

Wisconsin Public Employers
Group Health Insurance Program for
Participating Local Government Employees and Annuitants



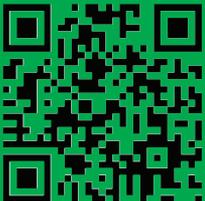
It's Your Choice 2015 Decision Guide

To Help You Choose Your Group Health Insurance Plan



Enrollment Period

October 6 to 31, 2014



Scan to read online.

ET-2128d-15 (10/8/2014)

Turn The Page
To Explore Your Options
For Health Insurance
Coverage

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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_Local_home.html

- Health Plan Report Card (15ET-2128rc)
- Other Quality Information Resources (15ET-2107qi)
- Glossary (15ET-2128g)
- Benefit Fair Dates (15ET-2107bf)

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 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 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 plans must select another plan.
State Maintenance Plan (SMP)	SMP is no longer available in Marquette County and is not qualified in Pepin County. Subscribers in Marquette County must select another plan or will be limited to the SMP providers remaining in other areas.
Health Plan Provider Network Changes	
Health plans listed below and on the next page have made significant changes by adding contracts with provider groups in one or more counties. Other plans have also made changes. Refer to the map on Page 21 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, Grant, Jackson, La Crosse, Lincoln, Marathon, Monroe, Oneida, Portage, Sawyer, Vernon and Washburn counties. For more counties with some providers available, see the health plan description page.

Choose Wisely — Important Changes

Health Plan Provider Network Changes (continued)	
Physicians Plus	Expanding into Dodge, Juneau, Vernon, Waukesha and Wood counties.
State Maintenance Plan (SMP)	Newly offered in Vilas County.
Health Plan Tier Changes	
Changing to Tier 3	Group Health Cooperative - Eau Claire and Humana Western.
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 automatically be moved into this new 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.
Changes to Dental Coverage	
Anthem Blue - Northeast and Southeast	Newly offers Uniform Dental coverage.
Gundersen Health Plan	Delta Dental will be this health plan’s new dental vendor. Members should verify if their current dentists are 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	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

Choose Wisely — Important Changes

Annuitant Medicare Prescription Drug Administrator Change (continued)	
Navitus MedicareRx (PDP) plan (continued)	<p>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.
Navitus MedicareRx (PDP) plan	<ul style="list-style-type: none"> • 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.
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_Local_home.html.</p> <ul style="list-style-type: none"> • Health Plan Report Card (15ET-2128rc) • Other Quality Information Resources (15ET-2107qi) • Glossary (15ET-2128g) <p>An interactive health plan map is also available at etf.wi.gov/members/IYC2015/IYC_Local_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 to report this information to the federal government in 2015 due to the Patient Protection and Affordable Care Act.</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>

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 others 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 provided to you by your employer or are shown on Page 17.
- 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_Local_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 26 and 27.
- 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 HealthCare.gov, call 1-800-318-2596 and see Frequently Asked Question 2 online at etf.wi.gov/members/IYC2015/IYC_Local_home.html in the *Frequently Asked Questions* (15ET-2128faq). 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.

If you don't have access to a computer, you may submit your enrollment change on a paper application (on Page 68). 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.

The screenshot shows the homepage of the myETF Benefits System. At the top left is the ETF logo. The main header reads "Employee Trust Funds (ETF) On-line Network for Members (ONM)". Below this is a welcome message: "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." Under the "Applications" section, there are links for "myETF Benefits Instructions", "Interactive Webcast", and "It's Your Choice Information". A large graphic says "Click On myETFBenefits". The "Guidelines for Use" section states: "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.

