible of \$1,500 single/\$3,000 family for 2015. The deductible must be met before the health plan covers any medical, prescription drug, or dental expenses with the exception of some preventive services or prescriptions as mandated by federal law.
- The HDHP employee premium rates are lower in exchange for increased employee cost sharing.
- All HDHPs will provide a uniform set of benefits.

What is an HSA?

An HSA is an account established by an individual to pay for health care expenses. To set up an HSA, the individual must be covered by a federally qualified HDHP. HSAs are owned by the individual, balances roll over from year to year and the funds are portable, meaning the employee keeps them if they leave the HDHP plan or state service. The funds in an HSA can be used to pay for qualified medical expenses that are not covered by your health plan, and can be saved for future expenses on a pre-tax basis. The funds can also be invested, but a \$2,000 account balance threshold is required in order to move funds into an HSA investment account with TASC (HSA vendor).

HSA Quick Facts

- An HSA is a savings account that you will own. The money in the account is always yours – even if you leave state service.
- Your employer will contribute to your account in 2015. You can also contribute pre-tax dollars up to the federal contribution limit.
- You can use the funds in your HSA to pay for eligible health care expenses such as costs incurred towards the deductible, dental, vision, and prescription drugs.

[See More on HDHP/HSA on pages 7-11 of this guide.](#)

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More Resources Found Online

The following sections have moved from this guide to the ETF website at:
etf.wi.gov/members/IYC2015/IYC_State_home.html

- Fall 2014 Benefit Fair Dates and Locations (15-ET-2107bf)
- Health Plan Report Card (15-ET-2107rc)
- Other Quality Information Resources (15-ET-2107qi)
- Glossary (ET-2107g)

Visit the *Contact ETF* page at etf.wi.gov/contact.htm and select the *Other* link under *E-mail Us* if you need a printed copy. Once on the page, fill in the required information, select the *Insurance (Health, Life)* button and indicate in the *Message* field which section you would like mailed by including the section's form name and number, which are listed above. You may also contact ETF toll-free at 1-877-533-5020 or 608-266-3285 and select options 1, 2, 2, 1, 1 and 6 when prompted.

*Photos courtesy of the Wisconsin Department of Transportation's
Wisconsin's Rustic Roads program*

Every effort has been made to ensure that the information in this guide is accurate. In the event of conflicting information, state statute, state health contracts and/or policies and provisions established by the State of Wisconsin Group Insurance Board shall be followed.

Choose Wisely — Important Changes

Important Changes — Effective January 1, 2015

Generally, if you plan to stay with your current health plan and you are not changing your coverage, you do not need to take any action during the It's Your Choice Open Enrollment period. However, you should review the following grid to understand how your coverage may change. If you have questions or concerns about any of these changes, contact your health plan using the information listed in the back of this guide.

New High Deductible Health Plan with Health Savings Account	
High Deductible Health Plan (HDHP)	All health plans will offer an HDHP option. This is a plan that has a minimum annual deductible and maximum out-of-pocket limit. Except as required by federal law, the health plan will not pay any medical, dental or prescription drug costs until your annual deductible has been met. See more information on pages 7-11.
Health Savings Account (HSA)	An HSA is a new offering for 2015. You must enroll in an HDHP in order to have a state-sponsored HSA. This account is yours and you can use the funds to pay for eligible medical expenses. Your employer will contribute to this account and you can, too. See more information on pages 7-11.
Limited Purpose Flexible Spending Account (LPFSA)	
Flexible spending for those with an HDHP and HSA	This new offering is available only for those enrolled in the HDHP and HSA. Federal law prohibits participation in both an HSA and a regular medical flexible spending account. An allowable option is a LPFSA, which can be used for vision, dental and post-deductible expenses only. See more information on Page 9.
New Health Plans	
Arise Health Plan Southeast	Offered in seven counties in southeast Wisconsin including: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington and Waukesha.
WEA Trust Northwest Mayo Clinic Health System	Current members in WEA Trust - Northwest who selected Mayo Clinic as their care system for 2014 will automatically be moved into this new plan. Offered in Barron, Buffalo, Chippewa, Dunn, Eau Claire, Pierce, St. Croix and Trempealeau counties. Note: your out-of-pocket costs for out-of-network care will be higher in 2015. See the plan description page for more detail.
Health Plans No Longer Available	
WPS Metro Choice Northwest and Southeast	Both WPS Metro Choice Northwest and Southeast are no longer available. Subscribers who have these health plans must select another plan.
State Maintenance Plan (SMP)	SMP is no longer qualified in Pepin County. However, providers remain available.

Choose Wisely — Important Changes

Health Plan Provider Network Changes	
Health plans listed below have made significant changes in their provider groups in one or more counties. Other plans have also made changes. Contact the health plan to verify if your provider is still in network. Refer to the map on pages 28 and 29 or call the health plan for more details.	
Arise Health Plan Northern	Added providers in Door and Waushara counties.
Dean Health Insurance	Added providers in Waukesha County.
Group Health Cooperative of Eau Claire	Expanding into Clark, Iron, Langlade, Lincoln, Marathon, Oneida, Price, Taylor and Vilas counties.
GHC of South Central Wisconsin	Expanding into Columbia, Marquette and Sauk counties.
HealthPartners Health Plan	Newly qualified in Ashland, Barron, Chippewa, Clark, Eau Claire, La Crosse, Marathon, Monroe, Sawyer and Washburn counties. For more counties with some providers available, see the health plan description page.
Physicians Plus	Expanding into Dodge, Juneau, Vernon, Waukesha and Wood counties.
State Maintenance Plan (SMP)	Newly offered in Vilas County.
Health Plan Name Changes	
Arise Health Plan Northern	Changing from Arise Health Plan
WEA Trust - East and WEA Trust - South Central	Removed the term “PPO” from their names, although the plan still offers out-of-network benefits. See the plan description pages for more detail.
WEA Trust - Northwest Chippewa Valley	To help clarify which doctors are in the network, this plan is renamed as Northwest Chippewa Valley. Current members in WEA Trust - Northwest who selected Chippewa Valley as their care system for 2014 will remain in this plan unless they file an It’s Your Choice application to change health plans. Note: your out-of-pocket costs for out-of-network care will be higher in 2015. See the plan description page for more detail.

Choose Wisely — Important Changes

Changes to Dental Coverage	
Dean Health Insurance and Dean Prevea 360	Delta Dental will be the new dental vendor for these health plans. Members will have access to Premier and PPO Delta Dental networks. Members should verify if their current dentists are in-network.
Gundersen Health Plan	Delta Dental will be this health plan's new dental vendor. Members should verify if their current dentist is in-network.
WEA Trust – East, NW Chippewa Valley, NW Mayo Clinic Health System and South Central	Delta Dental will be this health plan's new dental vendor. Members should verify that their current dentist is in-network.
Annuitant Medicare Prescription Drug Administrator Change	
Navitus MedicareRx (PDP) plan	<p>Effective January 1, 2015, the Navitus MedicareRx (PDP) plan, which provides Medicare Part D prescription drug coverage for eligible members of the State of Wisconsin and Wisconsin Public Employers Group Health Insurance programs, will be underwritten by Dean Health Insurance, Inc. From 2012 through 2014, the Navitus MedicareRx (PDP) plan was underwritten by Sterling Life Insurance Company. This change will not affect benefits members receive or who members contact about their coverage. In fact, the only two changes members will notice are:</p> <ul style="list-style-type: none"> • New ID Cards: Members who have previously been enrolled in the Navitus MedicareRx (PDP) plan will receive new ID cards that show Dean Health Insurance, Inc. as the underwriter. • Service Area Expanded to Puerto Rico: The Navitus MedicareRx (PDP) plan's service area will include all 50 states and will expand to Puerto Rico. However, other U.S. territories are not included in the service area.



Choose Wisely — Important Changes

Information on ETF's Internet Site	
Online Help	<p>The <i>It's Your Choice Decision Guide</i> and <i>It's Your Choice Reference Guide</i> are available at etf.wi.gov. Any known printing discrepancies will be clarified on this site. Additional insurance program information can also be found on this site.</p> <p>The following sections have moved from this guide to the ETF website at etf.wi.gov/members/IYC2015/IYC_State_home.html.</p> <ul style="list-style-type: none"> • Health Plan Report Card (15ET-2107rc) • Other Quality Information Resources (15ET-2107qi) • Glossary (15ET-2107g) • Benefit Fair Dates (15ET-2107bf) <p>An interactive health plan map is also available at etf.wi.gov/members/IYC2015/IYC_State_map.html.</p> <p>Look for the red envelope to sign up for ETF E-Mail Updates for the most current information at etf.wi.gov.</p>
Information Required	
Dependent Social Security Numbers Required	<p>Due to federal law, subscribers must provide Social Security numbers for all dependents if they have not already done so. Health plans and employers are required by the Patient Protection and Affordable Care Act (PPACA) to report this information to the federal government in 2015.</p>
Employee Reimbursement Accounts Program	
New vendor	<p>A new third party administrator, Total Administrative Services Corporation (TASC), will administer the Employee Reimbursement Account (ERA) Program for 2015. TASC will handle ERA enrollment during the 2015 It's Your Choice Open Enrollment period. See Page 77 for more information.</p>
\$500 Carryover	<p>A new carryover provision will be implemented for the 2015 plan year. Up to \$500 of health care ERA balances remaining at the end of the 2015 run-out period can be carried over into the next plan year, reducing the risk of forfeiting unused dollars. See details on Page 77.</p>
Health Plan Issued Financial Incentives	
All Plans	<p>Internal Revenue Service (IRS) tax code considers financial reimbursements for wellness-related expenses such as gym memberships, fitness classes and/or the cost to participate in Community Supported Agriculture, and rewards for participating in health or wellness programs or challenges to be a fringe benefit of employment; therefore, they must be treated as a taxable wage subject to income and payroll taxes. Payroll centers will receive financial data regarding incentives issued to employees and their covered family members. ETF will determine taxable wage reporting requirements for annuitants. Your health information is protected by federal privacy regulations and will never be shared with your employer. For more information, visit wellwisconsin.wi.gov.</p>

HDHP/HSA Option



HDHP Health Insurance Option With HSA

Beginning January 1, 2015, the State of Wisconsin Group Health Insurance Program will offer the option of a high deductible health plan (HDHP). In addition, those who enroll in the HDHP will be enrolled in a health savings account (HSA). This program option was part of the state's 2013-2015 biennial budget (2013 Wisconsin Act 20) and is now state law under Wis. Stat. 40.515.

HDHP Program Facts

1. The HDHPs will be offered through each of the health plans that are a part of the State of Wisconsin Group Health Insurance Program.
2. Each health plan's HDHP option will provide a uniform set of benefits.
3. An HDHP is a health plan that, under federal law, has a minimum annual deductible and a maximum annual out-of-pocket limit.
4. An HDHP generally begins paying for health care costs once the annual deductible has been met (except for preventive services mandated by federal law).
5. Preventive services mandated by federal law are covered at 100%, regardless of the deductible.
6. The plan is designed to offer a lower monthly premium in exchange for more shared health care costs by the member.

Program Annual Deductibles

Coverage Level	Deductible Amount
Single Plan	\$1,500
Family Plan	\$3,000

When Deductible is Met

When the deductible is met, Coinsurance Uniform Benefits or the Standard PPO benefits apply. The deductible does apply to Uniform Dental and pharmacy benefits. After the deductible is met, pharmacy copays apply up to the out-of-pocket limit. In a family plan, the entire \$3,000 deductible must be met before the coinsurance coverage begins.

Obligations After Deductible is Met

HDHP Uniform Benefits includes the deductibles, listed above, that apply to all services except for federally required preventive care. Such care is covered at 100% when care is received by an in-network provider.

After the deductible is met, services are subject to 90%/10% member coinsurance up to an overall out-of-pocket limit of:

- \$2,500 individual plan
- \$5,000 family plan

A full comparison of benefit options begins on Page 31.

HDHP/HSA Option

HSA Information

A health savings account (HSA) is a savings or investment account set up to pay for health care expenses. HSAs are owned by the individual employee and balances roll over annually. In addition, the funds in an HSA are portable, meaning that the employee keeps them if they leave the health plan or state service.

Employer HSA Contribution Amounts

This is the amount your employer will deposit to your HSA in 2015.

Coverage level	2015 contribution amount
Single Plan	\$170.00
Family Plan	\$340.00

Employees who enroll after Jan. 1 will have a pro-rated employer HSA contribution.

HSA Contribution Limits

This is the total amount that the IRS allows to be contributed to an individual HSA during 2015. If a married individual's spouse also has an HSA, the two can only contribute up to the total contribution limit between the two HSAs.

Coverage level	Annual contribution limit*	Additional annual catch-up contributions for those between 55-65 years old
Single Plan	\$3,350	\$1,000
Family Plan	\$6,650	\$1,000

* Contributions from all sources, such as employee and employer, count towards meeting the annual contribution limits.

Employer HSA Contribution Eligibility

Only active employees who are participating in the HDHP and HSA will be eligible for an employer HSA contribution. When an employee leaves state service (including retirees), they will become responsible for paying all fees associated with the HSA.

Employer HSA Contribution Timing

Employer Contributions will be made on an annual basis.

Use of HSA Funds

You can use the funds in your HSA to pay for qualified medical, dental and prescription drug expenses for yourself and your eligible tax dependents. You can find a list of qualified expenses and the definition of eligible tax dependents at etf.wi.gov.

HSA Administrator

The State of Wisconsin sponsored HSA will be administered by Total Administrative Services Corporation (TASC). You can visit the TASC website at tasconline.com to learn more about HSAs. A TASC representative will be available at many of the fall benefit fairs. See etf.wi.gov for details.

HDHP and HSA Eligibility

Who is eligible?

- State employees, except those who are eligible for the graduate assistant/short term academic staff benefits package and are not in the WRS.
- Limited Term Employees (LTEs) who are eligible for the State of Wisconsin Group Health Insurance Program.
- Annuitants younger than age 65.

Who is Ineligible?

- Medicare eligible annuitants 65 and older.
- Anyone on Medicare or covered by another disqualifying health plan (i.e. spouse's health plan, TRICARE). **Important note: You must notify ETF of any other medical coverage when enrolling in, and at any point while enrolled in, the HDHP and HSA.**
- Those eligible for the graduate assistant/short term academic staff benefits package and are not in the WRS.
- State Patrol Titled Classifications.
- Those who are a dependent of another person for tax purposes.

Premium Rates

See the employee contribution rates and the premium rate charts on pages 25-27 to compare HDHP and HSA rates with traditional rates.

Limited Purpose Flexible Spending Account

Individuals who enroll in the HDHP and HSA are not allowed to have a regular health care flexible spending account (FSA), otherwise known as an employee reimbursement account (ERA), according to IRS rules. This is because FSAs are considered to be disqualifying "other" insurance coverage by the IRS. Therefore, ETF will offer a Limited Purpose Flexible Spending Account (LPFSA). An LPFSA can be used for vision, dental and post-deductible expenses only. The annual contribution limit for an LPFSA is \$2,500, the same as a regular health care FSA. The LPFSA is new for 2015 and will also be administered by TASC.

You are only eligible to enroll in the LPFSA if you are also enrolled in both the HDHP and HSA. In general, both the HSA and LPFSA qualify for the same health care expenses and each type of account has annual contribution limits. As a result, some participants who save money in their HSA or have high dental or vision expenses may be interested in having this additional account (LPFSA) to contribute pre-tax dollars.

Learning Resources

E-Learning modules can be found at etf.wi.gov. Find out more by contacting TASC at tasconline.com, or 1-800-422-4661.

HDHP/HSA Option

HDHP Frequently Asked Questions

1. What is a High Deductible Health Plan (HDHP)?

It is a health plan that, under federal law, has a minimum annual deductible and a maximum annual out-of-pocket limit set by the IRS. An HDHP does not pay any health care costs until the annual deductible has been met (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act). The plan is designed to offer a lower monthly premium in return for more shared health care costs by the member.

2. What is a deductible?

A deductible is the fixed amount that you must pay before your insurance begins to make payments for covered medical, prescription drug and Uniform Dental services. For example, if you have a \$1,500 deductible, you must incur \$1,500 in covered medical expenses (for which you are responsible for paying) before your insurance pays anything (with the exception of preventive services mandated by the Patient Protection and Affordable Care Act).

3. How will I know when I've met my deductible?

Health plans will provide you with periodic explanation of benefit statements that will provide this information. While it's always a good idea to keep track of your out-of-pocket medical expenses, you can check with your health plan to determine where you are in meeting your deductible.

4. Are prescription and dental benefits still offered under the HDHP?

Yes, the prescription and dental benefit remains the same, with the exception of an added deductible. Certain prescription drugs that are considered preventive medications are provided with "first-dollar" coverage under the HDHP, meaning that your benefits pay for these drugs before you meet your deductible. In other words, your deductible does not apply to these certain preventive drugs and you will not have to pay for the full cost of the drug. You will still have to pay the copayment on these preventive medications in most cases; however, there are also some drugs which are covered at 100% by federal law, meaning you will not have to pay the copayment on these specific drugs. You can find the lists of preventive prescription drugs that are paid with "first-dollar" coverage and those that require no copayment under federal law on the Navitus Health Solutions website, www.navitus.com (Log in to the the members section and select "formulary.").

5. Why is the deductible so high?

An HDHP must meet certain requirements, including the minimum amount of the deductible and maximum out-of-pocket limit, as set by the IRS.

6. Are any services covered under the HDHP before I reach my deductible?

Yes, examples of covered services before the deductible is met include: in-network preventive medical services and certain preventive prescription drugs. See a list of preventive medical services at www.healthcare.gov/what-are-my-preventive-care-benefits/. See Question 4 for more information about preventive prescription drugs.

7. Is there a separate deductible for medical and prescription drug costs?

No, the amount you pay for medical claims submitted to your health plan and prescription drug claims submitted to the Pharmacy Benefit Manager (PBM), which is currently Navitus Health Solutions, LLC, along with payments for Uniform Dental services count towards the deductible.

More FAQs online at etf.wi.gov/members/IYC2015/IYC_State_faq.html.

HSA Frequently Asked Questions

1. What is a health savings account (HSA)?

An HSA is an account established to pay for health care. To set up an HSA, the individual must be covered by a federally qualified HDHP. HSAs are owned by the individual, balances roll over from year to year and the funds are portable, meaning the employee keeps them if they leave the HDHP plan or state service. The funds in an HSA can be used to pay for qualified medical expenses that are not covered by your health plan, and can be saved for future expenses on a pre-tax basis. The funds can also be invested. Contact TASC for investment options.

2. How is an HSA different from the health care FSA, also known as ERA, that is already offered to state employees?

A participant is only eligible for an HSA if they are enrolled in a federally qualified HDHP. A participant may not enroll in both an HSA and a health care FSA at the same time. Both types of accounts allow a participant to set aside money pre-tax to pay for health care expenses, however, there are some key differences shown in the table below:

HSA and Medical FSA Key Differences		
	HSA	FSA
Type of health insurance plan it works with	HDHP only	Any type
Account owner	Individual participant	Employer
Who contributes?	Can be anyone: employer, employee or other. See Page 8 for state employer contribution amounts.	Usually only the employee contributes. State employers do not contribute.
Do the funds roll-over from year to year?	Yes	Up to \$500 will rollover to the next plan year. Note: this is new for 2015.
What if the participant leaves state service?	The HSA is portable because it is owned by the participant. HSAs are not subject to COBRA continuation, when you leave state employment you keep the funds in your account, but you become responsible for paying any HSA associated fees and there will be no future employer contributions to your account.	FSAs are subject to COBRA continuation and a participant can choose to keep their FSA open and active. Otherwise, expenses can only be incurred through the last day of the month of the participant's last paycheck and then submitted for reimbursement.

3. Do I have to use my HSA to pay for my deductible?

No, you choose how you pay for your deductible.

4. What is a qualified medical expense?

For a list of eligible expenses, go to etf.wi.gov.

5. Are there expenses that I can't use my HSA to pay?

Yes, some of the expenses include cosmetic surgery, over-the-counter medications, insurance premiums and family or marriage counseling. You can find a list of qualified expenses on the ETF website.

More FAQs online at etf.wi.gov/members/IYC2015/IYC_State_faq.html.

Notes

Important Considerations

Generally, if you are satisfied with your current health plan, you do not have to do anything during It's Your Choice Open Enrollment. Your current coverage will automatically continue provided your health plan is still offered. You should, however, review this checklist and consider the following:

- Is your health plan still available next year? Sometimes health plans drop out of the State of Wisconsin Group Health Insurance Program, merge with other health plans or split off to form new health plans. These changes are listed in the *Choose Wisely - Important Changes* section of this guide. If this happens with your health plan, you will probably need to take some action to change your coverage.
- Have your premiums changed? Premiums change each year and as a result, the amount you pay may have increased. Premium contributions are shown on Page 25.
- Is your physician, clinic, hospital or dentist still affiliated with your health plan? Agreements between health plans and medical providers are subject to change each year. It is not unusual for medical providers to move from one health plan to another or to contract with more than one health plan. Provider listings are available from the health plans.
- Have benefits changed? Changes are summarized in the *Choose Wisely - Important Changes* section of this guide.
- How satisfied are participants with their health plans? Review and compare the Health Plan Report Card section on the ETF website at etf.wi.gov/members/IYC2015/IYC_State_rate.html.
- Do you want to change health plans or change from single to family coverage? If so, your benefits/payroll/personnel office (or Employee Trust Funds if you are an annuitant or are on continuation coverage) must receive your application on or before October 31, 2014. Coverage changes will be effective on January 1, 2015.
- How do health plans compare for wellness and health management programs? Health plans offer various programs. See the Features at a Glance charts on pages 38 and 39.
- Health Insurance Marketplaces—also known as the Exchanges—are available to individuals this fall and are separate from our program. These may be of particular interest to some of our members, including annuitants who are paying their health insurance premiums through annuity deduction or directly to their health plan. For more information visit www.HealthCare.gov, call 1-800-318-2596 and see Frequently Asked Question 2 online at etf.wi.gov/members/IYC2015/IYC_State_faq.html in the Frequently Asked Questions (15ET-2107faq). Also see the PPACA: Marketplace Notice in the *It's Your Choice 2015 Reference Guide* under the State and Federal Notifications section.

myETF Benefits System Instructions

myETF Benefits System Instructions

Employees* and annuitants are encouraged to submit their It's Your Choice Open Enrollment changes via the myETF Benefits Online Health Insurance Enrollment System. Enrolling in a health insurance plan is a quick and easy process through our dedicated and secure website.

*UW System and UW Hospital and Clinics employees: Do not use the myETF Benefits System to enroll in or make changes to coverage. UW System employees should go to the fall enrollment website at www.uwsa.edu/abe. UW Hospital and Clinics employees must complete a paper application and submit it to their payroll and benefits office.

If you don't have access to a computer, you may submit your enrollment change on a paper application (on Page 82). Employees should submit it to their benefits/payroll/personnel office. Initial enrollment must be established through your employer. Annuitants and continuants should send the form to ETF. The address appears on the back cover of this guide.

All changes must be entered online, submitted, faxed or postmarked no later than October 31, 2014.

Step 1

Go to myETF.wi.gov/ONM.html (Online Network for Members). In order to login, you will need a Web Access Management System (WAMS) ID and your ETF Member ID (explained in Step 3). Click on the myETF Benefits link to begin the login steps.

Employee Trust Funds (ETF)
On-line Network for Members (ONM)

Welcome to the Department of Employee Trust Funds On-line Network for Members (ONM) portal.
This is a new and innovative way to retrieve historical data, keep your information current, and request information regarding ETF administered benefits.
ONM is an interactive Internet application that is easy and convenient to use.

Applications

[myETF Benefits](#) | [Instructions](#) | [Instructional Webcast](#) | [It's Your Choice Information](#)

Description: Provides employees the ability to submit changes to their current coverage including address/name changes, new enrollments, and qualifying event changes to their existing coverage.

Click On
[myETFBenefits](#)

Guidelines for Use

This system is designed to be viewed using the latest version of Microsoft Internet Explorer or Firefox.

For the best viewing experience set your screen resolution to at least 1024 X 768.

Some pages within this system require [Adobe Acrobat Reader](#) be installed on your computer in order to view PDF files.

myETF Benefits System Instructions

Step 2—myIdentity Verification (WAMS ID)

Type your WAMS ID and password. Click **Login**. If you don't have a WAMS ID, click Register Now. You will be taken through the process to get one. If you need assistance registering please view the instructional webcast on the myETF Benefits home page at myETF.wi.gov/ONM.html. Keep track of your WAMS ID and password, as you will need it in the future to view and change your coverage.

