

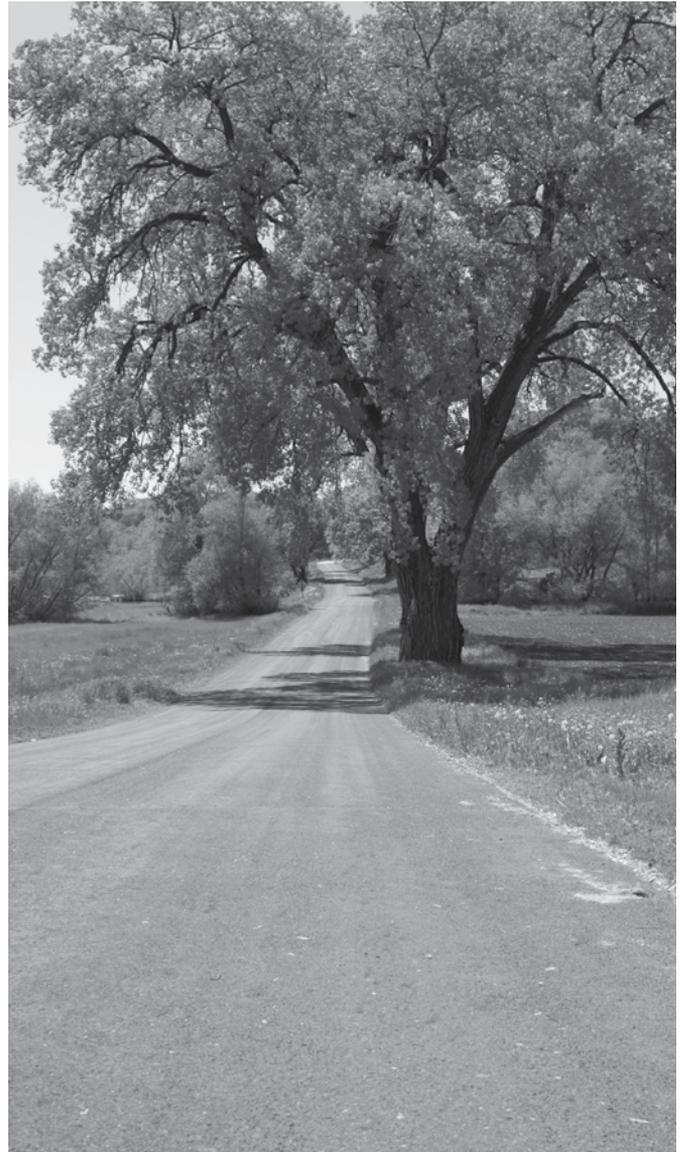
Comparison of Benefit Options

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 (not 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 (not 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 OOP, 50 visits per year. Plan may approve an additional 50 visits.	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOP, 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 OOP	Deductible must be met before coverage begins. After deductible: 80%/20% coinsurance to OOP	80%/20% coinsurance to annual \$500 OOP 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 OOP, 11 procedures	Deductible must be met before coverage begins. After deductible: 90%/10% coinsurance to OOP, 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 OOP ⁶ (non-specialty)	Level 1=\$5; 2=\$15; 3=\$35. OOP \$410 individual/\$820 family	Deductible must be met before coverage begins. After deductible: Level 1=\$5; 2=\$15; 3=\$35. OOP \$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. OOP \$410 individual/\$820 family
Specialty Drug Copays and OOP ⁶ - Preferred Pharmacy	Preferred drugs \$15 to OOP \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOP.	Deductible must be met before coverage begins. After deductible: Preferred drugs \$15 to OOP \$2,500 individual/\$5,000 family. Non-preferred drugs \$50, to OOP \$2,500 individual/\$5,000 family.	Preferred drugs \$15 to OOP \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOP.
Specialty Drug Copays and OOP ⁶ - Non-Preferred Pharmacy	Preferred drugs \$50 to OOP \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOP.	Deductible must be met before coverage begins. After deductible: Preferred and non-preferred drugs \$50 to OOP \$2,500 individual/\$5,000 family.	Preferred drugs \$50 to OOP \$1,000 individual/\$2,000 family. Non-preferred drugs \$50, no OOP.

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.