The screenshot shows the myETF Benefits system interface. At the top left is the 'etf' logo, and at the top right is the text 'myETF Benefits'. Below this is a disclaimer: '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.' The main content area is divided into two sections: 'Existing User' and 'New User'. The 'Existing User' section is titled 'Registered Users' and contains the text: 'If you are already a registered user, enter your user ID and password, then click the login button.' It features a 'User ID:' field, a 'Password:' field, and a 'Login' button. To the right of the password field is a 'WAPES' logo. Below the login fields is a list of links: 'If you forgot your WAMS ID, go here', 'If you need to change your WAMS ID email address, go here', and 'If you need to change your password, go here'. The 'New User' section is titled 'New Users' and contains the text: 'If you have not yet registered for online access, click the Register Now button. You will be guided through the registration process.' It features a 'Register Now' button. At the bottom of the page, there are 'Guidelines for Use' and a disclaimer: '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—myIdentify 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 page. At the top left is the ETF logo. The page title is "myETF Benefits" with "myInfo" below it. A navigation bar contains tabs for myInfo, Health, Life, Disability, WRS, Other Benefits, Help, and Log Off. The main content area is divided into three sections: Member Information, Spouse Information, and Contact Information. Each section lists fields and indicates that the information will appear there. At the bottom, there is a note about demographic information and three buttons: Edit, History of Changes, and myRequests.

Member Information		Spouse Information	
Member ID: SSN: Name: Date of Birth: Gender: Marital Status: Marital Status Date:	The subscriber's information will appear here.	Member ID: SSN: Name: Date of Birth: Gender:	The subscriber's spouse's information will appear here.

Contact Information	
Home Address:	The subscriber's address will appear here.
Primary Email: Primary Phone:	The subscriber's email and primary phone number will appear here.

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.

[Edit](#) [History of Changes](#) [myRequests](#)

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

Choose Wisely

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 insured annuitants to select one of the many health plans offered by the Wisconsin Public Employers Group Health Insurance Program. Today, there are more than 18 health plans participating.

The following list contains some of the most common questions about the enrollment period. An extensive list of frequently asked questions and answers to use now and throughout the year is available in the Frequently Asked Questions at the ETF website at etf.wi.gov/members/IYC2015/IYC_Local_home.html. You can also find information about key terms in the Glossary 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, change your coverage or cancel the coverage for your adult dependent child. It is offered only to employees and insured annuitants who are eligible under the Wisconsin Public Employers 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 the It's Your Choice *Frequently Asked Questions* web page on the ETF website at etf.wi.gov/members/IYC2015/IYC_Local_home.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 without restrictions as described below:

A. If an electronic or paper application is received by your benefits/payroll/personnel office

See the It's Your Choice Frequently Asked Questions section on the ETF website for information regarding dependent eligibility, family status changes and how to use your benefits.

for active employees, or ETF for annuitants/continuant, within **30 days** of the following 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, 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 date of birth, 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. Which other changes can only be made during the It's Your Choice Open Enrollment period if my health insurance premiums are taken pre-tax?

During the Open Enrollment period, you can add or drop coverage for yourself and/or your adult dependent children or do a *spouse/domestic partner to spouse/domestic partner* transfer of your health insurance coverage.

5. What if my spouse or domestic partner and I work for the same employer?

Your employer may determine whether married employees or domestic partners may each elect single or family coverage, or if they are eligible for family coverage through only one of the spouses/domestic partners.

Note: For domestic partners, further information is available at etf.wi.gov.

Choose Wisely

6. What if my spouse or domestic partner is a state of Wisconsin employee or annuitant?

You may each retain or select single coverage, family coverage or you may select one family plan. See *the Frequently Asked Questions* link on the ETF website at etf.wi.gov/members/IYC2015/IYC_Local_home.html.

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

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

If you decide to change to a different health plan, you are encouraged to make changes online using the myETF Benefits website (see pages 6 through 9 of this guide), or you may submit a paper application per the following instructions:

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

Applications received after the deadline will be not be accepted.

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

8. How do I use the myETF Benefits website?

Refer to pages 6 through 9 of this guide.

9. 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.

10. 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.

11. 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 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; or
- 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_Local_faq.html#cancellation.

Selecting a Health Plan

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

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

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

This can be a concern for members who travel frequently and those who have a covered dependent living elsewhere, such as a college student living away from home. When selecting a health plan, you will want to consider the following:

- 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.

14. 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. Neither ETF nor your benefits/payroll/personnel office maintains a current list of this information.

Medicare

15. 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 the *Frequently Asked Questions* at etf.wi.gov/members/IYC2015/IYC_Local_home.html for details.)