If you forgot your WAMS ID, click the appropriate **Go Here** link in the **Registered Users** section to recover your WAMS ID. If you need to change your WAMS ID e-mail address or password, click the appropriate **Go Here** link also in the **Registered Users** section.



myETF Benefits

This site provides access to the online services developed by the Department of Employee Trust Funds (ETF) for members and retirees. **You must be a Health Insurance Subscriber to use this system.**

Existing User

Registered Users
If you are already a registered user, enter your user ID and password, then click the login button.

→ **User ID:**

→ **Password:**

WAMS
WORLDWIDE ACCESS
MANAGEMENT SYSTEM

Login

If you need help with myETF Benefits, please contact your employer for assistance. If your employer cannot help you and recommends that you contact ETF, call the ETF Call Center at 1-877-533-5020 or 608-266-3285, or [Contact Us](#)

- * If you forgot your WAMS ID, [go here](#)
- * If you need to change your WAMS ID email address, [go here](#)
- * If you need to change your password, [go here](#)

New User
If you have not yet registered for online access, click the Register Now button. You will be guided through the registration process.

Register Now

Guidelines for Use:

- This system is designed to be viewed using the latest version of Microsoft Internet Explorer or Firefox.
- For the best viewing experience, set your screen resolution to at least 1024 X 768.
- Some pages within this system require that Adobe Acrobat Reader be installed on your computer in order to view PDF files.

This system is for authorized users only. System access is monitored. By using this system, you expressly consent to system monitoring. Evidence of unauthorized access will be provided to the appropriate law enforcement agencies for prosecution.

myETF Benefits System Instructions

Step 3—myIdentity Verification (ETF Member ID)

Type your ETF Member ID (Employees: available on your Navitus Prescription Drug ID card, ETF Statement of Benefits or from your employer. Annuitants: find your Member ID on your ETF Annuity Payment Statement or from ETF) and birth date. Your birth date should be entered per the guidelines on the screen, for example, 02/01/1960. Click **Verify** to continue.

Step 4—myIdentity Verification (Social Security Number)

Type your Social Security number without the dashes. This is a one-time event that only needs to be completed the first time you log in. After you are logged in, the myInfo page will appear.

myETF Benefits System Instructions

Step 5—myInfo

The myInfo screen displays your demographic information. On the top of the screen, there are tabs that you can use to navigate. Click on the **Health** tab and the Health Insurance Summary will appear with your current and historic health insurance information.

To make an It's Your Choice enrollment change, click the **Edit** button on the left toward the middle of the screen and complete the fields that appear. When complete, click the **Submit** button.

To log off of myETF Benefits, click the **Log Off** tab.

The screenshot shows the myETF Benefits myInfo interface. At the top, there is a navigation bar with the myETF logo and the text "myETF Benefits myInfo". Below this is a horizontal menu with tabs for "myInfo", "Health", "Life", "Disability", "WRS", "Other Benefits", "Help", and "Log Off".

The main content area is divided into three sections:

- Member Information:** Lists fields for Member ID, SSN, Name, Date of Birth, Gender, Marital Status, and Marital Status Date. A placeholder message states: "The subscriber's information will appear here."
- Spouse Information:** Lists fields for Member ID, SSN, Name, Date of Birth, and Gender. A placeholder message states: "The subscriber's spouse's information will appear here."
- Contact Information:** Lists fields for Home Address, Primary Email, and Primary Phone. A placeholder message states: "The subscriber's address will appear here." and "The subscriber's email and primary phone number will appear here."

Below the sections, a note reads: "Please note: The demographic information listed above is from your health insurance application and may differ from other addresses on file at ETF. ETF is working to consolidate demographic information."

At the bottom, there are three buttons: "Edit", "History of Changes", and "myRequests".

Employees with questions should contact their employers. Annuitants and continuants should contact ETF at 1-877-533-5020 or 608-266-2385.

Choose Wisely — Frequently Asked Questions

Frequently Asked Questions

It's Your Choice Open Enrollment Period

The It's Your Choice Open Enrollment period is the annual opportunity for eligible employees and annuitants to select one of the many health plans offered by the State of Wisconsin Group Health Insurance Program. Today, there are more than 18 health plans participating.

The following list contains some of the most commonly asked questions about the enrollment period. An extensive list of frequently asked questions and answers to use now and throughout the year is available at the ETF website at etf.wi.gov/members/IYC2015/IYC_State_home.html. See the Frequently Asked Questions link. You can also find information about key terms in the Glossary section online at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

1. What is the It's Your Choice Open Enrollment period?

The It's Your Choice Open Enrollment period is an opportunity to change plans, change from family to single coverage, enroll if you had previously deferred coverage, cancel your coverage or cancel the coverage for your adult dependent child. It is offered only to employees, annuitants and surviving spouses and dependents who are eligible under the State of Wisconsin Group Health Insurance Program. Changes made become effective January first of the following year.

Things to Consider During It's Your Choice Open Enrollment

2. May I change from single to family coverage during the It's Your Choice Open Enrollment period?

Yes, you have the opportunity to change from single to family coverage without a waiting period or exclusions for preexisting medical conditions. Coverage will be effective January 1 of the following year for all eligible dependents. Note that if you are subject to tax liability for dependents such as adult children, and/or a domestic partner and their child(ren), you can elect not to cover such individuals.

For information on changing from family to single coverage, see *It's Your Choice Frequently Asked Questions* on the ETF website at etf.wi.gov/members/IYC2015/IYC_State_fa.html.

3. If I do not change from single to family coverage during the It's Your Choice Open Enrollment period, will I have other opportunities to do so?

There are other opportunities for coverage to be changed from single to family coverage without restrictions as described below:

- A. If an electronic or paper application is received by your benefits/payroll/personnel office for active employees, or ETF for annuitants/continuant, within **30 days** of the following

See the *Frequently Asked Questions* section on the ETF website (etf.wi.gov) for information regarding dependent eligibility, family status changes and how to use your benefits.

Choose Wisely — Frequently Asked Questions

events, coverage becomes effective on the date of the following event:

- Marriage.
- The date ETF receives the completed *Affidavit of Domestic Partnership* (ET-2371).
- You or any of your eligible dependents involuntarily lose eligibility for other medical coverage or lose the employer contribution for the other coverage.
- An unmarried parent whose only eligible child becomes disabled and thus is again an eligible dependent. Coverage will be effective the date eligibility was regained.

B. If an application is received by your benefits/payroll/personnel office for active employees, or ETF for annuitants/continuant, within **60 days** of the following events, coverage becomes effective on the date of the following event:

- Birth or adoption of a child or placement for adoption (timely application prevents claim payment delays).
- Legal guardianship is granted.
- A single father declaring paternity. Children born outside of marriage become dependents of the father on the date of the court order declaring paternity, on the date the acknowledgement of paternity is filed with the Department of Health Services (or equivalent if the birth was outside of the state of Wisconsin) or on the date of birth with a birth certificate listing the father's name. The effective date of coverage will be the birth date, if a statement of paternity is filed within 60 days of the birth. If filed more than 60 days after the birth, coverage will be effective on the first of the month following receipt of application.

C. If an application is received by your benefits/payroll/personnel office for active employees or ETF for annuitants/continuant, upon order of a federal court under a National Medical Support Notice, coverage will be effective on either:

- the first of the month following receipt of application by the employer; or
- the date specified on the Medical Support Notice.

Note: This can occur when a parent has been ordered to insure one or more children who are not currently covered.

4. What if my spouse/domestic partner is also a state of Wisconsin employee, annuitant or the eligible employee or insured annuitant of a Wisconsin Public Employer who participates in the State of Wisconsin Group Health Insurance Program?

- You may each retain or select single coverage with your current health plan(s); or
- If your spouse/domestic partner is also an eligible state employee or annuitant, one of you may retain or select family coverage under one of your current health plans, which will cover your spouse and any eligible dependents.
- If your spouse/domestic partner is an eligible employee or insured annuitant of a

Choose Wisely — Frequently Asked Questions

Wisconsin Public Employer, one or both of you may retain or select family coverage under one of your current health plans, which will cover your spouse and any eligible dependents.

For details, see the Frequently Asked Questions section on the ETF website at etf.wi.gov/members/IYC2015/IYC_State_faq.html.

How do I Make Changes During It's Your Choice Open Enrollment

5. How do I change health plans during It's Your Choice Open Enrollment?

If you decide to change to a different health plan, you* are encouraged to make changes online using the myETF Benefits website (see Pages 15 through 18 of this guide), or you may submit a paper application using the following instructions:

- Active employees may use the application in the back of this guide, get one from etf.wi.gov/publications/et2301.pdf or receive paper applications from your benefits/payroll/personnel office to complete and return to that office.
- Annuitants and continuants should complete the application found in the back of this guide or get one from etf.wi.gov/publications/et2301.pdf and submit it to ETF.

Applications received after the deadline will not be accepted.

Note: If you plan to stay with your current plan for next year and you are not changing your coverage, you do not need to take any action.

6. How do I use the myETF Benefits website?

Refer to pages 15 through 18 of the *It's Your Choice Decision Guide*.

7. What happens if I entered my changes online, but did not submit them?

Your changes will not be stored unless you click on the **Submit** button. You will need to log back in and make the changes again. To view what you submitted, click the **myRequests** button on the bottom of the **myInfo** page.

8. What is the effective date of changes made during the It's Your Choice Open Enrollment period?

It's Your Choice coverage changes are effective January 1 of the following year.

9. What if I change my mind about the health plan I selected during the It's Your Choice Open Enrollment period?

You may submit or make changes anytime during the It's Your Choice Open Enrollment period, either online using the myETF Benefits website or by filling out and submitting a paper application. After that time, you may rescind, that is, withdraw your application (and keep your current coverage) by following these instructions before December 31:

- Active employees should inform their benefits/payroll/personnel office.

* UW System employees: Use the Annual Benefit Enrollment (ABE) website at www.uwsa.edu/abe to enroll in or make changes to coverage. Do not use the myETF Benefits System.

UW Hospital and Clinics employees: Submit a paper application to Human Resources to enroll in or make changes to coverage. Do not use the myETF Benefits System.

Choose Wisely — Frequently Asked Questions

- Annuitants and continuants should notify ETF.

Other rules apply when cancelling coverage. For more information, see the Cancellation/Termination of Coverage section of the Frequently Asked Questions online at etf.wi.gov/members/IYC2015/IYC_State_faq.html#cancellation.

Selecting a Health Plan

10. Can family members covered under one policy choose different health plans?

No, family members are limited to the health plan selected by the subscriber.

11. Can I receive medical care outside of my health plan network?

This can be a concern for members who travel and those with covered dependents living elsewhere, such as a college student living away from home. Consider the following when selecting a health plan:

- If you are covered through an HMO, you are required to obtain allowable care only from providers in the HMO's network. HMOs will cover emergency care outside of their service areas, but you must get any follow-up care to the emergency from providers in the HMO's network. Do not expect to join an HMO and get a referral to a non-HMO physician. An HMO generally refers outside its network only if it is unable to provide needed care within the HMO.
- If you are covered through a Preferred Provider Organization (PPO) such as WEA Trust or the Standard Plan, you have the flexibility to seek care outside a particular service area. However, out-of-network care is subject to higher deductible and coinsurance amounts.
- **Annuitants only:** If you or your dependents are covered through the Medicare Plus Plan, you have the freedom of choice to see any available provider for covered services.

In addition, Humana's Medicare Advantage-PPO offers coverage for participants with Medicare Parts A and B, with both in-network and out-of-network benefits. **Note:** Non-Medicare members are limited to Humana's HMO network.

12. How can I get a listing of the physicians and/or dental providers (if applicable) participating in each plan?

Contact the plan directly or follow the instructions provided in the *Health Plan Descriptions* section of this guide. ETF and your benefits/payroll/personnel office do not have this information.

Medicare

13. What do I need to do when my spouse or domestic partner or I become eligible for Medicare?

Most people become eligible for Medicare at age 65, but you may or may not need to sign up. For some people, Medicare eligibility occurs earlier due to disability or End Stage Renal Disease. (See the Medicare Information in the Frequently Asked Questions at etf.wi.gov/members/IYC2015/IYC_State_home.html for details.)

Introduction to Health Plan Options

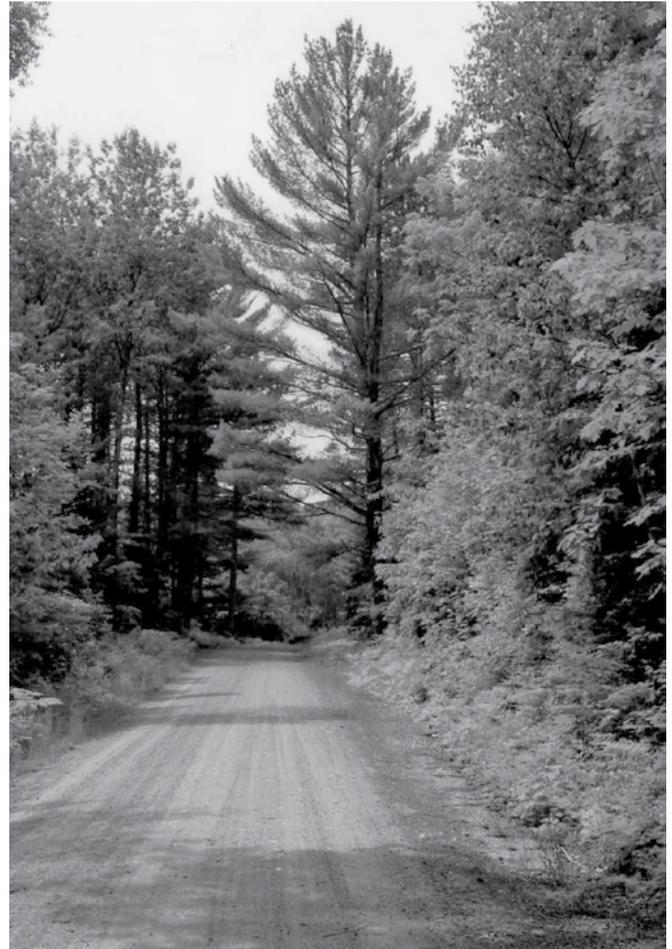
As a participant in the State of Wisconsin Group Health Insurance Program, all of the health plans listed in this guide are available to you. This includes 18 private insurers (also called the “Alternate Health Plans”), the “Standard Plan” and “State Maintenance Plan” (SMP). All of these options are described in more detail below. Definitions of terms also appear in the glossary on United States Department of Labor website at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf. You will want to choose the plan that works best for you, based on the location of providers, the premium costs and the Health Plan Report Card.

Alternate Health Plans

Nearly 98% of current state employees choose coverage through the Alternate Health Plans. These include 17 health maintenance organizations (HMOs) and one preferred provider organization (PPO). These health plans all administer a Uniform Benefits package, meaning you will receive the same package of covered benefits and services, regardless of your health plan selection. New this year—all are also offering a High Deductible Health Plan (HDHP) Uniform Benefits package. Note, benefits differ for those annuitants and their dependents who are enrolled in Medicare, versus all other members. Coinsurance, Traditional and the HDHP Uniform Benefits are described in detail in the *It's Your Choice Reference Guide*.

You should be aware that there are some differences among the Alternate Health Plans, and these can change annually. When choosing a health plan, you should consider the following:

- **Administrative Requirements:** Health plans may require you to select a primary



care provider (PCP), get a referral from your PCP before seeing a specialist or get a prior authorization before obtaining certain services such as for high-tech radiology (for example: MRI, PET and CT scans) and low back surgeries.

- **Benefit Determinations:** While all Alternate Health Plans offer the Coinsurance, Traditional and HDHP Uniform Benefits packages, this does not mean that all will treat all illnesses or injuries in an identical manner. Treatment will vary depending on patient needs, the physicians' preferred practices and the health plan's managed care policies and procedures.

Choose Your Health Plan

- **Dental Benefits (if offered):** Plans that choose to offer dental benefits provide a uniform package of covered dental benefits and services. Dental providers differ for each plan and may change from year to year.
- **Premium:** As an employee, your total monthly premium contribution amount can vary, depending on the health plan's Tier ranking. A description of the tiering system appears on Page 25.
- **Provider Network:** The location, quantity, quality and availability of the doctors, clinics, hospitals and emergency/urgent care centers differ for each health plan.

State Maintenance Plan (SMP)

The SMP is available only in counties that lack a qualified Tier 1 Alternate Plan HMO or PPO. It offers the same Coinsurance, Traditional and HDHP Uniform Benefits packages as the Alternate Health Plans. SMP does not offer Uniform Dental coverage.

Standard Plan

The Standard Plan is a PPO administered by WPS. The Standard Plan provides you with comprehensive freedom of choice among hospitals and physicians across Wisconsin and nationwide. You can compare the Traditional and HDHP Standard Plans to the Uniform Benefits package using the Comparison of Benefits Options chart starting on Page 31. Please note that the Standard Plan is a Tier 3 health plan for employees, meaning that your premium contribution will be higher if you select this option.

Health Plans Available to Annuitants

Medicare Coordinated Plans

All health plans have coverage options which are coordinated with Medicare, except

the HDHP. You will remain covered by the health plan you select after you are enrolled in Medicare Parts A and B. The following exceptions apply:

1. Members in an alternate health plan who become Medicare eligible will be moved into the Medicare Traditional Uniform Benefits plan. See the *Comparison of Benefit Options* starting on Page 31 for more information.
2. Members enrolled in the Standard Plans or the SMP will be moved to the Medicare Plus Plan on the member's Medicare effective date. See the *Comparison of Benefit Options* starting on Page 31 for more information.
3. Members enrolled in Humana will be enrolled in Humana's Medicare Advantage Preferred Provider Organization (MA-PPO) after enrolling in Medicare Parts A and B. See the plan description pages in this guide for more information.

Medicare Plus is a fee-for-service Medicare supplement plan administered by WPS. This plan is available to eligible annuitants enrolled in Medicare Parts A and B. Medicare Plus permits you and your eligible dependents to receive care from any qualified health care provider anywhere in the world for treatment covered by the plan. You may be responsible for filing claims and for finding the providers who can best meet your needs.

Medicare Advantage Preferred Provider Organization (MA-PPO) allows members to use any health care provider; however, you will have greater out-of-pocket expenses when you use out-of-network providers. The in-network MA-PPO benefit is modeled to replicate the Uniform Benefits package.

Health Plan 2015 Premium Rates

Active Employees

The Group Insurance Board and its consulting actuaries rank and assign each of the available health plans to one of three “Tier” categories, based on its efficiency and quality of care. Your premium contribution is determined by the Tier ranking of your health plan.

This approach encourages our members to choose the health plans that are most efficient in providing quality health care. Likewise, this provides a strong incentive for our health plans to hold down costs and deliver quality services.

Employee contribution rates and premium amounts for calendar year 2015 are provided to the right and on the following page.

Annuitants and Continuants

Premium amounts for calendar year 2015 appear on Page 27. These premium amounts may be withdrawn from your accumulated sick leave conversion credits or WRS annuity payment, or you may be directly billed by your health plan.

You and your dependents who are eligible for Medicare must be enrolled in Parts A and B upon retirement or when initially eligible. When you and/or your dependents are eligible, your group health insurance coverage will be coordinated with Medicare and your monthly premium will be reduced.

2015 Employee Monthly Contribution Rates

State of Wisconsin Employees Coinsurance Uniform Benefits (Except as stated below*)		
Tier	Single Rate	Family Rate
Tier – 1	\$92.00	\$230.00
Tier – 2	\$136.00	\$341.00
Tier – 3	\$267.00	\$666.00

State of Wisconsin Employees HDHP Uniform Benefits (Except as stated below*)		
Tier	Single Rate	Family Rate
Tier – 1	\$32.00	\$81.00
Tier – 2	\$76.00	\$192.00
Tier – 3	\$207.00	\$517.00

State Patrol Titled Classifications** Coinsurance Uniform Benefits		
Tier	Single Rate	Family Rate
Tier – 1	\$31.00	\$78.00
Tier – 2	\$69.00	\$173.00
Tier – 3	\$164.00	\$412.00

UW Graduate Assistants** Coinsurance Uniform Benefits		
Tier	Single Rate	Family Rate
Tier – 1	\$46.00	\$115.00
Tier – 2	\$68.00	\$170.50
Tier – 3	\$133.50	\$333.00

Note: Employees appointed to work fewer than 1,044 hours (50% of full time) pay 50% of the total monthly premium.

**For employees of the University of Wisconsin Hospital or other quasi-governmental authorities, questions about your premium contribution amounts should be directed to your benefits/payroll/personnel office.*

**Not eligible for the HDHP.

State of Wisconsin Employees, UW Graduate Assistants

2015 Total Monthly Premium Rates

Health Plan Name	Plan Tier	State of Wisconsin Employees - Coinsurance Uniform Benefits		State of Wisconsin Employees - HDHP		UW Graduate Assistants ¹	
		Single	Family	Single	Family	Single	Family
Anthem Blue Preferred Northeast	1	731.90	1,822.30	641.10	1,595.30	486.00	1,207.60
Anthem Blue Preferred Southeast	1	814.50	2,028.80	713.30	1,775.80	539.90	1,342.30
Arise Health Plan Northern	1	774.10	1,927.80	678.00	1,687.50	549.40	1,366.10
Arise Health Plan Southeast	1	798.30	1,988.30	699.20	1,740.50	567.60	1,411.60
Dean Health Insurance	1	676.00	1,682.60	592.10	1,472.80	446.90	1,109.80
Dean Health Insurance-Prevea360	1	810.40	2,018.60	709.70	1,766.80	541.00	1,345.10
GHC of Eau Claire	1	851.80	2,122.10	746.00	1,857.50	607.60	1,511.60
GHC of South Central Wisconsin	1	648.60	1,614.10	568.20	1,413.00	447.50	1,111.30
Gundersen Health Plan	1	793.40	1,976.10	694.90	1,729.80	563.90	1,402.30
Health Tradition Health Plan	1	813.80	2,027.10	712.70	1,774.30	544.00	1,352.60
HealthPartners Health Plan	1	725.20	1,805.60	635.20	1,580.50	512.80	1,274.60
Humana-Eastern	1	834.40	2,078.60	730.70	1,819.30	551.30	1,370.80
Humana-Western	1	834.40	2,078.60	730.70	1,819.30	551.30	1,370.80
Medical Associates Health Plans	1	675.20	1,680.60	591.40	1,471.00	448.80	1,114.60
MercyCare Health Plans	1	602.10	1,497.80	527.50	1,311.30	369.80	917.10
Network Health	1	799.30	1,990.80	700.00	1,742.50	568.40	1,413.60
Physicians Plus	1	683.00	1,700.10	598.30	1,488.30	481.20	1,195.60
Security Health Plan	1	814.50	2,028.80	713.30	1,775.80	579.70	1,441.80
Standard Plan ²	3	1,392.80	3,477.80	1,222.40	3,049.70	1,048.60	2,617.30
State Maintenance Plan (SMP)	1	862.00	2,150.20	757.40	1,887.30	651.60	1,624.40
UnitedHealthcare of Wisconsin	1	795.00	1,980.10	696.30	1,733.30	565.10	1,405.30
Unity Health Insurance-Community	1	774.80	1,929.60	678.60	1,689.00	549.90	1,367.30
Unity Health Insurance-UW Health	1	694.20	1,728.10	608.10	1,512.80	489.50	1,216.30
WEA Trust-East	1	794.90	1,979.80	696.20	1,733.00	565.10	1,405.30
WEA Trust-Northwest Chippewa Valley	1	831.20	2,070.60	727.90	1,812.30	592.30	1,473.30
WEA Trust-Northwest Mayo Clinic Hlth. Sys.	1	831.20	2,070.60	727.90	1,812.30	592.30	1,473.30
WEA Trust-South Central	1	665.60	1,656.60	583.00	1,450.00	468.10	1,162.80

¹The graduate assistant program does not offer Medicare reduced rates.

²Out-of-state residents assigned to work out of state receive the Standard Plan at a Tier 2 level.

Retired State of Wisconsin Employees & Continuant

2015 Total Monthly Premium Rates

Health Plan Name	Annuitants and Continuant						
	Non-Medicare				Medicare Rates - Traditional Uniform Benefits ¹		
	Coinsurance Uniform Benefits		HDHP ¹		Medicare Single	Medicare 1 ²	Medicare 2 ³
	Single	Family	Single	Family			
Anthem Blue Preferred Northeast	731.90	1,822.30	641.10	1,595.30	482.10	1,209.00	959.20
Anthem Blue Preferred Southeast	814.50	2,028.80	713.30	1,775.80	523.20	1,332.70	1,041.40
Arise Health Plan Northern	774.10	1,927.80	678.00	1,687.50	503.20	1,272.30	1,001.40
Arise Health Plan Southeast	798.30	1,988.30	699.20	1,740.50	515.30	1,308.60	1,025.60
Dean Health Insurance	676.00	1,682.60	592.10	1,472.80	422.80	1,093.80	840.60
Dean Health Insurance-Prevea360	810.40	2,018.60	709.70	1,766.80	512.80	1,318.20	1,020.60
GHC of Eau Claire	851.80	2,122.10	746.00	1,857.50	491.20	1,338.00	977.40
GHC of South Central Wisconsin	648.60	1,614.10	568.20	1,413.00	440.40	1,084.00	875.80
Gundersen Health Plan	793.40	1,976.10	694.90	1,729.80	366.30	1,154.70	727.60
Health Tradition Health Plan	813.80	2,027.10	712.70	1,774.30	408.10	1,216.90	811.20
HealthPartners Health Plan	725.20	1,805.60	635.20	1,580.50	478.80	1,199.00	952.60
Humana-Eastern	834.40	2,078.60	730.70	1,819.30	410.20	1,239.60	815.40
Humana-Western	834.40	2,078.60	730.70	1,819.30	410.20	1,239.60	815.40
Medical Associates Health Plans	675.20	1,680.60	591.40	1,471.00	357.80	1,028.00	710.60
Medicare Plus ⁴	NA ⁴	NA ⁴	NA ¹	NA ¹	365.00	NA ⁴	725.70
MercyCare Health Plans	602.10	1,497.80	527.50	1,311.30	369.10	966.20	733.20
Network Health	799.30	1,990.80	700.00	1,742.50	441.80	1,236.10	878.60
Physicians Plus	683.00	1,700.10	598.30	1,488.30	442.10	1,120.10	879.20
Security Health Plan	814.50	2,028.80	713.30	1,775.80	523.40	1,332.90	1,041.80
Standard Plan	1,392.80	3,477.80	1,222.40	3,049.70	NA ⁴	1,766.10	NA ⁴
State Maintenance Plan (SMP)	862.00	2,150.20	757.40	1,887.30	NA ⁴	1,230.40	NA ⁴
UnitedHealthcare of Wisconsin	795.00	1,980.10	696.30	1,733.30	513.70	1,303.70	1,022.40
Unity Health Insurance-Community	774.80	1,929.60	678.60	1,689.00	469.60	1,239.40	934.20
Unity Health Insurance-UW Health	694.20	1,728.10	608.10	1,512.80	433.30	1,122.50	861.60
WEA Trust-East	794.90	1,979.80	696.20	1,733.00	513.60	1,303.50	1,022.20
WEA Trust-Northwest Chippewa Valley	831.20	2,070.60	727.90	1,812.30	531.70	1,357.90	1,058.40
WEA Trust-Northwest Mayo Clinic Hlth. Sys.	831.20	2,070.60	727.90	1,812.30	531.70	1,357.90	1,058.40
WEA Trust-South Central	665.60	1,656.60	583.00	1,450.00	448.90	1,109.50	892.80

¹Medicare rates do not apply to the HDHP.

²Medicare 1 = Family coverage with at least one insured family member enrolled in Medicare Parts A, B and D.

³Medicare 2 = Family coverage with all insured family members enrolled in Medicare Parts A, B and D.

⁴Members with Standard Plan or SMP coverage who become enrolled in Medicare Parts A and B will automatically be moved to the Medicare Plus plan. All other non-Medicare family members will remain covered under the Standard Plan or SMP.

Choose Your Health Plan

Health Plan Map 2015

Health Plan Codes	
Anthem Blue-Northeast	AE
Anthem Blue-Southeast	AS
Arise Health Plan Northern	A
Arise Health Plan Southeast	AH
Dean Health Insurance	D
Dean Health Insurance-Prevea360	D3
Group Health Cooperative of Eau Claire	GEC
GHC of South Central Wisconsin	GSC
Gundersen Health Plan	G
Health Tradition Health Plan	HT
HealthPartners Health Plan	HP
Humana-Eastern	HE
Humana-Western	HW
Medical Associates Health Plans	MA
Medicare Plus (available in all counties)	N/A
MercyCare Health Plans	MC
Network Health	N
Physicians Plus	PP
Security Health Plan	S
Standard Plan (available in all counties)	N/A
State Maintenance Plan	SMP
UnitedHealthcare of Wisconsin	U
Unity Health Insurance-Community	UC
Unity Health Insurance-UW Health	UU
WEA Trust-East	WT
WEA Trust-Northwest Chippewa Valley	WN
WEA Trust-Northwest Mayo Clinic Health System	WM
WEA Trust-South Central	WC

The table below and on the next page shows which health plans are available in each county, with columns for *qualified plans* and *non-qualified plans*. A *non-qualified plan* is one that has limited provider availability in that area.

Since Standard Plan and Medicare Plus are available throughout the state, they do not appear in the table.

Health plan codes used on the below table are explained in the table to the left.

Health plan specific information is available on the *Health Plan Description* pages later in this guide.

County	Qualified Plans	Non-qualified plans
Adams	D, S, UC, WT	PP
Ashland	GEC, HP, S, WN	
Barron	HP, HW, S, WN, WM	G
Bayfield	SMP	GEC, S, WN
Brown	A, AE, D3, HE, N, U, WT	
Buffalo	SMP	HT, WM
Burnett	GEC, WN	HP, S
Calumet	AE, HE, N, U	A, WT
Chippewa	G, HP, HW, S, WN, WM	
Clark	GEC, G, HP, S, WN	A
Columbia	D, PP, UC, WT	GSC
Crawford	G, HT	HP, MA, UC
Dane	D, GSC, PP, UU, WC	
Dodge	AS, D, HE, N, PP, U, UC, WT	A
Door	A, AE, HE, N, U, WT,	D3
Douglas	GEC, HP, HW, S, WN	
Dunn	HW, WM	WN
Eau Claire	G, HP, HW, S, WN, WM	
Florence	SMP	A, WT
Fon du Lac	A, AE, D, HE, N, U, UC, WT	
Forest	SMP	A, S, WT
Grant	D, G, MA, UC	HT, HP, PP
Green	D, HE, UC	MC
Green Lake	AE, HE, N, U, WT	A, D, PP

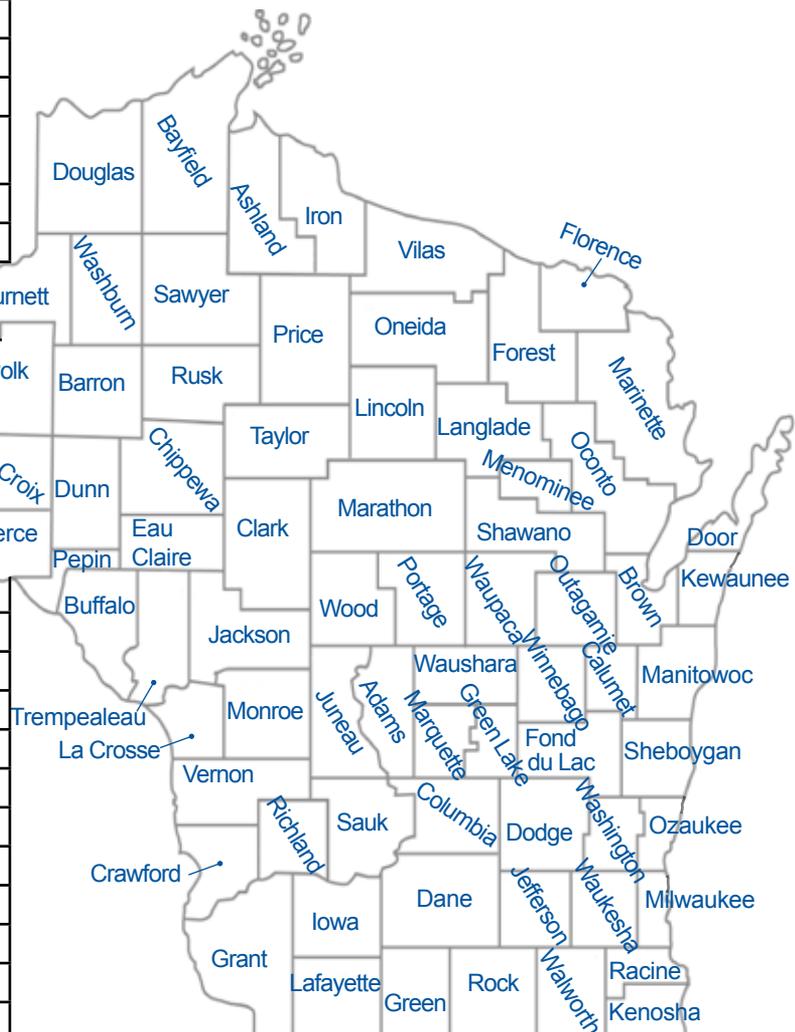
Visit ef.wi.gov/members/IYC2015/IYC_State_map.html for an interactive health plan map.

Choose Your Health Plan

Health Plan Map 2015

County	Qualified Plans	Non-qualified plans
Iowa	D, MA, PP, UC	
Iron	SMP	GEC, S, WN
Jackson	G, HT, S, WN	HP
Jefferson	AS, D, HE, MC, PP, U, UC, WT	A
Juneau	G, HT, UC, S, UC, WT	D, PP
Kenosha	AS, AH, HE, U, WT	
Keweenaw	A*, N*, WT*	AE, D3, HE, U
La Crosse	G, HP, HT	
Lafayette	MA	D, PP, UC
Langlade	A, GEC, S, WT	HP
Lincoln	GEC, S, WT	A, HP
Manitowoc	A, AE, D3, HE, N, U, WT	
Marathon	A, GEC, HP, S, WT	
Marinette	A, AE, HE, U, WT	D3
Marquette	SMP	A, GSC, N, PP, U, UC, WT
Menominee	SMP	WT
Milwaukee	AS, AH, HE, U, WT	
Monroe	G, HP, HT	
Oconto	A, AE, D3, HE, N, WT	U
Oneida	GEC, S, WT	A, HP
Outagamie	A, AE, HE, N, U, WT	D3
Ozaukee	AH, AS, HE, U, WT	
Pepin	WN	HP, HW, S
Pierce	HP, WN	HW, WM
Polk	HP, WN	HW
Portage	S, WT	A, HP
Price	GEC, S, WT	HP
Racine	AS, HE, U, WT	AH
Richland	D, G, PP, UC	HT
Rock	AS, D, HE, MC, U, UC, WT	PP
Rusk	S, WN	HP
Sauk	D, G, PP, UC	GSC, HT
Sawyer	GEC, HP, S, WN	G
Shawano	A, AE, HE, N, U, WT	
Sheboygan	A, AE, D3, HE, N, U, WT	
St. Croix	HP, HW, WN	WM
Taylor	A, GEC, S, WT	HP
Trempealeau	G, WM	HT, WN

County	Qualified Plans	Non-qualified plans
Vernon	G, HT, UC	D, HP, PP
Vilas	SMP	A, GEC, HP, S, WT
Walworth	AS, HE, MC, U, UC, WT	AH, D, PP
Washburn	GEC, HP, S, WN	G
Washington	AH, AS, HE, U, WT	
Waukesha	AH, AS, D, HE, U, WT	PP
Waupaca	A, AE, HE, N, S, U, WT	
Waushara	A, AE, HE, N, S, U, WT	PP
Winnebago	A, AE, HE, N, U, WT	
Wood	A, S, WT	HP, PP



*Qualified in a county with no hospital.

Notes

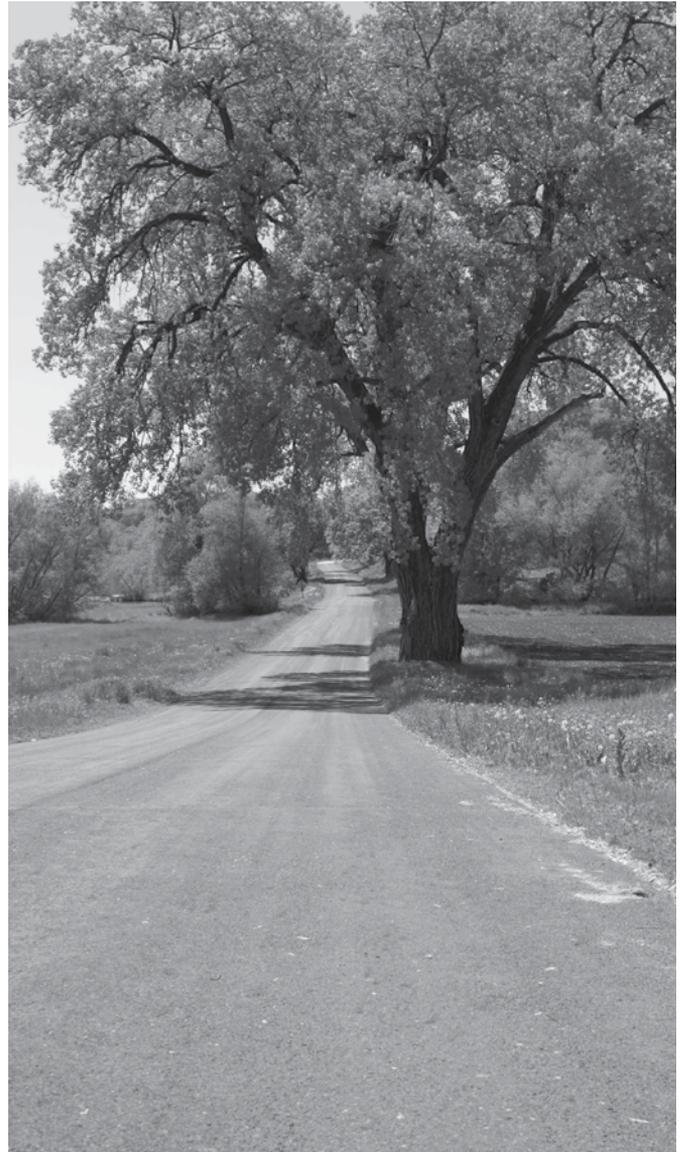
Comparison of Benefit Options

The charts on the following pages are designed to compare the Coinsurance, Traditional and High Deductible Health Plan (HDHP) Uniform Benefits, the Standard Plans and the Medicare Plus plan. There are differences in coinsurance between Uniform Benefits for participants for whom Medicare is the primary payor and Coinsurance and HDHP Uniform Benefits for non-Medicare plans.

The outlines are not intended to be a complete description of coverage. The Uniform Benefits packages are described in detail in your *It's Your Choice Reference Guide*. Details for the other plans are found in the *Medicare Plus* (ET-4113), *Standard Plan* (ET-2112) and *HDHP Standard Plan* (ET-2170) benefit booklets.

Differences might exist among the health plans in the administration of the Uniform Benefits packages. Treatment may vary depending on patient needs, the physicians' preferred practices and the managed care policies and procedures of the health plan.

Federally required Summaries of Benefits and Coverage (SBCs) and the Uniform Glossary are available at etf.wi.gov/members/IYC2015/IYC_State-health-plan-summaries15.html. If you need printed copies sent to you, please call the Department of Employee Trust Funds toll-free at 1-877-533-5020 or 608-266-3285 (local Madison) to let us know which plan's Summary of Benefits and Coverage you want.



Note: Footnotes below refer to the chart on the following pages.

¹ Deductible applies to all services, except prescription drugs.

² PPOs have out-of-network deductibles. See PPO Plan Descriptions (WEA Trust) for details.

³ Coinsurance applies to all services up to the listed out-of-pocket limit (OOPL), then all services are covered at 100%.

⁴ PPOs have out-of-network coinsurance. See health plan descriptions for detail.

⁵ As required by federal law, see list at www.healthcare.gov/what-are-my-preventive-care-benefits/. Note: coinsurance may vary by age.

⁶ This is separate from other out-of-pocket limits (OOPL), such as the medical.

⁷ Level 3 copays do not apply to the OOPL.

⁸ Medicare Plus supplements with Medicare's payment up to 100% coverage. If Medicare denies, this plan also denies except as stated.

Choose Your Health Plan

2015 State—Comparison of Benefit Options

Benefit	Coinsurance Uniform Benefits for Eligible Participants Who Are Not Eligible For, Nor Enrolled in Medicare as the primary payor	High Deductible Health Plan (HDHP) for eligible participants who are not enrolled in any other coverage.	Traditional Uniform Benefits for Retired Participants For Whom Medicare is the Primary Payor
Annual Deductible ¹	No deductible ²	\$1,500 per individual plan \$3,000 per family plan Deductible includes prescription drugs and Uniform Dental allowable services and applies to Out-of-Pocket-Limit (OOPL).	No deductible ²
Annual Coinsurance ³ & Out-of-Pocket Limit (OOPL)	90%/10% to annual OOPL \$500 individual/\$1,000 family except as described ⁴	90%/10% to annual OOPL \$2,500 individual/\$5,000 family except as described	As described in this grid and the one on the following page
Maximum Out-of-Pocket Limit (MOOP)	\$6,600 single / \$13,200 family for federally required essential health benefits	Identical to OOPL above, that is, \$2,500 individual/\$5,000 family except as described	None
Routine Preventive	100% ⁵	100%	100%
Hospital Days	90%/10% coinsurance to OOPL as medically necessary, plan providers only. No day limit.	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL as medically necessary, plan providers only. No day limit.	100% as medically necessary, plan providers only. No day limit.
Emergency Room	\$75 copay per visit, 90%/10% coinsurance thereafter to OOPL	Deductible must be met before coverage begins. After deductible: \$75 copay per visit, 90%/10% coinsurance thereafter to OOPL	\$60 copay per visit
Ambulance	90%/10% coinsurance to OOPL	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL	100%
Transplants (May cover these and others listed)	90%/10% coinsurance to OOPL. Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney with pancreas, heart with lung, and lung	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL. Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney with pancreas, heart with lung, and lung	100% Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney with pancreas, heart with lung, and lung

Footnotes explained on the preceding page.

Choose Your Health Plan

2015 State—Comparison of Benefit Options

Benefit	Coinsurance Uniform Benefits for Eligible Participants Who Are Not Eligible For, Nor Enrolled in Medicare as the primary payor	High Deductible Health Plan (HDHP) for eligible participants who are not enrolled in any other coverage.	Traditional Uniform Benefits for Retired Participants For Whom Medicare is the Primary Payor
Mental Health/ Alcohol & Drug Abuse	90%/10% coinsurance to OOPL Inpatient, Outpatient and Transitional	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL Inpatient, Outpatient and Transitional	100% Inpatient, Outpatient and Transitional
Hearing Exam	90%/10% coinsurance to OOPL	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL	100%
Hearing Aid (per ear)	Every three years: Adults, 80%/20%, up to plan paid \$1,000 (not to OOPL); dependents younger than 18 years, 90%/10% to OOPL	Deductible must be met before coverage begins. After deductible: Every three years: Adults, 80%/20%, up to plan paid \$1,000 (20% member cost to OOPL); dependents younger than 18 years, 90%/10% to OOPL.	Every three years: Adults, 80%/20%, up to plan paid \$1,000; dependents younger than 18 years, 100%
Cochlear Implants	Adults, 80%/20% for device, surgery for implantation, follow-up sessions (not to OOPL); 90%/10% hospital charge for surgery. Dependents under 18, 90%/10% coinsurance up to OOPL for all services.	Deductible must be met before coverage begins. After deductible: Adults, 80%/20% for device, surgery for implantation, follow-up sessions (20% member cost to OOPL); 90%/10% hospital charge for surgery. Dependents under 18, 90%/10% coinsurance up to OOPL for all services.	Adults, 80%/20% for device, surgery for implantation, follow-up sessions; 100% hospital charge. Dependents under 18, 100%.
Routine Vision Exam	90%/10% coinsurance to OOPL for all members except 100% for children ⁵	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL for all members except 100% for children ⁵	100%, one per year
Skilled Nursing Facility (non-custodial care)	90%/10% coinsurance to OOPL, 120 days per benefit period	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL, 120 days per benefit period	100%, 120 days per benefit period
Home Health (non-custodial)	90%/10% coinsurance to OOPL, 50 visits per year. Plan may approve an additional 50 visits.	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL, 50 visits per year. Plan may approve an additional 50 visits.	100%, 50 visits per year. Plan may approve an additional 50 visits.

Footnotes explained on Page 31.

Choose Your Health Plan

2015 State—Comparison of Benefit Options

Benefit	Coinsurance Uniform Benefits for Eligible Participants Who Are Not Eligible For, Nor Enrolled in Medicare as the primary payor	High Deductible Health Plan (HDHP) for eligible participants who are not enrolled in any other coverage.	Traditional Uniform Benefits for Retired Participants For Whom Medicare is the Primary Payor
Physical/ Speech / Occupational Therapy	90%/10% coinsurance to OOPL, 50 visits per year. Plan may approve an additional 50 visits.	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL, 50 visits per year. Plan may approve an additional 50 visits.	100%, 50 visits per year. Plan may approve an additional 50 visits.
Durable Medical Equipment	80%/20% coinsurance to OOPL	Deductible must be met before coverage begins. After deductible: 80%/20% coinsurance to OOPL	80%/20% coinsurance to annual \$500 OOPL per individual
Hospital Pre-Certification	Varies by plan	Varies by plan	Varies by plan
Referrals	In-network—varies by plan Out-of-network—required	In-network—varies by plan Out-of-network—required	In-network—varies by plan. Out-of-network—required
Treatment for Morbid Obesity	Excluded	Excluded	Excluded
Oral Surgery	90%/10% coinsurance to OOPL, 11 procedures	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOPL, 11 procedures	100%, 11 procedures
Dental Care	Uniform Dental Benefits	Deductible must be met before coverage begins. After deductible: Uniform Dental Benefits. Oral health assessments for children ten and under are covered at 100% in-network.	Uniform Dental Benefits
Drug Copays and OOPL ⁶ (non-specialty)	Level 1=\$5; 2=\$15; 3=\$35 ⁷ . OOPL \$410 individual/\$820 family	Deductible must be met before coverage begins. After deductible: Level 1=\$5; 2=\$15; 3=\$35. OOPL \$2,500 individual/\$5,000 family. Preventive prescription drugs are not subject to the deductible. See HDHP FAQ on Page 10.	Level 1=\$5; 2=\$15; 3=\$35 ⁷ . OOPL \$410 individual/\$820 family
Specialty Drug Copays and OOPL ⁶ - Preferred Pharmacy	Preferred drugs \$15 to OOPL \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOPL.	Deductible must be met before coverage begins. After deductible: Preferred drugs \$15 to OOPL \$2,500 individual/\$5,000 family. Non-preferred drugs \$50, to OOPL \$2,500 individual/\$5,000 family.	Preferred drugs \$15 to OOPL \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOPL.
Specialty Drug Copays and OOPL ⁶ - Non-Preferred Pharmacy	Preferred drugs \$50 to OOPL \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOPL.	Deductible must be met before coverage begins. After deductible: Preferred and non-preferred drugs \$50 to OOPL \$2,500 individual/\$5,000 family.	Preferred drugs \$50 to OOPL \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOPL.