Choose Your Health Plan

Introduction to Health Plan Options

As a participant in the Wisconsin Public Employers Group Health Insurance Program, all of the health plans listed in this guide are available to you. This includes 18 different 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 the 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 100% of current local 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. *Uniform Benefits* is 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:** The 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 Uniform Benefits package, 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.
- **Dental Benefits** (if offered): Plans that choose to offer dental benefits provide a uniform package of covered dental benefits and services. Note, however, that dental providers differ for each plan and may change.
- **Premium:** As an employee, your total monthly premium contribution amount can vary. Your employer will provide information about each plan’s cost to you.
- **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 Tier 1 qualified Alternate Plan HMO or PPO. It offers the same Uniform Benefits package as the Alternate Health Plans. SMP does not offer Uniform Dental coverage.

Choose Your Health Plan

The 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 throughout Wisconsin and nationwide. You can compare the Standard Plan to the Uniform Benefits package on pages 22 through 25.

Health Plans For Annuitants

Medicare Coordinated Plans

All health plans have coverage options, which are coordinated with Medicare. You will remain covered by the plan you select after you are enrolled in Medicare Parts A and B. The following exceptions apply:

1. Members enrolled in Humana will be enrolled in Humana's Medicare Advantage Preferred Provider Organization (MA-PPO) plan after enrolling in Medicare Parts A and B.

2. Members enrolled in the Standard Plan or 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 22 for more information.

The **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.

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.



Choose Your Health Plan

Health Plan 2015 Premium Rates



This section lists the total monthly premium for each plan. Your employer will provide information about each plan's cost to you.

Employers determine the amount they will contribute toward the premium under one of the two methods described here.

1. Your employer pays between 50% and 88% of the premium rate of the average Tier 1 qualified plan in the employer's service area for either single or family coverage for employees who are participants under the Wisconsin Retirement System (WRS).
 - **Note:** Your employer may pay as little as 25% of the premium for either single or family coverage for an employee appointed to a position working fewer than 1,044 hours per year and who is a WRS-participating employee.
2. A Three-Tier health insurance premium option is also available to employers. 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. The 2015 health plan Tiers appear on Page 19.

The employee's required contribution to the health insurance premium for coverage is generally the same dollar amount for all health plans in the same Tier, regardless of the total premium.

Note: Your employer may contribute any amount toward the premium for retired employees who continue group coverage.

Annuitants and their 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.

Local Government Employee and Annuitant Rates

2015 Monthly Traditional HMO Option - Standard PPO

Plan Name	Local Employees & Non-Medicare Annuitants*		Local Medicare Annuitants		
	Single	Family	Single	Medicare 1**	Medicare 2**
Anthem Blue Preferred Northeast	723.60	1,801.50	530.80	1,249.40	1,056.60
Anthem Blue Preferred Southeast	775.70	1,931.80	557.00	1,327.70	1,109.00
Arise Health Plan Northern	1,022.20	2,548.00	680.50	1,697.70	1,356.00
Arise Health Plan Southeast	1,054.80	2,629.50	696.80	1,746.60	1,388.60
Dean Health Insurance	694.70	1,729.30	509.40	1,199.10	1,013.80
Dean Health Insurance - Prevea360	843.80	2,102.00	582.20	1,421.00	1,159.40
GHC of Eau Claire	1,134.50	2,828.80	610.70	1,740.20	1,216.40
GHC of South Central Wisconsin	613.60	1,526.50	476.20	1,084.80	947.40
Gundersen Health Plan	790.20	1,968.00	420.70	1,205.90	836.40
Health Tradition Health Plan	687.70	1,711.80	513.20	1,195.90	1,021.40
HealthPartners Health Plan	887.50	2,211.30	591.90	1,474.40	1,178.80
Humana - Eastern	1,219.90	3,042.30	458.10	1,673.00	911.20
Humana - Western	1,219.90	3,042.30	458.10	1,673.00	911.20
Medical Associates Health Plans	649.80	1,617.00	438.40	1,083.20	871.80
Medicare Plus****	NA****	NA****	414.30	NA****	824.30
MercyCare Health Plans	637.70	1,586.80	446.80	1,079.50	888.60
Network Health	792.00	1,972.50	565.40	1,352.40	1,125.80
Physicians Plus	721.00	1,795.00	497.50	1,213.50	990.00
Security Health Plan	1,077.60	2,686.50	571.30	1,643.90	1,137.60
Standard Plan - Balance of State ¹	1,301.20	3,245.00	NA****	1,715.50	NA****
Standard Plan - Dane ²	1,205.90	3,006.90	NA****	1,620.20	NA****
Standard Plan - Milwaukee ³	1,408.30	3,513.30	NA****	1,822.60	NA****
Standard Plan - Waukesha ⁴	1,301.20	3,245.00	NA****	1,715.50	NA****
State Maintenance Plan (SMP)	865.20	2,157.00	NA****	1,279.50	NA****
UnitedHealthcare of Wisconsin	901.60	2,246.50	620.20	1,516.80	1,235.40
Unity Health Insurance - Community	660.10	1,642.80	470.70	1,125.80	936.40
Unity Health Insurance - UW Health	567.00	1,410.00	428.80	990.80	852.60
WEA Trust - East	823.20	2,050.50	581.00	1,399.20	1,157.00
WEA Trust - Northwest Chippewa Valley	963.50	2,401.30	651.10	1,609.60	1,297.20
WEA Trust - Northwest Mayo Clinic Hlth. Sys.	963.50	2,401.30	651.10	1,609.60	1,297.20
WEA Trust - South Central	781.90	1,947.30	560.30	1,337.20	1,115.60