Choose Your Health Plan

2015 State—Comparison of Benefit Options

Benefit	Standard Plan		HDHP Standard Plan	
	Preferred Provider	Non-Preferred Provider	Preferred Provider	Non-Preferred Provider
Annual Deductible ¹	\$200 individual/ \$400 family	\$500 individual/ \$1,000 family	\$1,700 individual/\$3,400 family	\$2,000 individual/ \$4,000 family
Annual Coinsurance ³ & OOP	90%/10% Annual OOP (includes deductible): \$800 individual/\$1,600 family	70%/30% Annual OOP (includes deductible): \$2,000 individual/\$4,000 family	90% / 10% after deductible Combined medical and drug OOP: \$3,500 individual/\$7,000 family (includes deductible)	70% / 30% after deductible Combined medical and drug OOP: \$3,800 individual/\$7,600 family (includes deductible)
Routine Preventive	100% ⁵	Deductible, coinsurance	100% ⁵	Deductible, coinsurance
Hospital Days	Deductible and coinsurance as Medically Necessary. No day limit.	Deductible and coinsurance as Medically Necessary. No day limit.	Deductible and coinsurance as Medically Necessary. No day limit.	Deductible and coinsurance as Medically Necessary. No day limit.
Emergency Room	\$75 copay per visit, deductible and coinsurance thereafter	\$75 copay per visit, Preferred Provider deductible and coinsurance thereafter	\$75, deductible and coinsurance thereafter. Applies to OOP and is limited by OOP	\$75, deductible and coinsurance thereafter. Applies to OOP and is limited by OOP
Ambulance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Transplants (May cover these and others listed)	Deductible and coinsurance Bone marrow, musculoskeletal, corneal, and kidney	Deductible and coinsurance Bone marrow, musculoskeletal, corneal, and kidney	Deductible and coinsurance as Medically Necessary. Bone marrow, musculoskeletal, corneal, and kidney	Deductible and coinsurance as Medically Necessary. Bone marrow, musculoskeletal, corneal, and kidney
Mental Health/ Alcohol & Drug Abuse	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Hearing Exam	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease to deductible and coinsurance
Hearing Aid (per ear)	For dependents younger than 18 years only, every three years—deductible and coinsurance	For dependents younger than 18 years only, every three years—deductible and coinsurance	For dependents younger than 18 years only, every three years—deductible and coinsurance	For dependents younger than 18 years only, every three years—deductible and coinsurance
Cochlear Implants	Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions	Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions	Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions	Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions
Routine Vision Exam	100% for children under age 5 ⁵ . Illness or disease only, deductible and coinsurance.	No benefit for routine. Illness or disease only, deductible and coinsurance.	100% for children under age 5 ⁵ . Illness or disease only, deductible and coinsurance.	No benefit for routine. Illness or disease only, deductible and coinsurance.

Footnotes explained on Page 31.

Choose Your Health Plan

2015 State—Comparison of Benefit Options

Benefit	Standard Plan		HDHP Standard Plan	
	Preferred Provider	Non-Preferred Provider	Preferred Provider	Non-Preferred Provider
Home Health (non-custodial)	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50 visits.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50 visits.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50 visits.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50 visits.
Physical/Speech/Occupational Therapy	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50 visits.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50 visits.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50 visits.	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50 visits.
Durable Medical Equipment	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance
Hospital Pre-Certification	WPS Medical Management Program for inpatient stays	WPS Medical Management Program for inpatient stays	WPS Medical Management Program for inpatient stays	WPS Medical Management Program for inpatient stays
Treatment for Morbid Obesity	Preferred provider deductible and coinsurance. Surgical treatment requires prior authorization.	Non-preferred provider deductible and coinsurance. Surgical treatment requires prior authorization.	Preferred provider deductible and coinsurance	Non-preferred provider deductible and coinsurance
Oral Surgery	23 procedures—deductible and coinsurance	23 procedures—deductible and coinsurance	23 procedures—deductible and coinsurance	23 procedures—deductible and coinsurance
Dental Care	No benefit	No benefit	No benefit	No benefit
Drug Copays and OOPL ⁶ (non-specialty)	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$1,000 individual/ \$2,000 family	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$1,000 individual/ \$2,000 family	Level 1=\$5; 2=\$15; 3=\$35 after deductible is met Combined medical and drug OOPL: \$3,500 individual/\$7,000 family	Level 1=\$5; 2=\$15; 3=\$35 after deductible is met Combined medical and drug OOPL: \$3,800 individual/\$7,600 family
Specialty Drug Copays and OOPL ⁶	Preferred drugs \$15 to OOPL \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOPL.	Preferred drugs \$50 to OOPL \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOPL.	Preferred drugs: After deductible is met, \$15 to combined medical and drug OOPL. Non-preferred drugs: After deductible is met, \$50 to combined medical and drug OOPL.	Preferred drugs: After deductible is met, \$50 to combined medical and drug OOPL. Non-preferred drugs: After deductible is met, \$50 to combined medical and drug OOPL.

Footnotes explained on Page 31.

Choose Your Health Plan

2015 State—Comparison of Benefit Options

Benefit	Medicare Plus and Medicare Part A, B and D ⁸
Annual Deductible ¹	No deductibles
Annual Coinsurance ³ & OOPL	100%
Routine Preventive	100% Covered by Medicare only
Hospital Days	100% 120 days; semi-private room
Emergency Room	100% no copay
Ambulance	100%
Transplants (May cover these and others listed)	100% for Medicare approved heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a Medicare-certified facility
Mental Health/Alcohol & Drug Abuse	Inpatient 100%, up to 120 days Outpatient and Transitional 100%
Hearing Exam	Benefit for illness or disease 100%
Hearing Aid (per ear)	For dependents younger than 18 years only, every three years—100%
Cochlear Implants	Dependents under 18, 100% device, surgery, follow-up sessions
Routine Vision Exam	No benefit for routine. Illness or disease only, 100%.
Skilled Nursing Facility (non-custodial care)	Medicare approved facility: 100% 120 days/benefit period. Non-Medicare approved facility, if transferred within 24 hours of hospital release, benefits payable up to 30 days/confinement.
Home Health (non-custodial)	100%
Physical/Speech/Occupational Therapy	100%,
Durable Medical Equipment	100%
Hospital Pre-Certification	None required
Treatment for Morbid Obesity	100% for Medicare covered service
Oral Surgery	100%
Dental Care	No benefit
Drug Copays and OOPL ⁶ (non-specialty)	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$410 individual/\$820 family
Specialty Drug Copays and OOPL ⁶	Drugs at preferred pharmacy, see Preferred Provider column. Drugs at non-preferred pharmacy, see Non-Preferred Provider column.

Footnotes explained on Page 31.

Health Plan Features—At a Glance

Health Plan Features—At a Glance

Individual Health Plan Features

You may think there is little difference among the available health plan options as all health plans provide medical coverage as detailed in Uniform Benefits. Additional services, requirements and programs can, however, vary from plan to plan. The chart on the following page will assist you in comparing the health plans. Following the chart are the individual plan description pages. These provide an overview of each health plan to assist with evaluating which health plan may be best for you.

Overall Performance Rating

Please note, in an effort to make the results more meaningful to our members, the health plan report card has changed this year. Each year participating health plans are evaluated based on care delivery in areas such as wellness, prevention, disease management, efficient use of resources and what people say about the quality of their plan. The new report card was shared with the health plans and their feedback was collected. The following are highlights of the changes:

- The measures selected better represent the conditions and diseases of our members, such as hypertension and diabetes.
- The health plans' audited survey results of all their members' responses about the quality of their plan were used. In the past, an outside vendor conducted such surveys of ETF members only.
- Measures were picked to compliment initiatives with our health plans, like care coordination.
- Four of the ratings are made up of a number of individual measures. This year, you can see these four ratings, and also how the plans do in each measure that make up the ratings.

Because of these revisions, the results this year are not comparable to past years.

The chart on the following page lists how the health plans rated on Overall Performance. Visit

etf.wi.gov/members/IYC2015/IYC_State_rate.html for detailed information on how the ratings are determined and to access the complete Health Plan Report Card.

Health Plan Services

The chart indicates which health plans offer the following services:

Dental coverage - If offered, coverage is outlined in the *It's Your Choice Reference Guide* under Uniform Dental Benefits.

Member web portal - Provided for secure communication with the health plan and for accessing account information via the Internet.

24-Hour Nurseline - For convenient access to medical advice or determining if you should seek medical treatment.

Disease Management and Wellness Programs

Most health plans offer educational and treatment programs to assist members with improving and managing their health, such as smoking cessation support and care management for asthma, diabetes and other chronic health conditions. There are also programs that support members through pregnancy, childbirth and caring for young children. Many health plans offer extensive health resources on their websites.

The Well Wisconsin \$150 incentive is available to most adult members. It is issued after completion of a biometric screening and the health plan provided health risk assessment. For more information on Well Wisconsin, visit wellwisconsin.wi.gov. Many health plans also offer wellness programs beyond the Well Wisconsin incentive.

The chart on the following page indicates which plans offer additional wellness incentives or discounts and those that provide programs to assist with back pain and weight management.

For complete details on health plan services and programs, contact the health plan or visit their website.

Stars: ★ 1-5, 5 being the highest

Health Plan Features—At a Glance

Health Plans	Overall Performance Rating	Health Plan Services			Wellness and Health Management Programs		
		Dental	Member Web Portal	24-hour Nurseline	Expanded Wellness ¹	Managing Back Pain ²	Weight ² Management
Anthem Blue	★☆☆☆☆	•	•	•	•		
Arise Health Plan	★★☆☆☆	•	•		•		
Dean Health Insurance	★★★★☆	•	•	•	•		•
GHC of Eau Claire	★★☆☆☆	•		•	•	•	•
GHC of South Central Wisconsin	★★★★☆	•	•	•	•	•	•
Gundersen Health Plan	★★★★★	•	•	•			•
Health Tradition Health Plan	★★★★☆	•	•	•	•	•	•
HealthPartners Health Plan	★★★★☆	•	•	•	•	•	•
Humana	★★★★☆	•	•	•			
Medical Associates Health Plans	★★★★☆	•	•	•			
MercyCare Health Plans	★★★★☆	•	•	•	•		•
Network Health	★★☆☆☆	•	•	•			•
Physicians Plus	★★☆☆☆	•	•	•	•		•
Security Health Plan	★★★★☆	•	•	•	•	•	•
State Maintenance Plan	Not available						
UnitedHealthcare	★★★★☆	•	•	•	•	•	
Unity Health Insurance	★★★★☆	•	•		•	•	•
WEA Trust	★☆☆☆☆	•	•		•		

Ratings are based on 2014 plan participation. Rating may not reflect performance of new service territories for 2015.

¹In addition to the Well Wisconsin incentive, health plan offers financial incentives or discounts for wellness activities or services.

²Health plan offers one-on-one or group programs. Program fees may not be a covered benefit. Contact the health plan for details.

Notes

Anthem Blue Preferred – Northeast Network

1-800-843-6447

anthem.com



Overall Performance Rating

What's New for 2015

Now available for you and your family: LiveHealth Online!

When you're not feeling well, LiveHealth Online is faster and more convenient than a visit to the urgent care center. You don't have to make an appointment, sit in traffic or wait in a waiting room. You just need the LiveHealth Online app or a computer with a webcam. Best of all, LiveHealth Online is part of your health plan. So your visit costs the same as a regular office visit.

With LiveHealth Online, you get:

- Immediate access to doctors 24 hours a day, 365 days a year.
- Secure and private two-way video chats with board-certified doctors.
- Prescriptions sent to your drugstore, if needed.

LiveHealth Online can help with colds, the flu, allergies, fevers, infections and more! But don't wait until you or your family members get sick. Just download the app or go to LiveHealthOnline.com on your computer and sign up.

Provider Directory

Go to anthem.com/stateofwisconsin to access a provider directory.

To request a printed directory be mailed to you, call 1-800-843-6447.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers except for non-emergency hospital stays. Prior authorization is required for some medical procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-843-6447 prior to the appointment.

Service Area

Brown, Calumet, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, Waushara and Winnebago counties.

Emergency and Urgent Care Outside Service Area

If you require emergency care when outside of the network, contact Anthem at 1-800-843-6447 within 24 hours of receiving care. Follow-up care must be received by an in-network provider.

For urgent care, contact our 24/7 Nurseline at 1-866-647-6120 for determining the appropriate level of care.

Mental, Behavioral Health and Substance Abuse

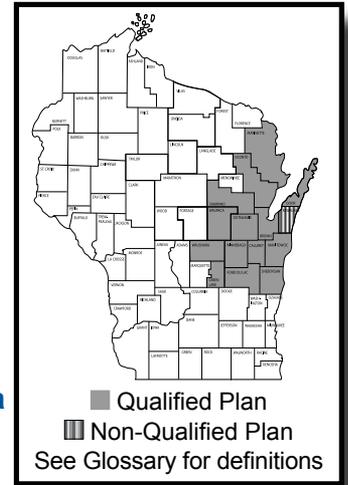
No referral is required for outpatient services from an in-network mental health provider. Prior authorization is required for inpatient services. For other services, contact 1-800-843-6447.

Dental Benefits

Dental services are provided through Anthem's 100/200/300 network. The dental provider network directory is located within the medical provider directory at anthem.com/stateofwisconsin or you may call 1-800-843-6447 for a provider directory. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

1-866-647-6120



Anthem Blue Preferred – Southeast Network

1-800-843-6447

anthem.com



What's New for 2015

Now available for you and your family: LiveHealth Online!

When you're not feeling well, LiveHealth Online is faster and more convenient than a visit to the urgent care center. You don't have to make an appointment, sit in traffic or wait in a waiting room. You just need the LiveHealth Online app or a computer with a webcam. Best of all, LiveHealth Online is part of your health plan. So your visit costs the same as a regular office visit.

With LiveHealth Online, you get:

- Immediate access to doctors 24 hours a day, 365 days a year.
- Secure and private two-way video chats with board-certified doctors.
- Prescriptions sent to your drugstore, if needed.

LiveHealth Online can help with colds, the flu, allergies, fevers, infections and more! But don't wait until you or your family members get sick. Just download the app or go to LiveHealthOnline.com on your computer and sign up.

Provider Directory

Go to anthem.com/stateofwisconsin to access a provider directory.

To request a printed directory be mailed to you, call 1-800-843-6447.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers except for non-emergency hospital stays. Prior authorization is required for some medical procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-843-6447 prior to the appointment.

Service Area

Dodge, Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Walworth, Washington and Waukesha counties.

Emergency and Urgent Care Outside Service Area

If you require emergency care when outside of the network, contact Anthem at 1-800-843-6447 within 24 hours of receiving care.

Follow-up care must be received by an in-network provider.

For urgent care, contact our 24/7 Nurseline at 1-866-647-6120 for determining the appropriate level of care.

Mental, Behavioral Health and Substance Abuse

No referral is required for outpatient services from an in-network mental health provider. Prior authorization is required for inpatient services. For other services, contact 1-800-843-6447.

Dental Benefits

Dental services are provided through Anthem's 100/200/300 network. The dental provider network directory is located within the medical provider directory at anthem.com/stateofwisconsin or you may call 1-800-843-6447 for a provider directory. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

1-866-647-6120



Arise Health Plan Northern

1-888-711-1444 toll free or 920-490-6900

wecareforwisconsin.com



Overall Performance Rating

What's New for 2015

Arise Health Plan has expanded its service area with coverage in Green Lake, Marquette and Waushara counties with the addition of Community Health Network (CHN). CHN brings Arise members access to 35 providers, providing services at two hospitals, Berlin Memorial Hospital and Wild Rose Community Hospital.

Provider Directory

Go to WeCareForWisconsin.com to access a provider directory. Select "Members" or "Visitors" and then "Find A Doctor." To print a provider directory, scroll to the bottom of the "Find a Doctor" page and select the link below the search options. To request a printed directory be mailed to you, call 1-888-711-1444.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. Prior authorization is required before the services are rendered for certain services, all non-participating providers, and tertiary-care specialists and facilities. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-888-711-1444 before the appointment or visit WeCareForWisconsin.com for complete list.

Service Area

Brown, Calumet, Clark, Dodge, Door, Florence, Fond du Lac, Forest, Green Lake, Jefferson, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Oconto, Oneida, Outagamie, Portage, Shawano, Sheboygan, Taylor, Vilas, Waupaca, Waushara, Winnebago and Wood counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact Arise Health Plan at 1-888-711-1444 within 48 hours of receiving care. Follow-up care must be received by an in-network provider.

Mental, Behavioral Health and Substance Abuse

Outpatient mental health and alcohol and drug abuse (AODA) services do not require a pre-service authorization, but a participating provider is required. Inpatient and transitional mental health and AODA services require a pre-service authorization and use of a participating provider.

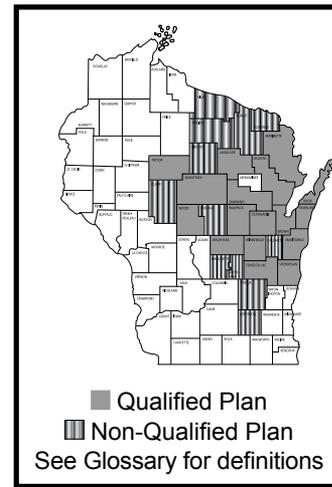
Dental Benefits

Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find in-network dentists, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Not available.



Arise
HEALTH PLAN

Arise Health Plan Southeast

1-888-711-1444 toll free or 920-490-6900

wecareforwisconsin.com


Overall Performance Rating

What's New for 2015

Arise Health Plan offers members in southeast Wisconsin access to a robust provider network that includes Aurora HealthCare and United Hospital Services, as well many independent practitioners. Our quality network offers access to 20 hospitals and hundreds of primary and specialty care practitioners.

Provider Directory

Go to WeCareForWisconsin.com to access a provider directory. Select "Members" or "Visitors" and then "Find A Doctor." To print a provider directory, scroll to the bottom of the "Find a Doctor" page and select the link below the search options. To request a printed directory be mailed to you, call 1-888-711-1444.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. Prior authorization is required before the services are rendered for certain services, all non-participating providers, and tertiary-care specialists and facilities. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-888-711-1444 before the appointment or visit WeCareForWisconsin.com for a complete list.

Service Area

Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington and Waukesha counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact Arise Health Plan at 1-888-711-1444 within 48 hours of receiving care. Follow-up care must be received by an in-network provider.

Mental, Behavioral Health and Substance Abuse

Outpatient mental health and alcohol and drug abuse (AODA) services do not require a pre-service authorization, but a participating provider is required. Inpatient and transitional mental health and AODA services require a pre-service authorization and use of a participating provider.

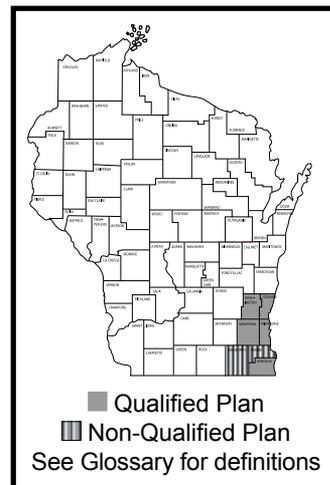
Dental Benefits

Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Not available.




HEALTH PLAN

Dean Health Insurance

1-800-279-1301

deancare.com/wi-employees



Overall Performance Rating

What's New for 2015

Effective 1/1/2015, your dental coverage will be moved from Ameritas Group Dental to Delta Dental of Wisconsin. Due to the change in dental networks, members should verify that their current dentist is in the Delta Dental network. Services performed by out-of-network providers will not be covered.

Our medical network has expanded to include ProHealth Care's network of physicians, clinics and hospitals throughout Waukesha County. ProHealth Care is a fully integrated system consisting of Waukesha Memorial and Oconomowoc Memorial hospitals, 16 clinics and more than 460 primary care and specialty physicians in Waukesha County.

We've also updated a couple of search features on our website to make it easier than ever to find a provider near you. The online provider directory now displays the in-network provider or location that is closest to you when you search by ZIP code. A new interactive map, supported by Google Maps, shows at a glance all the types of locations available—and where to find them.

Provider Directory

Go to deancare.com/wi-employees to access a provider directory. Select "Online Provider Directory" or "Printable Provider Directory." To request a printed directory be mailed to you, call 1-800-279-1301.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. You may check the status of your request at DeanConnect. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-279-1301 prior to the appointment.

Service Area

Adams, Columbia, Dane, Dodge, Fond du Lac, Grant, Green, Green Lake, Iowa, Jefferson, Juneau, Lafayette, Richland, Rock, Sauk, Vernon, Walworth and Waukesha counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact Dean Health Insurance at 1-800-279-1301 within 48 hours or as soon as reasonably possible of receiving care. Follow-up care must be received by an in-network provider.

Mental, Behavioral Health and Substance Abuse

Prior authorization and/or referrals are not required for Outpatient Mental Health Services when seeking services from an in-network provider. Inpatient Mental Health must be prior authorized.

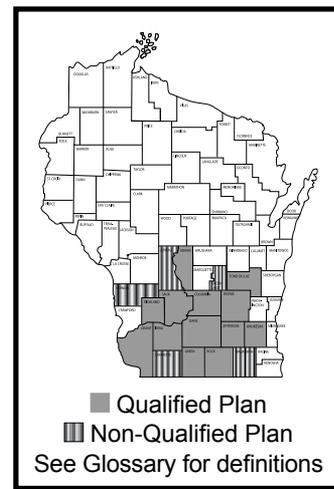
Dental Benefits

Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Dean On Call 1-800-576-8773



Dean[™]
HEALTH PLAN

Dean Health Insurance - Prevea360 Health Plan

1-877-230-7555

prevea360.com/wi-employees



What's New for 2015

Effective 1/1/2015, your dental coverage will be moved from Ameritas Group Dental to Delta Dental of Wisconsin. Due to the change in dental networks, members should verify that their current dentist is in the Delta Dental network. Services performed by out-of-network providers will not be covered.

Prevea360 Health Plan is underwritten by Dean Health Insurance, so you know it's a plan Wisconsinites have come to know and trust.

What makes Prevea360 so special is its proprietary network of hospitals, physicians and ancillary providers that is based on Prevea Health's multi-specialty physician group and HSHS partner hospitals, including St. Mary's and St. Vincent's Hospitals in Green Bay and St. Nicholas Hospital in Sheboygan, as well as other in-network hospitals in Oconto, Manitowoc and Door counties. This collaboration between health care experts, hospital partners, and insurance provider as an integrated health system leads to a better, more affordable experience for our members and patients—one that is centered around you.

Our goal as a health care system is to keep our members happy and healthy. Preventive care and wellness are integral parts of our care philosophy. Prevea360—a better kind of health care.

Provider Directory

Go to prevea360.com/wi-employees to access a provider directory. Select "Online Provider Directory" or "Printable Provider Directory." To request a printed directory be mailed to you, call 1-877-230-7555.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. You may check the status of your request at

MyPrevea. If you are unsure if a service, test or procedure requires prior authorization or a referral, call 1-877-230-7555 prior to the appointment.

Service Area

Brown, Door, Kewaunee, Manitowoc, Marinette, Oconto, Outagamie and Sheboygan counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact Prevea360 at 1-877-230-7555 within 48 hours or as soon as reasonably possible of receiving care. Follow-up care must be received by an in-network provider.

Mental, Behavioral Health and Substance Abuse

Prior authorization and referrals are not required for Outpatient Mental Health Services when seeking services with an in-network provider. Inpatient Mental Health must be prior authorized.

Dental Benefits

Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Prevea Care After Hours 1-888-277-3832



PREVEA360 health plan™

Group Health Cooperative of Eau Claire

1-888-203-7770 or 715-552-4300

group-health.com



Overall Performance Rating

What's New for 2015

The Cooperative is pleased to announce that we have expanded our service area to include Clark, Iron, Langlade, Lincoln, Marathon, Oneida, Price, Taylor and Vilas counties.

The Cooperative has enhanced our online Wellness library to include fitness and nutrition tools, and an eNewsletter which provides wellness tips via e-mail. The Cooperative is now on Facebook, which allows us to stay connected and inform our followers of local events, healthy recipes and much more.

Provider Directory

Go to group-health.com to access a provider directory. Use www.group-health.com/State/Default.aspx as a direct path or visit www.group-health.com/default.aspx, choose "Members," then "My Plan" and "State of WI Employees." To request a printed directory be mailed to you, call Member Services at 1-888-203-7770.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. You must get a prior authorization before receiving care from an out-of-network provider, for all admissions and for select outpatient services. You will receive written notification of the approval or denial for the prior authorization. Members with low back pain are required to participate in a shared decision making tool to review information on options, outcomes and to clarify personal values. For further information regarding authorization guidelines, please visit group-health.com or call 1-888-203-7770 to speak with Member Services.

Service Area

Ashland, Bayfield, Burnett, Clark, Douglas, Iron, Langlade, Lincoln, Marathon, Oneida, Price, Sawyer, Taylor, Vilas and Washburn counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care services while outside the network, please contact the Cooperative at 1-888-203-7770 within 48 hours of receiving services for care coordination purposes. Use the FirstCare Nurseline listed on your ID card if you need help determining the appropriate level of care. Follow-up care must be received from an in-network provider unless otherwise authorized by the Cooperative.

Mental, Behavioral Health and Substance Abuse

No referral is needed to see a provider in the Cooperative's network. Prior authorization guidelines may apply for certain services; please contact Member Services at 1-888-203-7770 for additional information. Please refer to the provider directory for a listing of mental health providers in the Cooperative's network.

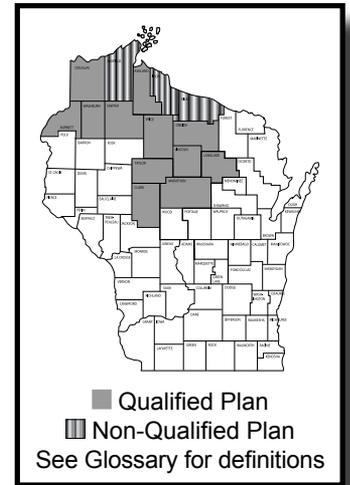
Dental Benefits

Dental services are provided through the Cooperative's in-network dental providers.

Go to group-health.com or call 1-888-203-7770 for a provider directory. Use www.group-health.com/State/Default.aspx as a direct path or visit www.group-health.com/default.aspx, choose "Members," then "My Plan" and "State of WI Employees." Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

FirstCare Nurseline
1-800-586-5473



Group Health Cooperative of South Central Wisconsin

608-828-4853 or 1-800-605-4327, ext. 4504

ghcscw.com



Overall Performance Rating

What's New for 2015

- Virtuwel. You can get a diagnosis and prescription in just a few minutes at virtuwel, your 24/7 online clinic.
- GHC-SCW has now expanded to offer services into Sauk County and Columbia County.
- GHC-SCW has changed the way Complementary Medicine Services are offered to our members. Please see the GHC-SCW website or call Member Services for additional information.

Provider Directory

Go to ghcscw.com, click on "Find a Provider," select "Primary Care" and click on the "State and WPEG Employee Provider Directory" on the right hand navigation bar. To request a printed directory be mailed to you, call Member Services at 1-800-605-4327, ext. 4504.

Referrals, Prior Authorizations, Out-of-Network Care

Your primary care provider will submit a referral request to GHC-SCW Care Management Department when you need to receive services outside of a GHC-SCW clinic or through a specialty care area. Certain procedures or tests also require a prior authorization for medical necessity review. You will receive a letter from GHC-SCW, as well as notification in your GHCMYChartSM account, letting you know if the referral/prior authorization has been approved.

Service Area

Columbia, Dane, Marquette and Sauk counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact GHC-SCW Member Services at 1-800-605-4327, ext. 4504 after receiving care. Follow-up care must be received from an in-network provider.

Mental, Behavioral Health and Substance Abuse

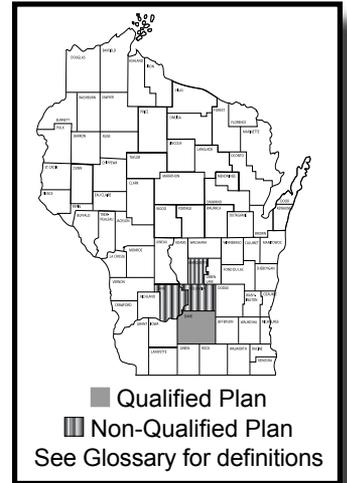
When you need mental health services, contact GHC-SCW mental health triage at 608-441-3290. Please refer to the GHC-SCW Provider Directory. A referral is not required for services provided in a GHC-SCW clinic. A referral is needed for transitional, outpatient and/or inpatient care.

Dental Benefits

Dental services are provided through Dental Health Associates. Go to dhamadison.com or call 608-661-6410 for a dental provider network directory. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

GHCNurseConnect 608-661-7350 or 1-855-661-7350



Gundersen Health Plan

1-800-897-1923 or 608-775-8007

gundersenhealthplan.org



Overall Performance Rating

What's New for 2015

Gundersen Health Plan (GHP) has partnered with Delta Dental of Wisconsin and we are pleased to offer dental benefits to WRS members through Delta Dental. Due to the change in dental networks, members should verify if their current dentist is an in-network dentist. Please see *Dental Benefits* for more details.

Don't forget to visit our new and improved website at gundersenhealthplan.org.

Provider Directory

Go to gundersenhealthplan.org/etf to access a printable or searchable provider directory.

To request a printed directory be mailed to you, call 1-800-897-1923.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-897-1923 prior to the appointment.

Service Area

Barron, Chippewa, Clark, Crawford, Eau Claire, Grant, Jackson, Juneau, La Crosse, Monroe, Richland, Sauk, Sawyer, Trempealeau, Vernon and Washburn counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact Gundersen Health Plan at 1-800-897-1923 within 24 hours of receiving care. Follow-up care must be received from an in-network provider.

Mental, Behavioral Health and Substance Abuse

No prior authorization or referral is required for inpatient or outpatient services from an in-network provider. Prior authorization is required for transitional care. For other services, contact 1-800-897-1923 between the hours of 8 a.m. and 5 p.m.

Dental Benefits

Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Telephone Nurse Advisor 1-800-858-1050 or 608-775-4454



GUNDERSEN HEALTH PLAN

Health Tradition Health Plan

1-877-832-1823 or 1-888-459-3020

healthtradition.com



What's New for 2015

There are no significant plan-specific changes to the Health Tradition Health Plan (HTHP) offering from last year. Please check the website periodically for additional details regarding health and wellness initiatives through HTHP. Refer to the online provider directory to make sure your provider/facility will be in the 2015 HTHP network for the State of Wisconsin plan.

Provider Directory

Go to healthtradition.com to access a provider directory. Click on "Provider Search" towards the top of the screen. To review the directory in a PDF format, go to healthtradition.com, click on "Already have Health Tradition," click on the blue "State of WI Employees" button and select "State of WI Employees Medical Provider Directory." To request a printed directory be mailed to you, call 1-888-459-3020.

Referrals, Prior Authorizations, Out-of-Network Care

You must get a referral approved by HTHP before you see providers outside the HTHP network, including Mayo Clinic–Rochester. Referrals are not needed when receiving care from in-network providers. Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-877-832-1823 prior to the appointment.

Service Area

Buffalo, Crawford, Grant, Jackson, Juneau, La Crosse, Monroe, Richland, Sauk, Trempealeau and Vernon counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact the Health Tradition Utilization Management Department at 1-888-459-3020 within 48 hours of receiving care. Follow-up care must be received from an in-network provider.

Mental, Behavioral Health and Substance Abuse

No prior authorization is required for outpatient services from an in-network mental health/substance abuse provider. Prior authorization is required for inpatient services, group therapy and psychiatric testing.

Dental Benefits

Dental services are provided through HTHP. Go to healthtradition.com or call 1-888-459-3020 for a provider directory. Click on "Provider Search" to access our online searchable directory. Click on "Already have Health Tradition," select the blue "State of WI Employees" button and then choose "WI Dental Provider Directory." Services performed by out-of-network providers will be covered at a lower benefit level.

24-Hour Nurseline

1-855-392-4050



Health Tradition Health Plan
A Mayo Clinic Health System Choice in Wisconsin

HealthPartners Health Plan

1-800-883-2177 or 952-883-5000

healthpartners.com/stateofwis



Overall Performance Rating

What's New for 2015

HealthPartners network has expanded to include new care systems including Park Nicollet, HealthEast and Fairview.

Whether you're at home or on the go, your myHealthPartners plan information is right at your fingertips. From your smartphone, you can:

- Check your plan balances
- Search for doctors near your location
- View your HealthPartners Member ID card and fax it to your doctor's office

Provider Directory

Go to healthpartners.com/stateofwis and click on the "Find a doctor or specialist" link. Click on the PDF listing or search our online directory for providers. To request a printed directory be mailed to you, call 1-800-883-2177.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-883-2177 prior to the appointment or visit healthpartners.com/stateofwis for a complete list.

Service Area

Ashland, Barron, Burnett, Chippewa, Clark, Crawford, Douglas, Eau Claire, Grant, Jackson, La Crosse, Langlade, Lincoln, Marathon, Monroe, Oneida, Pepin, Pierce, Polk, Portage, Price, Rusk, Sawyer, St. Croix, Taylor, Vernon, Vilas, Washburn and Wood counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, you do not need to contact us unless you are admitted into the hospital. If you are admitted, contact HealthPartners at 1-800-316-9807 as soon as reasonably possible. Follow-up care must be received from an in-network provider.

Mental, Behavioral Health and Substance Abuse

No referrals are necessary to see in-network behavioral health providers.

Dental Benefits

Dental services are provided through HealthPartners. Go to healthpartners.com/stateofwis and click on "Find a doctor or specialist," then choose the "Dental Network Listing" to view in-network providers, or call 1-800-883-2177 for a provider directory. Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Careline 1-800-551-0859



Humana – Eastern

1-855-STOFWIH or 1-855-786-3944

humana.com



What's New for 2015

Humana continues to offer HumanaVitality, a health and wellness program that rewards healthy lifestyle choices for members and their families. Visit humana.com/Vitality for more information.

Humana's robust online tools help you choose a provider, see claim status and more. For additional information, go to our.humana.com/stateofwi.

Humana continues to offer a dedicated team trained specifically on the State of Wisconsin health insurance program.

For Members on Medicare: Medicare Advantage

If you are retired and enrolled in Medicare Parts A and B, Humana will automatically enroll you in a Humana Medicare Advantage PPO plan.

Coverage will be Uniform Benefits coverage, plus more. You may see any medical provider in the country that accepts payments from the plan. For enrollment questions or to request an enrollment kit with area PPO directory, call Humana Group Medicare Enrollment at 1-855-STOFWIH or 1-855-786-3944.

Provider Directory for Non-Medicare Members

You are required to have a Wisconsin based primary care provider. Go to our.humana.com/stateofwi to request a provider directory.

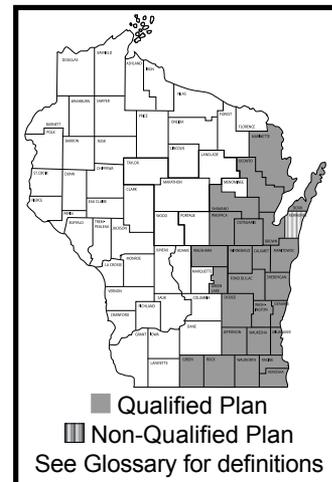
To request a printed directory be mailed to you, call 1-855-786-3944.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are needed when receiving care from in-network providers for certain circumstances. Please call 1-855-STOFWIH for more details. Prior authorization is required for some services and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-855-STOFWIH prior to the appointment.

Service Area for Non-Medicare Members

Brown, Calumet, Dodge, Door, Fond du Lac, Green, Green Lake, Jefferson, Kenosha, Kewaunee, Manitowoc, Marinette, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Rock, Shawano, Sheboygan, Walworth, Washington, Waukesha, Waupaca, Waushara and Winnebago counties.



Emergency and Urgent Care Outside Service Area

If you require emergency care when outside of the network, contact Humana at 1-800-523-0023 within 48 hours of receiving care. Follow-up care must be received from an in-network provider. For urgent care contact 1-855-STOFWIH for determining the appropriate level of care.

Mental, Behavioral Health and Substance Abuse

Prior to seeking mental, behavioral health or substance abuse services, contact 1-855-STOFWIH or 1-855-786-3944 between 8 a.m. and 5:30 p.m. for assistance from a behavioral health specialist.

Dental Benefits

Dental services are provided through HumanaDental. Go to humanadental.com and choose "Find a Dentist" for a dental provider directory, or call 1-855-STOFWIH. Services performed by out-of-network providers will not be covered. This restriction applies to both Medicare Advantage and non-Medicare members.

24-Hour Nurseline

HumanaFirst Nurse Advice 1-800-622-9529

Humana – Western

1-855-STOFWIH or 1-855-786-3944

humana.com



Overall Performance Rating

What's New for 2015

Humana continues to offer HumanaVitality, a health and wellness program that rewards healthy lifestyle choices for members and their families. Visit humana.com/Vitality for more information.

Humana's robust online tools help you choose a provider, see claim status and more. For additional information, go to our.humana.com/stateofwi.

Humana continues to offer a dedicated team trained specifically on the State of Wisconsin health insurance program.

For Members on Medicare: Medicare Advantage

If you are retired and enrolled in Medicare Parts A and B, Humana will automatically enroll you in a Humana Medicare Advantage PPO plan.

Coverage will be Uniform Benefits coverage, plus more. You may see any medical provider in the country that accepts payments from the plan. For enrollment questions or to request an enrollment kit with area PPO directory, call Humana Group Medicare Enrollment at 1-855-STOFWIH or 1-855-786-3944.

Provider Directory for Non-Medicare Members

You are required to have a Wisconsin based primary care provider. Go to our.humana.com/stateofwi to request a provider directory.

To request a printed directory be mailed to you, call 1-855-786-3944.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are needed when receiving care from in-network providers for certain circumstances. Please call 1-855-STOFWIH for more details. Prior authorization is required for some services and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-855-STOFWIH prior to the appointment.

Service Area for Non-Medicare Members

Barron, Chippewa, Douglas, Dunn, Eau Claire, Pepin, Pierce, Polk and St. Croix counties.

Emergency and Urgent Care Outside Service Area

If you require emergency care when outside of the network, contact Humana at 1-800-523-0023 within 48 hours of receiving care.

Follow-up care must be received from an in-network provider. For urgent care contact 1-855-STOFWIH for determining the appropriate level of care.

Mental, Behavioral Health and Substance Abuse

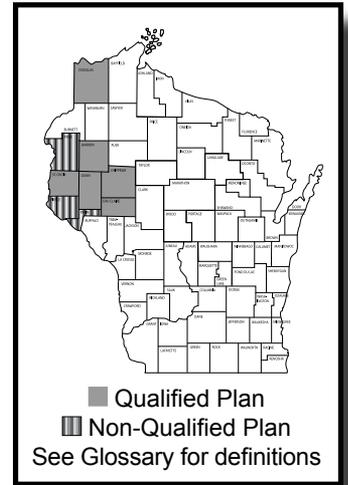
Prior to seeking mental, behavioral health or substance abuse services, contact 1-855-STOFWIH or 1-855-786-3944 between 8 a.m. and 5:30 p.m. for assistance from a behavioral health specialist.

Dental Benefits

Dental services are provided through HumanaDental. Go to humanadental.com and choose "Find a Dentist" for a dental provider directory. Services performed by out-of-network providers will not be covered. This restriction applies to both Medicare Advantage and non-Medicare members.

24-Hour Nurseline

HumanaFirst Nurse Advice 1-800-622-9529



Medical Associates Health Plans

1-800-747-8900

mahealthcare.com



What's New for 2015

When you choose Medical Associates Health Plans, you are entrusting your health to expert practitioners who are committed to your wellbeing. We are grateful to all our dedicated physicians, providers and staff for delivering services that meet or exceed the nation's highest standards in health care. There are no significant changes to the MAHP network. Check out the mahealthcare.com website to find plan information and many health-related topics or log into My e-Link for your personalized claims status/review, explanations of benefits and plan information.

Provider Directory

Go to mahealthcare.com/insurance-services to access a provider directory. Click on "Provider Directory" then enter the Employer Group Number found on your medical card. If you are not currently a MAHP member, simply type "wisesample" to view. To request a printed directory be mailed to you, call 1-800-747-8900.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-325-7442 prior to the appointment.

Service Area

Crawford, Grant, Iowa and Lafayette counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact MAHP Health Care Service Department at 1-800-325-7442 prior to receiving care or as soon as possible. Follow-up care must be received from an in-network provider.

Mental, Behavioral Health and Substance Abuse

No prior authorization or referral is required for outpatient services from a MAHP, in-network provider. Prior authorization may be required for inpatient services and transitional care. For additional details and services, contact 1-800-325-7442

Dental Benefits

Dental services are provided. The MAHP dental network is open to the dental provider of your choice.

24-Hour Nurseline

24 Hour HELP Nurse 563-556-HELP (4357) or 1-800-325-7442



MEDICAL ASSOCIATES
HEALTH PLANS®

Medicare Plus

Administered by WPS Health Insurance

1-800-634-6448 wpsic.com/state

Not Available
Overall Performance
Rating

What's New for 2015

Visit the Health Center at wpsic.com/healthcenter, a continually updated online resource designed to help you make good health decisions, whether you're looking for advice on treating a chronic condition or for tips on leading a healthy lifestyle.

General Information

Medicare Plus will continue to be a Medicare supplement plan for eligible annuitants and their dependents who select the Standard Plan. Medicare Plus will pay your Medicare Part A and B deductibles and coinsurance. This group plan is superior to individual Medicare supplements as it provides protections from fees that exceed usual, customary and reasonable amounts if members use a provider who is not affiliated with Medicare. It also offers coverage during foreign travel. Note, however, in cases where Medicare excludes coverage for a service, this plan will also deny coverage.

The Medicare Plus plan is designed to supplement, not duplicate, the benefits available under Medicare for State of Wisconsin Group Health Insurance Program annuitants.

See the Comparison of Benefit Options section of this guide for benefit differences, and view the Health Care Benefit Plan booklet at etf.wi.gov/publications/et4113.pdf.

Provider Directory

None. This plan provides you with freedom of choice among hospitals and physicians in Wisconsin, nationwide and for travel abroad.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals and prior authorizations are not necessary under this plan as benefits only supplement approved Medicare benefits.

Mental, Behavioral Health and Substance Abuse

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license. Inpatient services will be limited to 120 days.

Dental Benefits

No dental coverage provided.

24-Hour Nurseline

Not available.

MercyCare Health Plans

1-800-895-2421

mercycahealthplans.com



What's New for 2015

MercyCare's network of facilities was recently updated, to include new modern clinics in Elkhorn, Delavan and Edgerton.

Our website has also been revised to better manage your healthcare needs. Visit our newly enhanced, user friendly website at mercycahealthplans.com.

You can still hold your place in line at a Mercy emergency room or urgent care facility by using Mercy Health System's website at mercyinquicker.org.

Provider Directory

Go to mercycahealthplans.com to access a provider directory. On the right side of the page, click "State of Wisconsin Members" then click "Provider Directory." To request a printed directory be mailed to you, call 1-800-895-2421.

Referrals, Prior Authorizations, Out-of-Network Care

MercyCare requires referrals from the member's Primary Care Physician for all specialist visits, both in- and out-of-network.

Service Area

Green, Jefferson, Rock and Walworth counties.

Emergency and Urgent Care Outside Service Area

If you require emergency care when outside of the network, contact MercyCare at 1-800-895-2421 within 48 hours of receiving care. Follow-up care must be received from an in-network provider. Both in- and out-of-network emergency and urgent care visits are covered without notification.

Mental, Behavioral Health and Substance Abuse

No prior authorization or referral is required for outpatient services from an in-network provider. Prior authorization and referral is required for inpatient services and transitional care out-of-network. For other services, contact 1-800-895-2421.

Dental Benefits

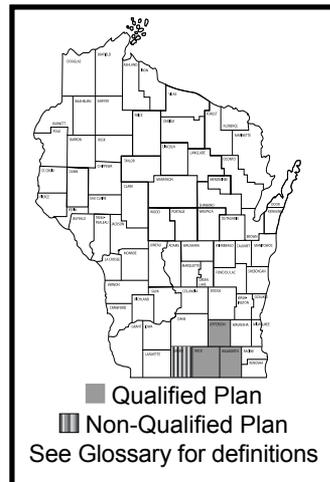
Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab.

Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Healthline 608-758-5770 or 1-888-756-6060



Network Health

1-800-826-0940

networkhealth.com



Overall Performance Rating

What's New for 2015

Froedtert Hospital, Medical College of Wisconsin, Children's Hospital of Wisconsin and Children's Hospital of Wisconsin Fox Valley will be available to members in our current service area. By increasing your choices for great doctors and hospitals, Network Health gives you the options you need.

Provider Directory

Go to networkhealth.com to access a provider directory. Click "Find a Doctor," choose "State of Wisconsin Employee" as your plan, enter your location and search for a provider, or click on "Printable Directory."

To request a printed directory be mailed to you, call 1-800-826-0940.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers. Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. If you are unsure if a service, test or procedure requires prior authorization or a referral, call 1-800-826-0940 prior to the appointment.

Service Area

Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marquette, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, Waushara and Winnebago counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact Network Health within 48 hours of receiving care. Follow-up care must be received from an in-network provider.

Mental, Behavioral Health and Substance Abuse

Prior authorization is required for all mental, behavioral health and substance abuse services. Contact 1-800-555-3616 for assistance. After hours, call your provider or NurseDirect at 1-800-362-9900.

Dental Benefits

Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab.

Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Affinity NurseDirect 1-800-362-9900



Physicians Plus

608-282-8900 or 1-800-545-5015

pplusic.com



What's New for 2015

Effective January 1, 2015, all UW Health providers and facilities are part of the Physicians Plus provider network, including UW Hospital & Clinics and American Family Children's Hospital.

Additionally, the following counties are added to the Physicians Plus service area in 2015: Dodge, Juneau, Vernon, Walworth, Waukesha and Wood.

Provider Directory

Go to directory.pplusic.com to access a provider directory.

To search for a provider, select "State of Wisconsin/Wisconsin Public Employee (State/WPE)" under the network drop-down menu. To print the provider listing, select the "State PDF Directory" on the bottom of the page. To request a printed directory to be mailed to you, call 608-282-8900.

Referrals, Prior Authorizations, Out-of-Network Care

Prior authorization is not required for most covered services delivered by Physicians Plus network providers. Prior authorization is required for out-of-network specialty services. Members must have their provider submit a prior authorization request to Physicians Plus before receiving care from out-of-network providers. Written decisions will be provided to members and providers. Visit pplusic.com for a summary of prior authorization requirements.

Service Area

Adams, Columbia, Dane, Dodge, Grant, Green Lake, Iowa, Jefferson, Juneau, Lafayette, Marquette, Richland, Rock, Sauk, Vernon, Walworth, Waukesha, Waushara and Wood counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact Physicians Plus at 1-800-545-5015 within 48 hours of receiving care. Follow-up care must be received from an in-network provider.

Mental, Behavioral Health and Substance Abuse

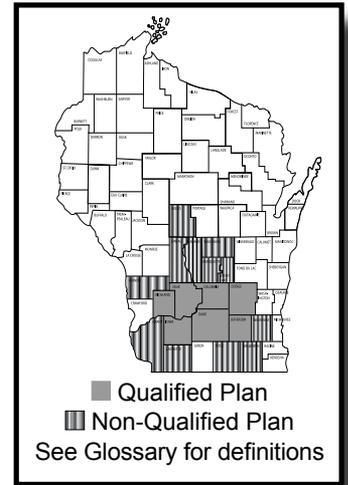
Contact UW Behavioral Health at 608-417-4709 for prior authorization or provider information, Monday through Friday, 8 a.m. to 5 p.m. A mental health professional will assess your situation and refer you to the appropriate provider. For emergencies, please contact your therapist directly or call 911.

Dental Benefits

Dental services are provided through Madison Family Dental Associates. Go to pplusic.com and choose "Find a Provider" or call 1-800-545-5015 to search for participating providers. Dental providers are also listed within the Primary-Specialty Care State "PDF Directory." Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

NursePlus 1-866-775-8776



Security Health Plan

1-800-472-2363 or 715-221-9555

securityhealth.org/state



Overall Performance Rating

What's New for 2015

New this year! Smart Cost Advisor lets Security Health Plan members compare common medical procedure costs before receiving services. Security Health Plan is offering a \$100 reimbursement annually towards a gym or health club membership.

Last year, we added a new service called Care My Way. We've enhanced this service recently by increasing the hours of operation to 7 a.m. to 9 p.m. Call our regular 24-Hour Nurse Line to participate. If you have one of the diagnoses that can be treated by Care My Way, they will treat you over the phone and even call in a prescription to your nearest pharmacy. Deductibles apply for members enrolled in the High Deductible Health Plan. For all other plans, there is no charge for the first three Care My Way treatments. Fees apply for additional treatments. See the SHP Customer Guide or website for more details.

Provider Directory

Visit securityhealth.org/state and click on "Find a Doctor" to access a provider directory. Once you are there, select "State of Wisconsin Employer Sponsored Plan" from the drop-down menu. To request a printed directory be mailed to you, call customer service at 1-800-472-2363.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are needed when receiving care from in-network providers for certain specialties. View a complete list on our website or call our customer service team at 1-800-472-2363.

Prior authorization is required for knee replacement, hip replacement, back surgery, hysterectomy, knee arthroscopy and carpal tunnel surgery; and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization.

If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-472-2363 prior to the appointment, or visit securityhealth.org/authorization for a complete listing of services that require prior authorization.