Please refer to the following page for footnoted information.

Choose Your Health Plan

Local Premium Rate Footnotes



Note that single and family rates apply when no family members are eligible for Medicare. At least one insured family member must be eligible for and enrolled in Medicare in order for the Medicare rates to apply. In addition, Medicare premium rates apply only to subscribers who have terminated employment.

Footnotes from preceding page:

NA = "not applicable."

*Members of new participating employers may have a surcharge added to their rates. Your employer will inform you. Contact your payroll office with questions.

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

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

****Members 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.

Standard Plan rates are determined by the employer county or the retiree county of residence. Counties are divided into the following rate categories:

1. **Balance of State:** All other Wisconsin counties not listed below. (Code A4)
2. **Dane:** Dane, Grant, Jefferson, La Crosse, Polk and St. Croix. (A1)
3. **Milwaukee:** Milwaukee County. Also applies to retirees and continuants living out of state. (A2)
4. **Waukesha:** Kenosha, Ozaukee, Racine, Washington and Waukesha. (A3)

Local Health Plan Tiers

2015 Health Plans
TIER 1
ANTHEM BLUE-NORTHEAST
ANTHEM BLUE-SOUTHEAST
ARISE HEALTH PLAN NORTHERN
ARISE HEALTH PLAN SOUTHEAST
DEAN HEALTH INSURANCE
DEAN HEALTH INSURANCE-PREVEA360
GHC OF SOUTH CENTRAL WISCONSIN
GUNDERSEN HEALTH PLAN
HEALTH TRADITION HEALTH PLAN
HEALTHPARTNERS HEALTH PLAN
MEDICAL ASSOCIATES HEALTH PLANS
MERCYCARE HEALTH PLANS
NETWORK HEALTH
PHYSICIANS PLUS
STATE MAINTENANCE PLAN (SMP)
UNITEDHEALTHCARE OF WISCONSIN
UNITY HEALTH INSURANCE-COMMUNITY
UNITY HEALTH INSURANCE-UW HEALTH
WEA TRUST-EAST
WEA TRUST-NORTHWEST CHIPPEWA VALLEY
WEA TRUST - NORTHWEST MAYO CLINIC HEALTH SYSTEM
WEA TRUST-SOUTH CENTRAL
TIER 2
NO TIER 2 HEALTH PLANS
TIER 3
GROUP HEALTH COOPERATIVE OF EAU CLAIRE
HUMANA-EASTERN
HUMANA-WESTERN
SECURITY HEALTH PLAN
STANDARD PLAN

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 continuing to the next page shows which health plans are available in each county, with columns designated *qualified plans* and *non-qualified plans*. A *non-qualified plan* is one that has limited provider availability in that area.