Service Area

Adams, Ashland, Barron, Bayfield, Burnett, Chippewa, Clark, Douglas, Eau Claire, Forest, Iron, Jackson, Juneau, Langlade, Lincoln, Marathon, Oneida, Pepin, Portage, Price, Rusk, Sawyer, Taylor, Vilas, Washburn, Waupaca, Waushara and Wood counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact Security Health Plan at 1-800-472-2363 by the next business day or as soon as possible to ensure appropriate claim benefit. Follow-up care must be received from an in-network provider unless otherwise approved by Security Health Plan.

Mental, Behavioral Health and Substance Abuse

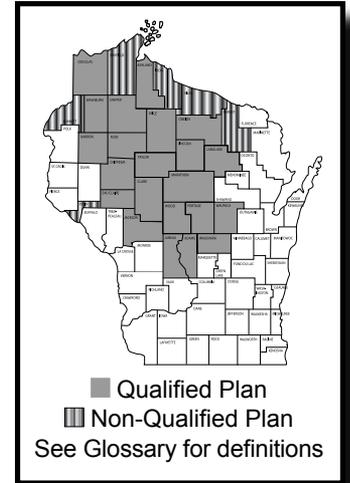
You may see any provider in the network for mental/behavioral health care. You do not need a referral or authorization.

Dental Benefits

Visit the dentist of your choice, anywhere in Wisconsin or the U.S. Click on "Dental" at securityhealth.org/state to view the 2015 dental benefits.

24-Hour Nurseline

1-800-549-3174



Standard Plan

Administered by WPS Health Insurance

1-800-634-6448 wpsic.com/state

Not Available
Overall Performance
Rating

What's New for 2015

Visit the Health Center at wpsic.com/healthcenter, a continually updated online resource designed to help you make good health decisions, whether you're looking for advice on treating a chronic condition or for tips on leading a healthy lifestyle.

General Information

The Standard Plan is a comprehensive health plan that provides you with freedom of choice among hospitals and physicians in Wisconsin and nationwide. A higher level of benefits is available by using preferred or in-network providers, which are available nationwide. See the Comparison of Benefit Options section of this guide for benefit differences and view the Health Care Benefit Plan booklet for more complete details at etf.wi.gov/publications/et2112.pdf.

Provider Directory

Go to www.wpsic.com/state and click "Find a Doctor." Choose your plan to search for a provider in your network. To request a printed directory be mailed to you, call 1-800-634-6448.

Pre-Certification

To avoid a \$100 inpatient benefit reduction, you, a family member or a provider must notify WPS of any inpatient hospitalization to request pre-certification.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not required for this plan.

Members or providers may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved

prior authorization, WPS may deny payment. Visit wpsic.com/state and follow the "Member Materials" link to obtain a copy of a Medical Preauthorization Request Form or call member services. You will receive written notification of the approval or denial for the prior authorization.

Prior authorization is required for low back surgery and high-tech radiology services.

Bariatric surgery requires prior authorization, and members must meet the eligibility criteria as outlined in the *Standard Plan* (ET-2112) booklet.

Emergency and Urgent Care Outside Service Area

For emergency and urgent care, in-network hospital emergency rooms or urgent care facilities should be used if possible. If you are unable to reach an in-network provider, go to the nearest appropriate medical facility and contact WPS as soon as possible.

Mental, Behavioral Health and Substance Abuse

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their licenses and processed based on the provider's network status.

Dental Benefits

No dental coverage provided.

24-Hour Nurseline

Not available.

SMP – State Maintenance Plan

Administered by WPS Health Insurance

1-800-634-6448 wpsic.com/state

Not Available
Overall Performance
Rating

What's New for 2015

Visit the Health Center at wpsic.com/healthcenter, a continually updated online resource designed to help you make good health decisions, whether you're looking for advice on treating a chronic condition, or for tips on leading a healthy lifestyle.

Provider Directory

Go to www.wpsic.com/state and click "Find a Doctor." Choose your plan to search for a provider in your network. To request a printed directory be mailed to you, call 1-800-634-6448.

Referrals, Prior Authorizations, Out-of-Network Care

You must get a referral approved by WPS before getting care outside the WPS SMP network. **Your provider must request the referral.** Retroactive referrals are not allowed. It is ultimately the member's responsibility to make sure the referral is submitted and approved prior to receiving services.

Members or providers may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. Visit wpsic.com/state and follow the "Member Materials" link to obtain a copy of a Medical Preauthorization Request Form or call member services. You will receive written notification of the approval or denial for the prior authorization.

Prior authorization is required for low back surgery and high-tech radiology services.

Service Area

Bayfield, Buffalo, Florence, Forest, Iron, Marquette, Menominee and Vilas counties.

Emergency and Urgent Care Outside Service Area

For emergency and urgent care, in-network hospital emergency rooms or urgent care facilities should be used if possible. If you are unable to reach an in-network provider, go to the nearest appropriate medical facility and contact WPS as soon as possible.

Mental, Behavioral Health and Substance Abuse

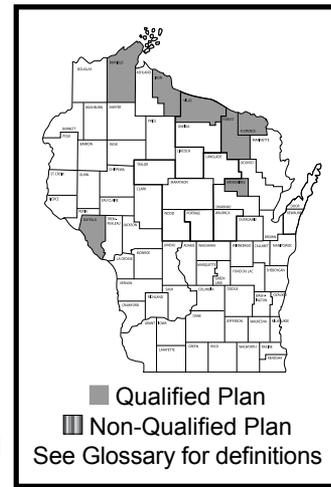
Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their licenses and processed based on the provider's network status.

Dental Benefits

No dental coverage provided.

24-Hour Nurseline

Not available.



UnitedHealthcare of Wisconsin

Open Enrollment Information: 1-866-873-3903 or state.welcometouhc.com
1-800-357-0974 myuhc.com



What's New for 2015

For members traveling out of the service area, including students, please contact customer service at 1-800-357-0974 (current members) or 1-866-873-3903 (non-current member) for our available national providers.

Provider Directory

Go to state.welcometouhc.com, click on "Find a Doctor/Hospital" and then select the "State of WI employee Provider Directory" link. For a print version, call Customer Service at 1-800-357-0974 (current member) or 1-866-873-3903 (non-current member). A full directory or ZIP code search may be requested. If you are currently enrolled, you will be able to register on myuhc.com for your personal search criteria.

Referrals, Prior Authorizations, Out-of-Network Care

You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception." You are responsible for notifying UHC's Care Coordination before obtaining services for dental/oral surgery or within 24 hours (or as soon as possible) of an emergency admission to a non-network hospital. Certain tests and procedures, including high tech radiology and low back surgery, require prior authorization. You and your physician will be notified in writing of UHC's decision and coverage determination.

Service Area

Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Jefferson, Kenosha, Kewaunee, Manitowoc, Marinette, Marquette, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Rock, Shawano, Sheboygan, Walworth, Washington, Waukesha, Waupaca, Waushara and Winnebago counties.

Emergency and Urgent Care Outside Service Area

If you are out of the service area and need urgent or emergency care, go to the nearest appropriate facility, unless you can safely return to the service area or receive care from one of our nationally contracted providers. Follow-up care must be completed with your local participating provider or one of our national HMO contracted providers.



Mental, Behavioral Health and Substance Abuse

Prior to seeking mental, behavioral health or substance abuse services, contact Optum Behavioral Health at 1-800-851-5188 for assistance from a behavioral health specialist, 8 a.m. - 5 p.m. CST. 24-hour service outside standard business hours are for emergency assistance only.

Dental Benefits

Dental services are provided through National Options PPO 30. Go to www.myuhcdental.com and choose "Find a Dentist" and select the "National Options PPO 30" directory for a list of providers. You may also call 1-877-816-3596 for a provider directory. Services performed by out-of-network providers will be covered at the out-of-network benefit level, but charges are payable only up to the usual and customary levels.

24-Hour Nurseline

myNurseLine 1-800-846-4678

Unity Health Insurance – Community

1-800-362-3310

ChooseUnityHealth.com



Overall Performance Rating

What's New for 2015

Contacting Unity is now easier than ever. Unity has extended its Customer Service hours. You can reach us Monday through Friday, from 7 a.m. to 7 p.m. You can also contact Customer Service through our website using the Chat With Us feature. Or, you can send a secure message through unitymychart.com.

ChooseUnityHealth.com has been redesigned and is now easier to navigate and understand. Plus, the website is now mobile friendly. You will also find much more Spanish content on it.

Provider Directory

Go to ChooseUnityHealth.com to access a provider directory and select “Find a Doctor.” Then select “State/Local Community” as your network. To request a printed directory be mailed to you, call 1-800-362-3310.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers.

Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. You may check the status of your request at unitymychart.com.

If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-362-3310 prior to the appointment or visit unityhealth.com/priorauth.

Service Area

Adams, Columbia, Crawford, Dodge, Fond du Lac, Grant, Green, Iowa, Jefferson, Juneau, Lafayette, Marquette, Richland, Rock, Sauk, Vernon and Walworth counties, as well as providers located in Black Earth and Cambridge.

Emergency and Urgent Care Outside Service Area

If you require emergency care when outside of the network, seek care at the nearest medical facility. Follow-up care must be received from an in-network provider.

For urgent care, contact your primary care physician for determining the appropriate level of care.

Mental, Behavioral Health and Substance Abuse

For assistance in accessing mental, behavioral health or substance abuse services, call UW Behavioral Health at 1-800-683-2300.

Dental Benefits

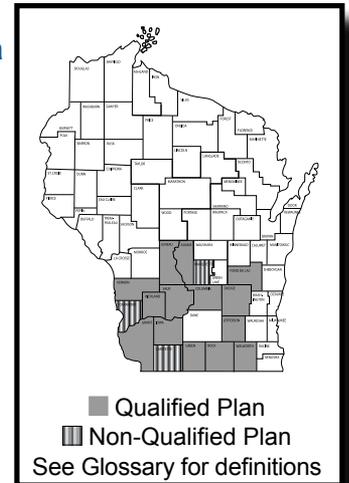
Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click “Provider Search” and then “Find A Network Dentist” in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to either the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the “Provider Search” tab.

Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Not available.



Unity Health Insurance – UW Health

1-800-362-3310

ChooseUnityHealth.com



What's New for 2015

Contacting Unity is now easier than ever. Unity has extended its Customer Service hours. You can reach us Monday through Friday, from 7 a.m. to 7 p.m. You can also contact Customer Service through our website using the Chat With Us feature. Or, you can send a secure message through unitymychart.com.

ChooseUnityHealth.com has been redesigned and is now easier to navigate and understand. Plus, the website is now mobile friendly. You will also find much more Spanish content on it.

Provider Directory

Go to ChooseUnityHealth.com to access a provider directory and select “Find a Doctor.” Then select “State/Local UW Health” as your network. To request a printed directory be mailed to you, call 1-800-362-3310.

Referrals, Prior Authorizations, Out-of-Network Care

Referrals are not needed when receiving care from in-network providers.

Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. You may check the status of your request at unitymychart.com.

If you are unsure if a service, test or procedure requires prior authorization or a referral, contact 1-800-362-3310 prior to the appointment or visit unityhealth.com/priorauth.

Service Area

Dane County, except providers located in Black Earth and Cambridge.

Emergency and Urgent Care Outside Service Area

If you require emergency care when outside of the network, seek care at the nearest medical facility. Follow-up care must be received from an in-network provider.

For urgent care, contact your primary care physician for determining the appropriate level of care.

Mental, Behavioral Health and Substance Abuse

For assistance in accessing mental or behavioral health services, call UW Behavioral Health at 1-800-683-2300. For accessing substance abuse services, call UW Behavioral Health & Recovery Clinic at 1-800-785-1780.

Dental Benefits

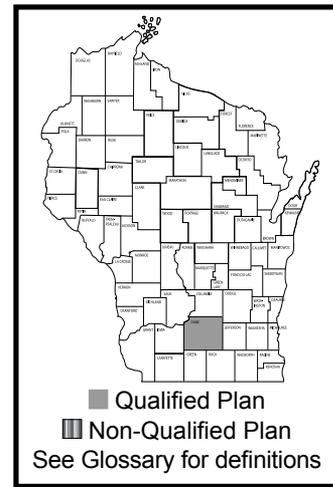
Dental services are provided through Momentum Insurance Plans.

For a listing of in-network providers, call 1-855-729-6569 or go to momentumplans.com to view a provider directory. To find in-network dentists on the Momentum website, choose “Unity” at the top, then select “Unity State UW Health,” and choose the “2015 Provider Listing” link.

Services performed by out-of-network providers will not be covered.

24-Hour Nurseline

Not available.



WEA Trust – East

1-800-279-4000 or 608-276-4000

weatruststatehealthplan.com



Overall Performance Rating

What's New for 2015

Starting January 1, 2015, we are partnering with Delta Dental of Wisconsin to expand our dental network. The new network will include 90% of Wisconsin dentists, giving our members a much broader choice of dental providers.

Our enhanced online “Find A Doctor” tool at weatruststatehealthplan.com/providers makes it easy to find a network doctor in your service area.

Provider Directory

Go to weatruststatehealthplan.com/providers to search for providers or to access a directory. To request a printed directory be mailed to you, call 1-800-279-4000.

Referrals and Prior Authorizations

Referrals are not required for this plan. Prior authorization is required for certain services and procedures before you receive care. A list of services requiring preauthorization can be found at weatrust.com. You will receive notification of the approval or denial for the prior authorization.

Out-of-Network Care

WEA Trust will reimburse for covered services at 70% of our maximum allowable fee, subject to an annual deductible of \$1,000 individual and \$2,000 family. For those enrolled in the High Deductible Health Plan, covered services are reimbursed at 70% of our maximum allowable fee, subject to an annual deductible of \$5,000 single and \$10,000 family.

Service Area

Adams, Brown, Calumet, Columbia, Dodge, Door, Florence, Fond du Lac, Forest, Green Lake, Jefferson, Juneau, Kenosha, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Milwaukee, Oconto, Oneida, Outagamie, Ozaukee, Portage, Price, Racine, Rock, Shawano, Sheboygan, Taylor, Vilas, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago and Wood counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact the WEA Trust at 1-800-279-4000 within 72 hours of receiving care. Follow-up care must be performed by a network provider to receive network benefits.

Mental, Behavioral Health and Substance Abuse

No prior authorization is required for outpatient services from a network provider, except for psychiatric and neuro-psychiatric testing. Prior authorization is required for in-patient and transitional care. For other services, contact 1-800-279-4000.

Dental Benefits

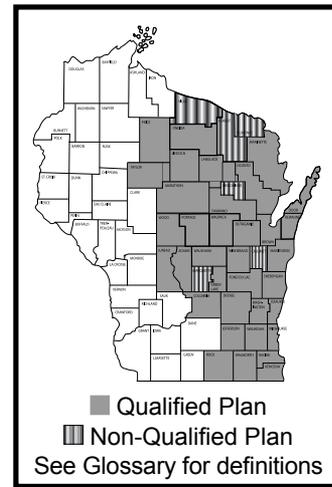
Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the “Provider Search” tab, then “Find A Network Dentist” in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the “Provider Search” tab.

Services performed by out-of-network providers will also be covered, at the out-of-network benefit level.

24-Hour Nurseline

Not available.



WEA Trust – Northwest Chippewa Valley

1-800-279-4000 or 608-276-4000

weatruststatehealthplan.com



Overall Performance Rating

What's New for 2015

To help clarify which doctors are in our network, the WEA Trust will offer two distinct plans in our northwest service area in 2015. The WEA Trust Northwest-Chippewa Valley plan offers a variety of provider groups and more than 20 hospitals throughout the service area. If you are a current member of the WEA Trust Northwest plan and have the Chippewa Valley Network, no action is required on your part as you will automatically be enrolled in this plan for 2015.

If you see non-network providers, your out-of-pocket costs will be higher in 2015 (see section on Out-of-Network Care).

Starting January 1, 2015, we are partnering with Delta Dental of Wisconsin to expand our dental network. The new network will include 90% of Wisconsin dentists, giving our members a much broader choice of dental providers.

Provider Directory

Go to weatruststatehealthplan.com/providers to search for providers or to access a directory. To request a printed directory be mailed to you, call 1-800-279-4000.

Referrals and Prior Authorizations

Referrals are not required for this plan. Prior authorization is required for certain services and procedures before you receive care. A list of services requiring preauthorization can be found at weatrust.com. You will receive notification of the approval or denial for the prior authorization.

Out-of-Network Care

For out-of-network care, the WEA Trust will reimburse for covered services at 50% of our maximum allowable fee, subject to an annual deductible of \$5,000 individual and \$10,000 family.

Service Area

Ashland, Barron, Bayfield, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Iron, Jackson, Pepin, Pierce, Polk, Rusk, Sawyer, St. Croix, Trempealeau and Washburn counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact the WEA Trust at 1-800-279-4000 within 72 hours of receiving care. Follow-up care must be performed by a network provider to receive network benefits.

Mental, Behavioral Health and Substance Abuse

No prior authorization is required for outpatient services from a network provider, except for psychiatric and neuro-psychiatric testing. Prior authorization is required for in-patient and transitional care. For other services, contact 1-800-279-4000.

Dental Benefits

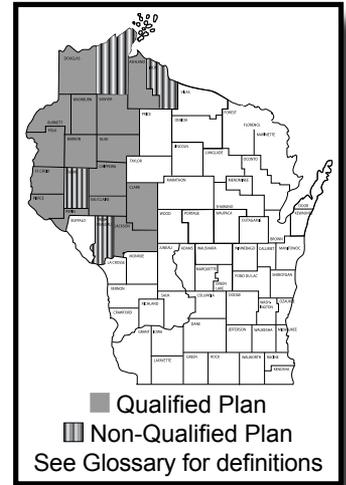
Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab.

Services performed by out-of-network providers will also be covered, at the out-of-network benefit level.

24-Hour Nurseline

Not available.



WEA Trust – Northwest Mayo Clinic Health System

1-800-279-4000 or 608-276-4000

weatruststatehealthplan.com



What's New for 2015

To help clarify which doctors are in our network, the WEA Trust will offer two distinct plans in our northwest service area in 2015. The WEA Trust Northwest-Mayo Clinic Health System plan consists of Mayo Clinic Health System providers and hospitals. If you are a current member of the WEA Trust Northwest plan and have the Mayo Clinic Health System Network, no action is required on your part as you will automatically be enrolled in this plan for 2015.

If you see non-network providers, your out-of-pocket costs will be higher in 2015 (see section on Out-of-Network Care).

Starting January 1, 2015, we are partnering with Delta Dental of Wisconsin to expand our dental network. The new network will include 90% of Wisconsin dentists, giving our members a much broader choice of dental providers.

Provider Directory

Go to weatruststatehealthplan.com/providers to search for providers or to access a directory. To request a printed directory be mailed to you, call 1-800-279-4000.

Referrals and Prior Authorizations

Referrals are not required for this plan. Prior authorization is required for certain services and procedures before you receive care. A list of services requiring preauthorization can be found at weatrust.com. You will receive notification of the approval or denial for the prior authorization.

Out-of-Network Care

For out-of-network care, the WEA Trust will reimburse for covered services at 50% of our maximum allowable fee, subject to an annual deductible of \$5,000 individual and \$10,000 family.

Service Area

Barron, Buffalo, Chippewa, Dunn, Eau Claire, Pierce, St. Croix and Trempealeau counties.

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact the WEA Trust at 1-800-279-4000 within 72 hours of receiving care. Follow-up care must be performed by a network provider to receive network benefits.

Mental, Behavioral Health and Substance Abuse

No prior authorization is required for outpatient services from a network provider, except for psychiatric and neuro-psychiatric testing. Prior authorization is required for in-patient and transitional care. For other services, contact 1-800-279-4000.

Dental Benefits

Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab.

Services performed by out-of-network providers will also be covered, at the out-of-network benefit level.

24-Hour Nurseline

Not available.



WEA Trust – South Central

1-800-279-4000 or 608-276-4000

weatruststatehealthplan.com



What's New for 2015

Starting January 1, 2015, we are partnering with Delta Dental of Wisconsin to expand our dental network. The new network will include 90% of Wisconsin dentists, giving our members a much broader choice of dental providers.

The WEA Trust South Central service area serves Dane County and features Meriter-UnityPoint Health and other independent providers. This focused network brings strong coordination between your clinic, hospital and home. Our enhanced online "Find A Doctor" tool at weatruststatehealthplan.com/providers also makes it easy to find a network doctor without needing a password.

Provider Directory

Go to weatruststatehealthplan.com/providers to search for providers or to access a directory. To request a printed directory be mailed to you, call 1-800-279-4000.

Referrals and Prior Authorizations

Referrals are not required for this plan. Prior authorization is required for certain services and procedures before you receive care. A list of services requiring preauthorization can be found at weatrust.com. You will receive notification of the approval or denial for the prior authorization.

Out-of-Network Care

WEA Trust will reimburse for covered services at 70% of our maximum allowable fee, subject to an annual deductible of \$1,000 individual and \$2,000 family. For those enrolled in the High Deductible Health Plan, covered services are reimbursed at 70% of our maximum allowable fee, subject to an annual deductible of \$5,000 single and \$10,000 family.

Service Area

Dane County

Emergency and Urgent Care Outside Service Area

If you require emergency or urgent care when outside of the network, contact the WEA Trust at 1-800-279-4000 within 72 hours of receiving care. Follow-up care must be performed by a network provider to receive network benefits.

Mental, Behavioral Health and Substance Abuse

No prior authorization is required for outpatient services from a network provider, except for psychiatric and neuro-psychiatric testing. Prior authorization is required for in-patient and transitional care. For other services, contact 1-800-279-4000.

Dental Benefits

Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

To find an in-network dentist, click the "Provider Search" tab, then "Find A Network Dentist" in the drop-down box. Enter your address, city, and state or ZIP code. You can then narrow your search to the Delta Dental Premier or Delta Dental PPO network. You can download a complete provider directory under the "Provider Search" tab.

Services performed by out-of-network providers will also be covered, at the out-of-network benefit level.

24-Hour Nurseline

Not available.



Notes



Pharmacy—NAVITUS HEALTH SOLUTIONS™

Toll-Free Customer Care—1-866-333-2757
navitus.com

Formulary Information

The four-level formulary requires copayments of \$5 (Level 1), \$15 (Level 2), \$35 (Level 3) and \$50 (Level 4). Unless a drug is considered preventive, anyone on the HDHP plan is responsible for the full amount of the drug cost until the deductible is met, then the copays take effect until the out-of-pocket limit is met. Copayments for non-preferred drugs (all Level 3 and some Level 4 drugs) are not applied against the prescription drug or specialty medication out-of-pocket limit (OOPL). The most up-to-date formulary information is available on the Navitus website through Navi-Gate for Members. Under **Quick Links** click on **Members - Your Formulary** to log in, and then select the formulary named **State of WI and WI Public Employers (administered through ETF) Formulary**. You may also call Navitus Customer Care toll free at 1-866-333-2757 with questions about the formulary.

Level 4 Copayments for Specialty Medications

A \$50, Level 4 copayment applies to covered, preferred and non-preferred prescription drugs classified as specialty medications. A reduced, \$15 copayment applies when a covered, preferred specialty medication is filled at **Diplomat Specialty Pharmacy**. These preferred specialty medications are marked with “ESP” on the formulary. Please see additional information in the Specialty Medications Program section on the next page.

Level 4 Out-of-Pocket Limits (OOPL)

A separate Level 4 OOPL applies to covered, preferred specialty medications: \$1,000 individual/\$2,000 family. This OOPL will accumulate separately from the Level 1/Level 2 OOPL for non-specialty, preferred drugs. Copayments for preferred specialty medications accumulate to the Level 4 OOPL; however, copayments for non-preferred drugs do not apply to any OOPL.

Medicare Prescription Drug Coverage

All Medicare-eligible retirees, as well as Medicare-eligible dependents of retirees, will be automatically enrolled in the Navitus MedicareRx (PDP) plan, which is underwritten by Dean Health Insurance, Inc., a Federally-Qualified Medicare Contracting Prescription Drug Plan. This is Medicare Part D coverage through an employer group waiver plan.

Prior Authorization (PA) Requirements

A prior authorization is initiated by the prescribing physician on behalf of the member. Navitus will review the prior authorization request within two business days of receiving all necessary information from your physician. Medications that require prior authorization for coverage are marked with “PA” on the formulary.

Diabetic Supply Coverage

Diabetic supplies and glucometers are covered with a 20% coinsurance. In most cases this coinsurance applies to your prescription drug OOPL. Contact Navitus Customer Care if you have questions about your copayment applying to the OOPL.

90-Day-at-Retail Program

A 90-day supply of most maintenance medications can be purchased at your retail pharmacy. To take advantage of this program, you must have three consecutive claims already processed for that drug in the Navitus claims system immediately before the 90-day supply is requested. In addition, your doctor must write the prescription specifically for a 90-day supply. Three copayments are still required. More information can be found on Navitus' website or by calling Navitus Customer Care.



NAVITUS HEALTH SOLUTIONS™ —Pharmacy

1-866-333-2757—Toll-Free Customer Care

navitus.com



Mail Order Program

Up to a 90-day supply of Level 1 and Level 2 medications can be purchased for only two copayments through our mail-order service. Level 3 medications may also be available for up to a 90-day supply, but three copayments will apply. More detailed information can be found on the Navitus website; the WellDyneRx website (<https://www.welldynernx.com/>) or by calling Navitus Customer Care. To register for mail-order service, call WellDyneRx Customer Care toll free at 1-866-490-3326, 24 hours a day, seven days a week.

RxCENTS Tablet-Splitting Program

By splitting a higher-strength tablet in half to provide the needed dose, you receive the same medication and dosage while buying fewer tablets and saving on copayments. Medications included in the program are marked with “¢” on the Navitus formulary. Members may obtain tablet splitting devices at no cost by calling Navitus Customer Care.

Generic Copay Waiver Program

Your first fill of a sample medication through this program is free. Medications included in this program are marked with “GW” on the Navitus formulary. To try this program, your doctor needs to write a prescription for one of the program medications. If it is your first time filling this prescription, you get the medication at no cost.

Specialty Medication Program

(Self-Injectables and Specialty Medications)

If you are on a specialty medication, the Navitus SpecialtyRx Program is offered through a partnership with Diplomat Specialty Pharmacy to help coordinate members’ specialty pharmacy needs. Prescriptions for preferred specialty medications, marked with “ESP” in the formulary, that are filled at Diplomat receive a reduced \$15 copayment. The reduced copayment does not apply to covered, non-preferred specialty medications. To begin receiving your self-injectable and other specialty medications from the specialty pharmacy, please call Navitus SpecialtyRx Customer Care at 1-877-651-4943 or visit diplomatpharmacy.com.

Coordination of Benefits

Coordination of benefits applies when, as determined by the order of benefit determination rules, you have primary coverage under another policy and Navitus is your secondary coverage. All claims need to be submitted to your other policy first. Navitus covers the remaining cost of any covered prescriptions up to the allowed amount under your State plan. Coordination of benefits does not guarantee that all of your out-of-pocket costs will be covered.

Pharmacy—NAVITUS MedicareRx (PDP)

Dean Health Insurance, Inc.

Toll-Free Customer Care—1-866-270-3877 medicarerx.navitus.com

Each January 1st, all Medicare-eligible participants covered under an annuitant contract will be automatically enrolled in the Medicare Part D prescription drug program called Navitus MedicareRx (PDP), underwritten by Dean Health Insurance, Inc., a Federally-Qualified Medicare Contracting Prescription Drug Plan. Eligible individuals enrolled as members in the State of Wisconsin Group Health Insurance Program were covered by creditable coverage through Navitus Health Solutions prior to being enrolled in Navitus MedicareRx (PDP).

What does this mean to you?

You do not need to take any further action. You will maintain your current benefits. You will receive a new pharmacy benefit ID card that you will need to present to your pharmacy when you fill a prescription. The new ID card will be different than the regular Navitus ID cards issued to active employees and retirees not eligible for Medicare.

When you become eligible for coverage under Medicare Part D, you will be enrolled in the Navitus MedicareRx (PDP) through your employer group coverage. As required by Uniform Benefits, a supplemental wrap benefit is also included to provide full coverage to program members when they reach the Medicare coverage gap, also known as the “donut hole.” You will be automatically enrolled in this supplemental wrap coverage. Your formulary will include a four-level copayment structure which includes: \$5 (Level 1), \$15 (Level 2), \$35 (Level 3) and \$50/\$15 (Level 4). Information regarding your Medicare Part D benefit will be mailed to you by Navitus MedicareRx (PDP) upon confirmed enrollment from Medicare.

Your welcome packet will include the following:

- **Your new ID card**
- **Summary of Benefits**
- **Pharmacy Directory**
- **Formulary**
- **Evidence of Coverage (details about your pharmacy coverage)**

PLEASE READ THIS NOTE CAREFULLY AND KEEP IT WHERE YOU CAN FIND IT.

This notice has information about your prescription drug coverage with the program for people with Medicare.

By completing your enrollment application or maintaining your enrollment with the State of Wisconsin Group Health Insurance Program, you agree to the following:

I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Navitus MedicareRx (PDP) of any prescription drug coverage that I have or may obtain in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare prescription drug plan, my enrollment in Navitus MedicareRx (PDP) will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Medicare Part D Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.



NAVITUS MedicareRX (PDP)—Pharmacy

Dean Health Insurance, Inc.

Toll-Free Customer Care—1-866-270-3877 medicarerx.navitus.com

Navitus MedicareRx (PDP) serves a specific service area. If I move out of the area that Navitus MedicareRx (PDP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Navitus MedicareRx (PDP) network pharmacies. Once I am a member of Navitus MedicareRx (PDP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Navitus MedicareRx (PDP) when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Navitus MedicareRx (PDP), he/she may be paid based on my enrollment in Navitus MedicareRx (PDP). Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Navitus MedicareRx (PDP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Navitus MedicareRx (PDP) will release

my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on my enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on my form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on my application means that I have read and understand the contents of the application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete the enrollment; and 2) documentation of this authority is available upon request by Medicare or by my employer group.

This notice is provided each year, prior to the next Medicare prescription drug coverage enrollment period or whenever program coverage changes. For more information please contact either ETF or Navitus MedicareRx (PDP).

Navitus MedicareRx (PDP) Customer Care

Call: 1-866-270-3877—Calls to this number are free. Members can reach Navitus Customer Care 24 hours a day/seven days a week, except Thanksgiving and Christmas.

TTY: 711—This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. TTY access is available 24 hours a day/seven days a week, except Thanksgiving and Christmas.

Write: Navitus MedicareRx (PDP) Customer Care, P.O. Box 1039, Appleton, WI 54912-1039

Website: medicarerx.navitus.com

Wisconsin Public Employers (WPE) Life Insurance—*Minnesota Life Insurance Company*

1-866-295-8690 etf.wi.gov/members/benefits_life_ins.htm

The life insurance program offers employees coverage of up to five times annual earnings. For the Basic, Supplemental and Additional plans, one unit of coverage is equal to your highest prior calendar year's earnings, rounded up to the next thousand.

- **Basic Plan** coverage will continue in a reduced amount for your lifetime, without cost, for eligible retirees older than age 65 and for active employees older than age 70.
- **Supplemental Plan** coverage may continue up to age 65, if retired, or age 70 for active employees.
- **Additional Plan** provides up to three units of coverage, which may continue until you terminate employment or cancel coverage.
- **Spouse and Dependent Plan** provides up to two units of coverage for your spouse or domestic partner and all dependent(s). Each unit of coverage provides \$10,000 in spouse coverage and \$5,000 coverage for each dependent.
- **Conversion of life insurance to pay health or long-term care premiums.**
Retirees who have WPE life insurance and have reached age 66 may be eligible to convert the present value of their life insurance to pay ETF-administered health or long-term care insurance premiums. See *Converting Your Group Life Insurance to Pay Health or Long-term Care Insurance Premiums* (ET-2325) at etf.wi.gov/publications/et2325.pdf.
- **Living Benefits**—Insured persons may apply to receive all or part of the value of their life

insurance while still living, if they are diagnosed with a terminal condition caused by illness or injury and have a life expectancy of 12 months or less. See the *Living Benefits* (ET-2327) brochure at etf.wi.gov/publications/et2327.pdf.

- **Eligibility and Enrollment**—You have an open enrollment opportunity for life insurance coverage if you:
 - are younger than age 70;
 - have worked six or more months in service covered by the WRS; and
 - apply within 30 days of your first eligibility.

Note: Employees who reach 70 years old before becoming eligible for the coverage may be insured under the Additional Plan only. This is subject to evidence of insurability.

You may also enroll for one level of employee coverage or increase your coverage by one level if you have a qualifying family status change event: marriage, domestic partnership as defined in Wis. Stat. 40.02(21d) or the birth, adoption, placement for adoption or award of legal guardianship of a dependent child.

For Spouse and Dependent coverage only, you may apply when you first have a spouse, domestic partner or dependent to insure. If you do not enroll for all available coverage when you are first eligible, you may apply for future coverage only through *Evidence of Insurability* (ET-2305) at etf.wi.gov/publications/et2305.pdf.

- See the *Wisconsin Public Employers Group Life Insurance Program* (ET-2101) brochure at etf.wi.gov/publications/et2101.pdf for complete program details, including current premium costs.

MINNESOTA LIFE

A Securian Company

ERA Benefits—Administered by TASC

608-241-1900 or 1-800-422-4661

www.tasconline.com

Employee Reimbursement Accounts (ERA) Program

The Employee Reimbursement Accounts (ERA) Program is an optional benefit that allows you to set aside pre-tax income to pay for eligible IRS approved expenses. These accounts are known as Flexible Spending Accounts (FSAs).

New Third Party Administrator

There is a new administrator for the 2015 plan year, Total Administrative Services Corporation or TASC.

New Carryover for 2015 Plan Year

Starting with the 2015 plan year, you have the flexibility to carry over up to \$500 of your unused health care FSA balance remaining at the end of the 2015 plan year run-out period (March 31, 2016) into 2016. You no longer risk losing these dollars, as they can be used for eligible expenses incurred in the new year.

Health Care Employee Reimbursement Account (Health Care FSA)

For yourself and your dependents, you may set aside as much as \$2,550 tax-free each year for health care expenses not covered by insurance, such as coinsurance, deductible and copays; and non-covered items, such as eyeglasses and dental expenses. Keep in mind that Coinsurance Uniform Benefits imposes a coinsurance of 90%/10% with an annual out-of-pocket limit of \$500 single/\$1,000 family on most illness or injury related services. (Preventive services are paid at 100%.) These expenses can be reimbursed through this account. If you choose the High Deductible Health Plan along with a Health Savings Account, you are not allowed to also have a regular health care FSA. You may choose a limited purpose flexible spending account (see Page 9 for more information).

Dependent Day Care Employee Reimbursement Account (Dependent Care FSA)

This account may be used for day care expenses for eligible dependent(s) that are incurred to allow you (and your spouse, if married) to work, look for work, or attend school full time.

Commuter Benefits

You can enroll in commuter benefits at any time. You can use the commuter benefit program for parking, vanpool and public transit costs, and adjust it with your needs as they change throughout the year.

Plan carefully before you enroll.

In exchange for the tax advantages, the IRS has imposed strict rules. Funds remaining in your FSA account(s) at the end of the plan year, in excess of \$500 for the health care FSA only, after all eligible expenses have been reimbursed, will be forfeited. Also, once your coverage begins, the FSA benefit election(s) (including the insurance benefits for which premiums are being deducted on a pre-tax basis) cannot be cancelled or changed during the plan year, unless you experience a valid Change In Status event as described in IRS regulations, and as permitted by the plan documents and health plan guidelines as applicable.

Before you enroll, check out the ERA Reference Guide, available on the ETF website, for more detailed plan information. Review your health, vision and dental benefits for the 2015 plan year to determine the available benefits, coinsurance, copayments and/or deductibles. Also, review the Navitus formulary to determine your drug copayments. Keep in mind the out-of-pocket limits for drug coverage apply only to Level 1, Level 2 and Level 4 drugs in most cases. See the Schedule of Benefits in the Uniform Benefits section of the *It's Your Choice Reference Guide* for more information.

Open Enrollment Period

The ERA program 2015 plan year open enrollment is October 6 to 31, 2014. Employees may enroll online at www.tasconline.com. See the ERA reference guide at etf.wi.gov.

Employee Pay-all Optional Insurance Plans

etf.wi.gov/members/benefits_other_insurance.htm

State agencies are authorized by the Group Insurance Board to offer approved optional insurance plans to their employees to supplement group health insurance. Not every agency offers every optional plan.

Anthem DentalBlue, EPIC and VSP all have some changes for 2015. You can find more details and what's new on each of these plans at etf.wi.gov/members/benefits_other_insurance.htm including a link to each plan's website, and comparison charts for dental insurance and vision insurance.

It is important to note:

- Each state agency or employer chooses whether or not to offer any of these plans to its employees.
- Only **active** employees may newly enroll in optional insurance plans, with the exception of VSP and long-term care insurance.
- Employers do not contribute to the premiums for these plans.
- If you expect to retire within the next year and will want to carry optional dental insurance, you must enroll during It's Your Choice (if you are not already enrolled).
- With few exceptions, once enrolled, you must remain in the plan for the full year. Mid-year cancellation procedures follow those for health insurance—see the *Frequently Asked Question* “How do I cancel coverage” online at etf.wi.gov/members/IYC2015/IYC_State_home.html.
- You may cancel your new or existing enrollment during the It's Your Choice Open Enrollment period, or before 12-30-14.
- Examine waiting periods, exclusions for preexisting conditions and limits on maximum benefits when deciding whether to enroll in an optional insurance plan.

Plan	Enrollment Offered ¹	Year-round Enrollment ²	2015 Changes ³
Anthem DentalBlue	•		•
Aflac Accident Advantage Plus	•		
EPIC Benefits+	•		•
EPIC Dental Wisconsin			•
Hartford Accidental Death	•	•	•
Mutual of Omaha		•	
VSP	•		•

¹Plans under this category offer open or special enrollment during this It's Your Choice Open Enrollment period. Members who currently participate will remain enrolled for 2015 without taking any action. Newly eligible members may enroll within 30 days of their eligibility throughout the year.

²Plans in this category offer year-round purchase of optional insurance plans to those who qualify.

³Read the plan description on the next page to see what is new for 2015.

Employee Pay-all Optional Insurance Plans

etf.wi.gov/members/benefits_other_insurance.htm

Aflac Accident Advantage Plus is an indemnity plan that pays you or your covered dependents a specific amount for specific kinds of accidental injuries and follow-up care. This type of insurance is meant to supplement comprehensive health insurance, not replace it. For more information visit enrollment.aflac.com/AccountSites/S_U/StateofWI/Homepage.aspx or call Aflac Group customer service 1-800-433-3036.

Anthem DentalBlue offers three dental coverage plans: a) Dentacare HMO, b) Anthem Preferred PPO (which allows you to see out-of-network providers) and c) Anthem Supplemental, the lower cost option that does not cover diagnostic or preventive procedures and requires that you have other basic dental coverage. For 2015 the Supplemental offers increased coverage. Dentacare HMO and Preferred PPO have decreased premiums. See anthem.com/dental-stateofwi/ or call: during open enrollment 1-866-511-4476; balance of year 1-888-589-0852.

EPIC Benefits+ is a multi-part plan, designed to wrap around State of Wisconsin Group Health Insurance. It includes major dental and orthodontic benefits. For 2015, EPIC is doubling the hospital and surgical indemnity payment, increasing the accidental death and dismemberment coverage, and enhancing the optional vision materials rider. EPIC Benefits+ uses Delta Dental as its dental plan administrator. See www.epiclif.com/products/state_intro.shtm or call 1-800-520-5750.

EPIC Dental Wisconsin will decrease the premium for its PPO plan, which includes coverage for diagnostic and preventive dental services, along with major and complex restorations such as crowns.

EPIC also offers the Select plan, which does not cover those basic services, but allows members to see any dentist (with no balance billing at Premier provider network). EPIC Dental Wisconsin uses Delta Dental as its plan administrator. For more information visit epiclif.com/wi-state-employees/ or call 1-800-520-57501.

Hartford Accidental Death and Dismemberment provides payments based on your salary for specific amputation injuries, such as loss of a limb, or for accidental death. It now includes travel insurance and insures against identity theft. See etf.wi.gov/members/benefits_ADD.htm. For enrollment questions, see your payroll/benefits representative; for claims questions call 1-800-523-2233.

Mutual of Omaha offers a long-term care insurance plan through HealthChoice. It is available to employees, their spouses, domestic partners and the parents of spouses and partners, and can be purchased any time of year for those who qualify. Each member's policy will be individually underwritten—premiums are based on that person's age, gender and health at the time of enrollment. For more information visit etf.wi.gov/members/benefits_ltci.htm or call 1-800-833-5823.

VSP is a vision service plan that focuses on personalized eye care from a nationwide network of doctors. It offers discounts on eye exams, frames and lenses for glasses or contacts at in-network and out-of-network rates. New for 2015: premium increase of 3% for Active members; premium decrease of 10% for Annuitants. See www.vsp.com/go/stateofwiemployees or call 1-800-400-4569.

Does your employer offer any optional insurance plans?

For a table showing agency names and the insurers available, go to etf.wi.gov/members/benefits_other_insurance.htm and click on 2015 Agency/Plan Table.

Note: UW System employees are not eligible to use VSP's Internet or telephone enrollment process. Please go to UW System Annual Benefit Enrollment (ABE) website at www.uwsa.edu/abe for enrollment information. Contact your UW institution's payroll and benefits office if you have questions about the enrollment process.

Supplemental Retirement Savings

Wisconsin Deferred Compensation Program

Toll-free 1-877-457-9327 from 7:00 a.m. to 7:00 p.m. Monday-Friday - www.wdc457.org

The Wisconsin Deferred Compensation Program

The Wisconsin Deferred Compensation (WDC) Program is a supplemental retirement savings program offered to all state employees and local public employees whose employer offers this benefit. The WDC provides a low-cost option for saving and investing for retirement with powerful tools to help you reach your retirement dreams. You can contribute to a traditional account on a before-tax basis and/or to a Roth account on an after-tax basis.

You are immediately eligible to enroll upon your hire date, and there is no minimum amount per paycheck required. The federal maximum contribution in 2014 is \$17,500 per year. Participants age 50 and older are eligible to make additional special catch-up contributions. WDC participants are able to save and invest consistently and automatically, choose from a variety of investment options and learn more about saving and investing for their financial futures. Account flexibility allows participants to change deferral amounts at any time. At termination of employment participants can choose from distribution options that include lump

sum payments, partial lump sum payments and periodic payments. You can request distributions from your WDC account as soon as you leave your public service position. After you terminate employment or retire, you may elect a distribution date any time up to April 1 of the calendar year following the year you reach age 70½ or the year you terminate employment, whichever is later.

WDC Participant Administrative Fees	
Participant Account Balance	Monthly/Annual Fee
\$1-\$5,000	\$0/\$0
\$5,001-\$25,000	\$1/\$12
\$25,001-\$50,000	\$2/\$24
\$50,001-\$100,000	\$4/\$48
\$100,001+	\$5.50/\$66

Find out when a WDC representative will be at your location—see the Presentation Schedules link near the bottom of the WDC website at wdc457.org.

Group Health Insurance Application

Submit your completed application and retain one for your records if, for next year, you want to:

- change health plans
- change to family or single coverage
- drop your adult dependent child
- enroll (if you previously deferred coverage and are an eligible employee, annuitant or surviving spouse/dependent)

Copies of the Group Health Insurance Application/Change Form (ET-2301) are also available at etf.wi.gov/publications/et2301.pdf.

Your application must be submitted electronically (see pages 15 through 18), handed in, faxed or postmarked by the last day of the It's Your Choice Open Enrollment period (October 31, 2014). Late applications will not be accepted.



4.ENROLLMENT INFORMATION

New Hire or Return from Leave and Coverage has Lapsed—I want my coverage to be effective:

- When employer contributes to premiums
- As soon as possible (employee will pay entire monthly premium until eligible for employer contribution)
- Decline/Waive Coverage
- Decline coverage because I have other coverage

Eligibility reason* Employee Graduate assistant Continuant (COBRA) Retired Survivor

Coverage desired*
 Single
 Family

Are you selecting an HDHP health plan?
 Yes No

Health plan selected* (enter plan name)

State and some WPE employees (see your employer) may select the HDHP (High Deductible Health Plan) as explained in the Information Pages Section 4.

5.REASON FOR APPLICATION*

Please select the event that allows you to enroll outside of initial hire. Reasons marked with require supporting documentation. See Page 10 for required documentation listing. **IYC = Annual It's Your Choice**

Add Coverage

- Spouse/DP to spouse/DP transfer
- Transfer from one employer to another employer
Previous Employer* _____
- HIPAA (birth, adoption, marriage, DP, divorce
- LTE new hire (state only)
- Loss of Other Coverage/Employer Contributions
- IYC (eff. Jan. 1)
- COBRA (ET-2311 required)
- State retiree re-enroll**

Effective date* _____

Other _____

Event date* _____

Add dependent

- HIPAA (birth, adoption, marriage, DP, divorce
- National medical support notice
- Paternity acknowledgment
- Legal ward/guardianship
- Eligible dependent not on initial enrollment (excludes DP and adult dependents)
- Loss of other coverage/ employer contributions
- Disabled, age 26+
- IYC (eff. Jan. 1)
- Other _____

Event date* _____

Remove dependent

- Divorce/DP terminated
- Death of dependent
- Legal ward/guardianship ends
- Disabled dependent: Disability ends or support and maintenance less than 50%.
- Grandchild's parent turns age 18
- Adult dependent eligible for other coverage
- IYC (eff. Jan 1)
- Other _____

Event date* _____

If adding or removing dependents, please list them in Section 3.
If removing dependents, please list their address in Section 3 if it is different from your own.

Change Health Plan (Check one box below, enter new county for a move from service area, indicate current health plan, provide date of event, update Section 1, if applicable.)

Status Change events may include birth, adoption, marriage, creation of DP, divorce or termination of DP.

- Move from service area
- Eligible Status Change
- Annual IYC (Jan.1)

Status Change event*: _____

New county* _____ Current health plan* _____ Event date* _____

Family to Single Coverage: If your employee premium share is taken pre-tax, IRC Section 125 restricts midyear changes to your coverage.

My employee-required premium contribution is deducted: (Check one box, list event date and update Section 1.)

- Pre-tax and my employee premium contribution has increased significantly
- Pre-tax eligible Status Change event : Event _____
- Pre-tax change to single during annual It's Your Choice (Jan. 1)
- Post-tax (midyear changes to coverage level can be made at any time)

Event date* _____

For more information on IRC Section 125 limitations, see the Information Pages Section 5 attached to this application



MID

SSN

Cancel Coverage – If your premiums are deducted on a post-tax basis, you may cancel coverage at any time. If they are deducted on a pre-tax basis, you must provide the event allowing midyear cancellation. *If transferring family coverage to your spouse/DP, please indicate the IRC Section 125 Status Change Event below.*

Retiree sick leave depleted—effective end date of coverage _____

My Premiums are Deducted: Pre-tax (select an event below) Post-tax (no event required)

- I am terminating employment I and all eligible dependents became eligible for and enrolled in other coverage
- I am going on unpaid leave of absence
- My employee premium share has increased significantly Spouse/DP to Spouse/DP Transfer
- Annual It's Your Choice Enrollment (Jan. 1)

Status Change Event*

Additional Information* Is any dependent listed under Section 3 your or your spouse/DP's grandchild?

No Yes If yes, name of parent _____

Medicare Information/Update Medicare Information* Are you or any person you insure, covered by Medicare?

No Yes

If yes, list the eligibility reason, names of insured and Medicare Parts A and B **effective** dates.

Medicare eligible reason: Age Disabled End stage renal disease

Name: _____ HIC# _____ Dates: Part A _____ Part B _____

Name: _____ HIC# _____ Dates: Part A _____ Part B _____

Other Health Insurance Coverage/Update* (State employees are ineligible for HDHP if they have other coverage.)

Do you or any of your dependents have other medical or health care Flexible Spending Account coverage that has a balance available as of the effective date of this coverage? (excludes dental or vision)

No Yes If yes, complete the following.

Name of company _____ Policy No. _____ Group No. _____

Name(s) of Insured: _____

6.SIGNATURE* (Read the **Terms and Conditions** on Page 4 and sign and date the application.)

By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the state of Wisconsin and I have read and agreed to the **Terms and Conditions**. A copy of this application is considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. Providing false information is punishable under Wis. Stat. §943.395. Additional documentation may be required by ETF at any time to verify eligibility.

Sign and date Here & return to employer (ETF for Retirees/Continuants)



Date Signed (mm/dd/yy)

7.EMPLOYER COMPLETES (Coding instructions are in the Employer Health Insurance Administration Manual.)