Since the 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 on 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, PP, S, UC, WT	
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	G, GEC, 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
Fond du Lac	A, AE, D, HE, N, U, UC, WT	
Forest	SMP	A, S, WT
Grant	D, G, HP, MA, PP, UC	HT
Green	D, HE, UC	MC
Green Lake	AE, HE, N, U, WT	A, D, PP

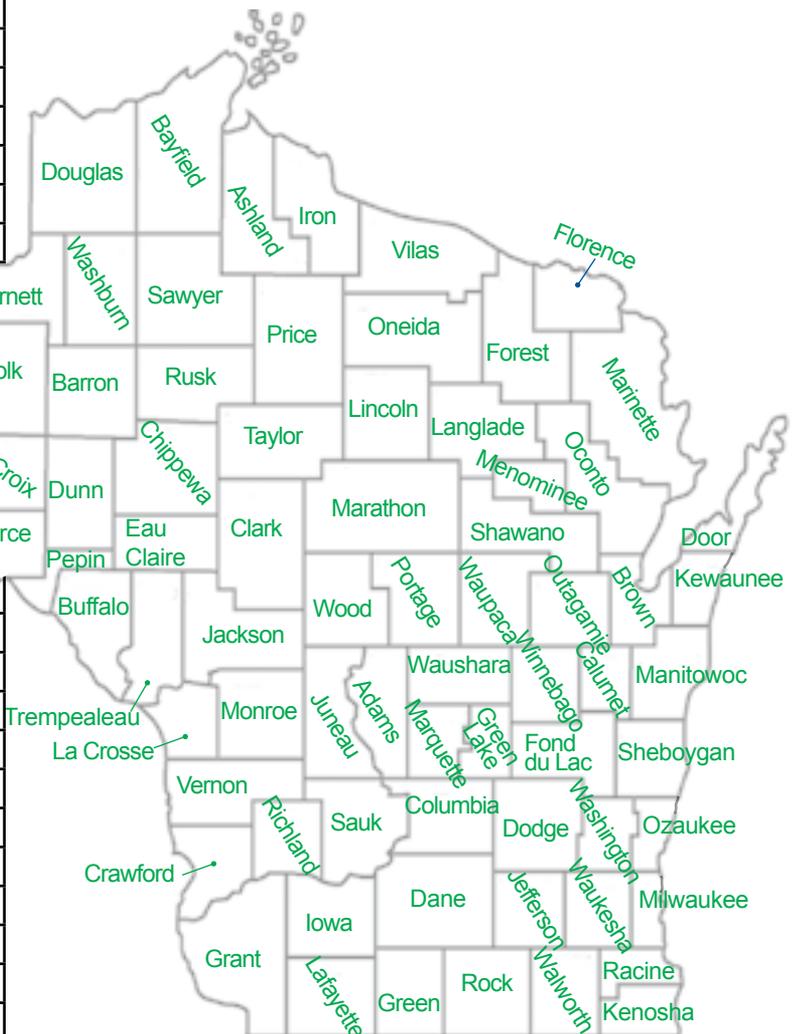
Visit etf.wi.gov/members/IYC2015/IYC_Local_map.html for an interactive health plan map.

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, HP, HT, S, WN	
Jefferson	AS, D, HE, MC, PP, U, UC, WT	A
Juneau	G, HT, PP, S, UC, WT	D
Kenosha	AH, AS, HE, U, WT	
Keweenaw	A*, N*, WT*	AE, D3, HE, U
La Crosse	G, HP, HT	
Lafayette	MA, PP	D, UC
Langlade	A, GEC, S, WT	HP
Lincoln	GEC, HP, S, WT	A
Manitowoc	A, AE, D3, HE, N, U, WT	
Marathon	A, GEC, HP, S, WT	
Marinette	A, AE, HE, U, WT	D3
Marquette	PP, WT	A, GSC, N, U, UC
Menominee	SMP	WT
Milwaukee	AH, AS, HE, U, WT	
Monroe	G, HP, HT	
Oconto	A, AE, D3, HE, N, WT	U
Oneida	GEC, HP, S, WT	A
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	HP, S, WT	A
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, HP, HT, UC	D, 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, PP, S, U, WT	
Winnebago	A, AE, HE, N, U, WT	
Wood	A, S, WT	HP, PP