EIN 69-036-	Employer name	Payroll representative e-mail	
Group number	Employee type	Coverage code	Health plan name/suffix
Employment status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> LTE		Employee deductions: <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax	
Previous service – complete information			
1. Are you a WRS participating employer? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, answer remaining questions)			
2. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. Did employee participate in the WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Source of previous service check? <input type="checkbox"/> Online Network for Employers (ONE) <input type="checkbox"/> ETF			
Date WRS eligible employment or graduate appointment began or hire date	Employer received date	Event date	Prospective coverage date
Payroll representative signature			Phone number ()



TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage, employment action, and/or criminal charges/sanctions under Wis. Stat. § 943.395.
2. I authorize the Department of Employee Trust Funds (ETF) to obtain any information from any source necessary to administer this insurance.
3. I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.
4. I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me or any dependent(s). If medical records are needed, my health plan and/or ETF will provide me with an authorization form. I agree to respond to questions from health plans and ETF, including, but not limited to, audits, in a timely manner.
5. I have reviewed and understand the eligibility criteria for dependents under this coverage and affirm that all listed dependents are eligible. I understand that children may be covered through the end of the month they turn 26. Children may also be covered beyond age 26 if they:
 - have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or
 - are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.
6. I understand that if my insured domestic partner and/or dependent child(ren) of my insured domestic partner are not considered "tax dependents" under federal law, my income will include the fair market value of the health insurance benefits provided to my domestic partner and/or domestic partner's dependent child(ren). Furthermore, I understand this may affect my taxable income and increase my tax liability.
7. I understand that it is my responsibility to notify the employer, or if I am a retiree or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce, marriage or domestic partnership, a change in the "tax dependent" status of my domestic partner and/or domestic partner's dependent children, or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependent(s).
8. I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependent(s)) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 18, 29, or 36 months, depending on the type of qualifying event, from the date of the qualifying event or the date of the notice from my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary(ies) and there is a second qualifying event (i.e., loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.
9. I understand that if I am declining enrollment for myself or my dependent(s) (including spouse or domestic partner) because of other health insurance coverage, I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have (a) new dependent(s) as a result of marriage, domestic partnership, birth, acknowledgement of paternity, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) if I request enrollment within 30 days after the marriage or effective date of the domestic partnership, or within 60 days after the birth, acknowledgement of paternity, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am a retiree or continuant).
10. I understand that I am responsible for enrolling in Medicare Parts A and B when I am first eligible and required by this coverage, and that as the subscriber I am responsible for ensuring my spouse, domestic partner and any other eligible dependents also enroll in Medicare Parts A and B when they are first eligible, to ensure proper coordination of benefits with Medicare. In the event I or any eligible dependent does not enroll in Medicare Parts A and B when first eligible and required by this group health insurance program, I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.
11. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the *It's Your Choice* guides.

Information Pages

Initial Eligibility

You must enroll online through myETF Benefits or submit this application to your employer if you are actively employed, or to the Department of Employee Trust Funds if you are a retiree or on continuation. Your initial enrollment period is as follows:

- a) Within 30 days of your date of hire to be effective the first of the month on or following receipt of application by the employer; or
- b) **Active State Employees only** – Before becoming eligible for state employer contributions (completion of two months of state service under the Wisconsin Retirement System for permanent or project employees). Limited Term Employees (LTE) must complete six months of state service to be eligible for employer contributions. Employees of WISCRAFT must complete 1,000 hours of service to be eligible for employer contributions. This **does not** apply to UW unclassified faculty/academic staff.
- c) **Wisconsin Public Employers' participants only** – Within 30 days prior to becoming eligible for employer contribution as determined by your employer, not to exceed six months.
- d) **Graduate Assistants only** – When you are notified of your appointment, immediately contact your benefits/payroll/personnel office for health insurance enrollment information and an application. If eligible, you may enroll for single or family coverage in any of the available health plans. Your benefits/payroll/personnel office must receive your application within 30 days of the date of your first eligible appointment. Your health insurance coverage will be effective the first day of the month on or following receipt of your application by your employer.

If this is not your first eligible appointment, you may still be eligible for the initial 30-day enrollment period if you had a 30-day employment break in service between appointments. If you are currently or later become an active participant under the WRS, you will not be eligible for coverage under the graduate assistant program as a WRS participant.

- e) **Retirees only** – Health insurance continues automatically upon retirement. To change or cancel your existing coverage during the open enrollment period, complete this application or go online to myETF Benefits at myetf.wi.gov/ETFmMEBWeb/mMEB/mMEBLogon.jsp. Changes become effective the first of the year and cancellations are effective the end of the month in which they are received or a future end of the month if specified. Cancellations cannot be back-dated but can be done at any time of the year by mailing or faxing a signed request to ETF - Retiree Services Section.

If you choose to enroll within your initial enrollment period, we recommend that you submit this application to your employer immediately upon employment. If you missed your enrollment opportunity there may be other enrollment opportunities available. There are no interim effective dates, except as required by federal HIPAA law. If your application is submitted after these enrollment opportunities, you will not be eligible to enroll until the annual It's Your Choice Open Enrollment period. For complete enrollment and program information, **read the *It's Your Choice Decision and Reference guides***.

Information Pages

1. Applicant Information

Please provide the information requested in this section as completely as possible. Please provide physician/clinic information unless you have selected WPS/Standard Plan as your health plan. Please provide your care system if you have selected WEA Trust NW as your health plan. Include your e-mail address if you would like ETF to contact you by e-mail if we need to request information related to your health coverage.

Indicate your marital status and date (single does not require a date). The effective date of a DP is the date that ETF receives the *Affidavit of Domestic Partnership* (ET-2371) form; your health application must be received within 30 days of this date if you also wish to provide health coverage for your domestic partner (DP). If you are divorced, the entry of judgment of divorce is typically when the judge signs the divorce decree and the clerk of courts date stamps the decree.

Personal Data Update/Correction: Please check the update box under Section 1, 2, or 3 if you are only updating demographic information (address, SSN, birth date, marital status, gender, phone or e-mail) for yourself, your spouse/DP, or your dependents.

2. Spouse/Domestic Partner (DP) Information

The Centers for Medicare and Medicaid Services (CMS) require that ETF report the name, SSN, birth date, and prior name, if any, for your spouse or DP, even if they are not covered on your health insurance. If you indicate your marital status is married or DP, you must provide this information even if you elect single coverage. If you do not file an *Affidavit of Domestic Partnership* (ET-2371) form with ETF, then you are **not** in a domestic partnership for purposes of health insurance, and this information is not required for your DP. If you apply for family coverage, please also provide gender, tax dependent status (yes or no) and physician/clinic (required for all covered individuals). If you select WEA Trust NW, you must select a care system. **Exception:** you do not need to select a physician/clinic or care system if you have elected the Standard Plan/WPS.

3. Dependent Information

If you are covering dependents other than your spouse/DP or are updating information for a currently covered dependent in the Personal Data Update/Correction Section, please provide the information requested.

For Rel. Code, use the following codes to describe the relationship of dependents to you:

01=Spouse	24=Dependent of Minor Dependent
15=Legal Ward	53=Domestic Partner
17=Stepchild	38=Dependent of Domestic Partner
19=Child	

03=Minor Parent of Minor Dependent (This relationship is a Legal Ward, Stepchild, Child, or Dependent of DP who is younger than age 18 and is the parent of any of your or your spouse's/DP's grandchildren listed as an eligible dependent on this application. Grandchildren cannot be covered on your contract unless the parent of the grandchild is covered and is younger than age 18.)

Indicate "Yes" or "No" if any dependent older than age 26 is disabled.

Indicate "Yes" or "No" if your DP/dependent of DP is considered a "tax dependent" under federal law.

If removing **adult** dependents, list their address in this section if it is different from your own.

Information Pages

4. Enrollment Information

New Hire Only: If you are a newly hired employee, please indicate when you want coverage to start: 1) immediately (as soon as possible) or 2) when you become eligible for the employer contribution toward the health insurance premium. Coverage will be effective the first of the month following receipt of the application or eligibility for the employer contribution. If you **do not** wish to enroll, please mark if you: 1) decline/waive coverage or 2) decline coverage because you have other coverage.

Eligibility Reason: Please indicate your eligibility reason by indicating if you are an employee, graduate assistant, COBRA continuant, surviving dependent of a covered employee or you are retired and receiving an annuity.

A **High Deductible Health Plan (HDHP)** has a minimum annual deductible and a maximum annual out-of-pocket limit. An HDHP generally begins paying for health care costs once the annual deductible has been met. Preventive services mandated by federal law are not subject to the annual deductible. For more information, please see the *It's Your Choice 2015 Decision and Reference* guides. If you are unsure if you are enrolling in an HDHP, please contact your employer or ETF.

For state employees, you may not select an HDHP if you are enrolled in a health care Flexible Spending Account or Employee Reimbursement Account that has a balance available as of the effective date of this coverage, even if you have a qualifying HIPAA event during the plan year.

Coverage Desired: Indicate if you wish to have *single* coverage (for yourself only), *family* coverage (yourself and all eligible dependents), *HDHP single* coverage (for yourself only), or *HDHP family* coverage.

Health Plan Selected: Indicate which health plan you wish to provide your health insurance. A listing of health plans available is located in the *It's Your Choice Decision Guide*.

5. Reason for Application

Indicate if you are using this application to *Add Coverage* (other than if you are a New Hire), *Add Dependent(s)*, *Remove Dependent(s)*, *Change Health Plan*, *Switch from Family to Single* coverage, or if you are updating or correcting personal data for yourself, spouse/DP, or dependent(s) by selecting a reason under the appropriate heading.

If the reason is Add Coverage, Add Dependent, or Remove Dependent and none of the reasons provided suit your situation, please select *other* and provide the reason as well as the event date if an event is associated with your reason. This may result in your request being denied if the reason is not allowed under the contract. Your employer will be notified if this is the case.

When removing a spouse and stepchildren, if any, due to divorce, the entry of judgment of divorce is typically when the judge signs the divorce decree and the clerk of courts date stamps the decree.

Adult Dependents younger than age 19 cannot be dropped from coverage when family coverage is in place. Once the dependent turns 19, that adult dependent can be dropped at the end of the calendar year they turned 19 during the annual It's Your Choice (IYC) Open Enrollment period. An adult dependent older than 19 can be dropped or added during any IYC period.

Change Health Plan: Please indicate the event that makes you eligible to change plans, list your new county if moving from the service area, your **current** health plan, and the date of the event that qualified you to make the change.

If you are changing health plan **and** wish to change coverage level at the same time due to a HIPAA qualifying event, you **must** submit two separate applications. The coverage level change will be effective on the event date and the carrier change will be effective the first of the month following the receipt of the applications which must be received within 30 days of the event.

For state employees, you may not select an HDHP if you are enrolled in a health care Flexible Spending Account or Employee Reimbursement Account, even if you have a qualifying HIPAA event during the plan year.

Information Pages

Family to Single Coverage: To make a change from family to single coverage other than during annual IYC, you must qualify to do so under one of the reasons provided if your health insurance premiums are deducted pre-tax. Please select a reason from the list and provide an event date. If your deductions are taken post-tax, please check the post-tax box.

Retiree premiums are deducted on a post-tax basis and a change from Family to Single Coverage may be done at any time by submitting this form or by applying online through myETF Benefits at myetf.wi.gov/ETFmMEBWeb/mMEB/mMEBLogon.jsp. The change will be effective the first of the month following receipt of your paper or online application.

Internal Revenue Code (IRC) Section 125: If you are enrolled in a Section 125 plan for premium conversion, medical or dependent day care coverage, then section 125 may limit your ability to make some changes to your coverage, for example, it will prevent you from canceling coverage at any time unless you have a change of status event. For the most part, these change of status events correspond to HIPAA qualifying events, but in certain circumstances we will need to ask you to state the section 125 change of status event you fall under.

Cancel Coverage: Please indicate if your health insurance premiums are deducted pre-tax or post-tax. If you are unsure, your human resources person should be able to tell you. After indicating the tax status of your premiums, please select a reason for your cancellation and provide the change in status event that is allowing the cancellation if you are cancelling under IRC Section 125. Cancellation is effective the end of the month on or following receipt of the application by ETF.

Retirees pay premiums post-tax and do not need to provide a reason for cancellation. If you wish to cancel on a future date, please provide that date on the line provided under Cancel Coverage. Otherwise, coverage will end at the end of the month following receipt of your request.

Additional Information: Indicate “Yes” or “No” and list the name of your or your spouse/DP’s grandchild’s parent.

Medicare Information/Update Medicare Information: Indicate “Yes” or “No” if you or any of your dependents (including your spouse/DP) are covered by Medicare, and list their names. Provide the Medicare eligibility reason, Health Insurance Claim Number (HIC#), and date(s) Medicare Part A and/or Part B are effective. This information can be found on the Medicare card of the Medicare eligible person. Please send a copy of the Medicare card and the *Medicare Eligibility Statement* (ET-4307) to ETF.

If you are an active employee and your age 65 or older domestic partner is covered on your insurance, they **must** be enrolled in Medicare parts A **and** B. Medicare will be the primary payer for your Medicare eligible domestic partner’s medical expenses.

Other Health Insurance Coverage/Update: Please provide any information regarding any other group health insurance coverage under which you or your dependent(s) (including your spouse/DP) are covered. For state employees, you are not eligible for the HDHP if you have other health insurance coverage (including, but not limited to, coverage from a spouse’s plan, Medicare, TRICARE, or a health care Flexible Spending Account or Employee Reimbursement Account).

Note: “Other coverage” does **not** include supplemental insurance (examples: EPIC or DentalBlue). For State employees, other coverage **does** include health care Flexible Spending Accounts or Employee Reimbursement Accounts for purposes of HDHP eligibility. If you have an available balance in a health care FSA or ERA as of the effective date of HDHP coverage, then you are ineligible for HDHP coverage.

During Annual It’s Your Choice, if you are not making **any** changes to your coverage you do **not** need to submit an application.

Information Pages

6. SIGNATURE

Your signature is **required**. Applications without a signature will be rejected.

Read the **Terms and Conditions** on Page 4 of this application packet. Only after you have read this should you sign, date, and submit your application to your employer (or to ETF, if you are a retiree or continuant).

1. When submitting an application for any reason, you are required to read the **Terms and Conditions** on the last page of this application and sign and date the application. By signing the application, you are acknowledging that you have read and agree to the **Terms and Conditions**.
2. Make a copy of the application for your records and submit the original application to your payroll or benefits representative. If you are a retiree or continuant, please submit your application directly to ETF.
3. Your employer will complete Section 7 and provide a copy of the application to you. For retirees or continuants, ETF will complete Section 7 and provide a copy of the application to you.

4. Documentation Requirements

Reason for Change or Enrollment	Type of Documentation
Loss of Other Coverage	Certificate of Creditable Coverage from health plan; COBRA notice if coverage end date, covered individuals, and health plan are indicated; or letter from administrator if self-funded health plan. If loss of employer premium contributions, letter from employer indicating they no longer contribute towards their employee's premium.
Divorce Family to single	No documents required but ETF may request per the Terms and Conditions on Page 4 of this application, Number 7.
Divorce Family coverage remains in place when more dependents than spouse/stepchildren covered	Copy of <i>Continuation/Conversion Notice</i> (ET-2311) sent to ex-spouse of the subscriber (ETF may request copy of divorce decree from clerk of courts showing date of entry of divorce if needed per the Terms and Conditions on Page 4 of this application, Number 7).
Adoption	Recorded copy of court order granting adoption or letter of placement for adoption.
Legal Ward	Court Order (Letters of Guardianship) granting permanent guardianship of person.
National Medical Support Notice	Copy of National Medical Support Notice.
Paternity	Court order declaring paternity, or Voluntary Paternity Acknowledgement (HCF-5024) filed w/DHS, or birth certificate.
Creating a domestic partnership	Copy of <i>Acknowledgement Letter</i> (ET-2373) indicating effective date of domestic partnership submitted to employer by employee. Health application adding DP should be submitted to employer when <i>Affidavit of Domestic Partnership</i> (ET-2371) is submitted to ETF.
Cancel coverage due to enrollment in other health insurance coverage when premium contributions are deducted pre-tax	Copy of medical ID card or letter from health plan indicating effective date of other coverage. Must be received within 30 days of enrollment in other coverage.**
Family to single because all dependents enrolled in other coverage	Same rules as Cancel above.**
Birth	Original birth certificate not required. ETF may request documentation per the Terms and Conditions on Page 4 of this application, Number 7.
Marriage	Original marriage certificate is not required (ETF may request per the Terms and Conditions on Page 4 of this application, Number 7).
Ending a domestic partnership	<i>Affidavit of Termination of Domestic Partnership</i> (ET-2372). (ETF may request copy of marriage certificate if marriage is reason for termination of domestic partnership per the Terms and Conditions on Page 4 of this application, Number 7.)
Change of address/telephone	None (ETF may request documentation per the Terms and Conditions on Page 4 of this application, Number 7.)
Eligible and enrolled in Medicare	Copy of Medicare card and <i>Medicare Eligibility Statement</i> (ET-4307). (Note: If you are on COBRA Continuation and the subscriber or dependents become Medicare eligible after the COBRA effective date, subscriber or dependent(s) is no longer eligible to continue on COBRA.)
Death	Original death certificate.
Legal change of name (other than due to marriage or divorce)	Copy of court order.
Social Security number change	Copy of card or letter from Social Security Administration.
State retiree re-enroll	Same as loss of other coverage and an ET-4317. During IYC, no documentation required.
Disabled, age 26+	Copy of letter from health plan approving disabled status

 Documentation Required/Must Be Submitted to ETF.

**Does not apply to retirees.

How to Choose Your Group Health Insurance Plan

The *It's Your Choice Decision Guide* is filled with information to help eligible employees, annuitants and continuants select one of the many health plans offered by the State of Wisconsin Group Health Insurance Program. This page may assist you in selecting your health plan.

1. Open this *It's Your Choice Decision Guide* to the map and charts on pages 28-29 and locate your county, or find an interactive version of the map online at etf.wi.gov/members/IYC2015/IYC_State_map.html.
2. On the grid below, list the plan codes of the health plans available in your region (keeping in mind how far you are willing to travel for covered services).
3. Using the health plan codes on Page 28, list the plan names associated with the codes in your chart.
4. Note the monthly premium cost for single or family coverage below. Most state of Wisconsin employees and UW graduate assistants will find their monthly premium contributions on Page 25. Other employees will receive this information from their benefits/payroll/personnel office. Note that employee contribution rates are based on plan Tiers. Annuitants and continuants should see Page 27.
5. View the Health Plan Descriptions (found on Pages 41-68) and list the overall performance rating below. View Report Cards on the ETF website at etf.wi.gov/members/IYC2015/IYC_State_rate.html. Consider the following and note anything that stands out when considering your or your family's health needs, then list it under Notes below:
 - **Provider Networks Including Specialists and Hospitals**
 - **Referrals and Prior Authorizations**
 - **Dental Network**

Note: For specific network and other plan information, you will need to call each plan directly or visit their website. Contact information can be found in the upper left-hand corner of each plan description page or on the inside back cover of this *It's Your Choice Decision Guide*.

Plan Code	Health Plan Name	Premium Rate	Overall Rating (★★★★★)	Notes

Notes

Notes

Health Plan Contact Information

Anthem Blue

P.O. Box 105187
Atlanta, GA 30348
Tele: 1-800-843-6447
24/7 Nurseline: 1-866-647-6120
Website: anthem.com

Arise Health Plan

P.O. Box 11625
Green Bay, WI 54307-1625
Tele: 1-888-711-1444, 920-490-6900
Fax: 920-490-6942
Website: WeCareForWisconsin.com

Dean Health Insurance

1277 Deming Way
Madison, WI 53717
Tele: 1-800-279-1301
Fax: 608-827-4212
Dean On Call: 1-800-576-8773
Website: deancare.com/wi-employees

Dean Health Insurance-Prevea360 Health Plan

P.O. Box 28467
Green Bay, WI 54324-0467
Tele: 1-877-230-7555
Prevea Care After Hours: 1-888-277-3832
Website: prevea360.com/wi-employees

Group Health Cooperative of Eau Claire (GHC-EC)

P.O. Box 3217
Eau Claire, WI 54702
Tele: 1-888-203-7770, 715-552-4300
Fax: 715-552-3500
FirstCare Nurseline: 1-800-586-5473
Website: group-health.com

Group Health Cooperative of South Central Wisconsin (GHC-SCW)

1265 John Q. Hammons Drive
P.O. Box 44971
Madison, WI 53744-4971
Tele: 1-800-605-4327, 608-828-4853
Fax: 608-662-4186
GHC Nurse Connect: 1-855-661-7350
Website: ghcscw.com

Gundersen Health Plan

1900 South Avenue
LaCrosse, WI 54601
Tele: 1-800-897-1923, 608-775-8007
Fax: 608-775-8042
Nurse Advisor: 1-800-858-1050
Website: www.gundersenhealthplan.org

HealthPartners Health Plan

P.O. Box 1309
Minneapolis, MN 55440-1309
Tele: 1-800-883-2177, 952-883-5000
Fax: 952-883-5666
Careline: 1-800-551-0859
Website: healthpartners.com/stateofwis

Health Tradition Health Plan

P.O. Box 188
LaCrosse, WI 54602-0188
Tele: 1-888-459-3020, 608-781-9692
Fax: 608-781-4620
24/7 Nurseline: 1-855-392-4050
Website: healthtradition.com

Humana

N19 W24133 Riverwood Drive #300
Waukesha, WI 53188
Tele: 1-855-786-3944
HumanaFirst Nurse Advice:
1-800-622-9529
Website: our.humana.com/stateofwi

Medical Associates Health Plans

1605 Associates Drive, Suite 101
P.O. Box 5002
Dubuque, IA 52004-5002
Tele: 1-800-747-8900, 563-556-8070
Fax: 563-556-5134
24 Hour HELP Nurse: 1-800-325-7442
Website: mahealthcare.com

MercyCare Health Plans

580 N. Washington Street
P.O. Box 550
Janesville, WI 53547-0550
Tele: 1-800-895-2421, 608-752-3431
Fax: 608-752-3751
Healthline: 1-888-756-6060
Website: mercycareshealthplans.com

Navitus Health Solutions

P.O. Box 999
Appleton, WI 54912-0999
Tele: 1-866-333-2757
Website: www.navitus.com

Navitus MedicareRx (PDP) (Prescription drug coverage for Medicare eligible retirees)

P.O. Box 1039
Appleton, WI 54912-1039
Tele: 1-866-270-3877
Website: medicarerx.navitus.com

Network Health

1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Tele: 1-800-826-0940, 920-720-1300
Fax: 920-720-1900
Nurse Direct: 1-800-362-9900
Website: networkhealth.com

Physicians Plus

2650 Novation Parkway
Madison, WI 53713
Tele: 1-800-545-5015, 608-282-8900
Fax: 608-327-0325
NursePlus: 1-866-775-8776
Website: pplusic.com

Security Health Plan

1515 Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
Tele: 1-800-472-2363, 715-221-9555
Fax: 715-221-9500
24-hour Nurse Line: 1-800-549-3174
Website: securityhealth.org/state

Standard Plans, Medicare Plus and SMP

WPS Health Insurance

1717 W. Broadway
P.O. Box 8190
Madison, WI 53707-8190
Tele: 1-800-634-6448
Fax: 608-243-6139
Website: wpsic.com/state

UnitedHealthcare of Wisconsin Inc.

P.O. Box 13187
3100 AMS Blvd.
Green Bay, WI 54307-3187
Tele: 1-800-357-0974
Fax: 1-866-674-5637
Care24: 1-888-887-4114
Website: welcometouhc.com/state

Unity Health Insurance

840 Carolina Street
Sauk City, WI 53583-1374
Tele: 1-800-362-3310
Fax: 608-643-2564
Website: ChooseUnityHealth.com

WEA Trust

45 Nob Hill Road
P.O. Box 7338
Madison, WI 53707-7338
Tele: 1-800-279-4000, 608-276-4000
Fax: 608-276-9119
Website: weatruststatehealthplan.com

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Get free ETF E-mail Updates



Look for the red envelope at etf.wi.gov

Wisconsin Department of Employee Trust Funds

801 W. Badger Road
(visitor address)

PO Box 7931
Madison, WI 53707-7931
(mailing address)

1-877-533-5020 (toll free)
608-266-3285 (local to Madison)
Fax 608-267-4549