*Qualified in a county with no hospital

2015 Comparison of Benefit Options

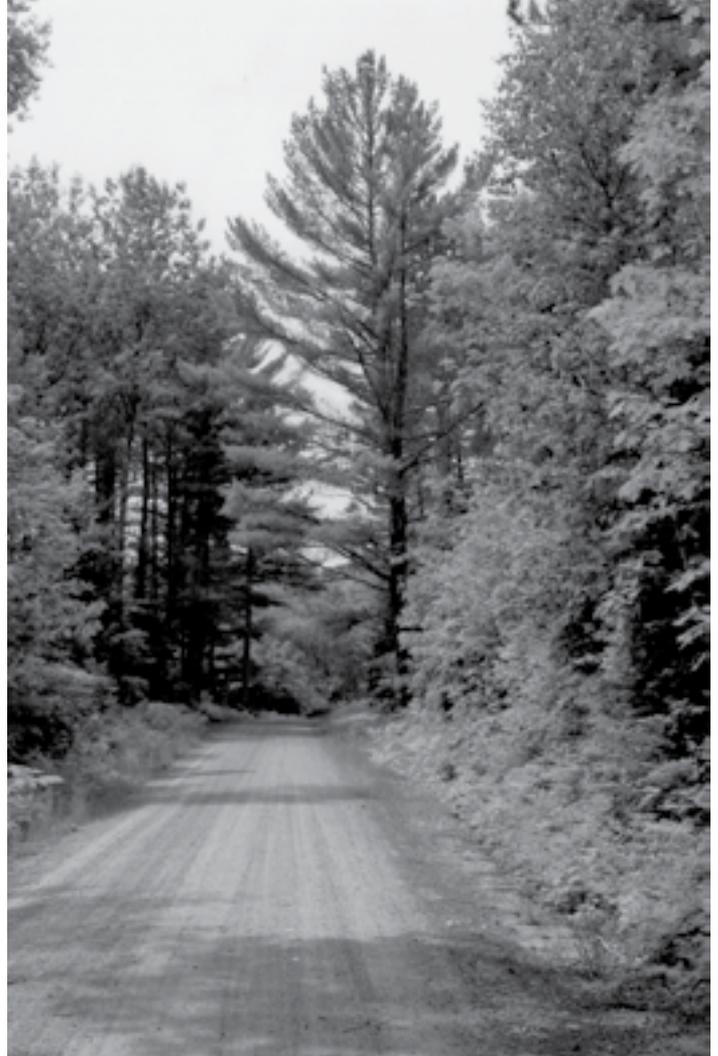
Comparison of Benefit Options

The chart on the following pages is designed to compare Uniform Benefits, the Standard Plan and the Medicare Plus Plan.

This outline is not intended to be a complete description of coverage. The Uniform Benefits package is described in detail in your *It's Your Choice Reference Guide*. Details for the other plans are found in the *Standard Plan* (ET-2131), and the *Medicare Plus* (ET-4113) 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_Local-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 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 Uniform Benefits medical services when employer selects deductible option. Deductible applies to Standard Plan services. Deductible does not apply to certain preventive services and prescription drugs.
- ² PPOs have out-of-network deductibles. See PPO Plan Descriptions (WEA Trust) for details.
- ³ Coinsurance out-of-pocket limit (OOPL) does not include deductible.
- ⁴ PPOs have out-of-network coinsurance. See health plan descriptions for details.
- ⁵ As required by federal law see list at: healthcare.gov/what-are-my-preventive-care-benefits. Note: coinsurance may vary by age.
- ⁶ This is separate from other out-of-pocket limits (OOPLs), such as the medical.
- ⁷ Level 3 copays do not apply to the OOPL.
- ⁸ Medicare Plus supplements Medicare's payment up to 100% coverage. If Medicare denies, this plan also denies except as stated.

2015 Comparison of Benefit Options

BENEFIT	TRADITIONAL UNIFORM BENEFITS	STANDARD PLAN (If under Medicare Age)		MEDICARE Plus (and Medicare Part A, B and D ⁸)
		Preferred Provider	Non-Preferred Provider	
Annual Deductible ¹	No deductible ²	\$100 individual/ \$200 family	\$500 individual/ \$1,000 family	No deductible
Annual Coinsurance & OOP ³	As described below ⁴	None	80%/20% Annual OOP (includes deductible): \$2,000 individual/\$4,000 family	100%
Maximum Out-of-Pocket Limit (MOOP)	For non-Medicare members \$6,600 single/\$13,200 family for federally required essential health benefits. For Medicare eligible and enrolled, none.	\$6,600 single/\$13,200 family for federally required essential health benefits	None	None
Routine Preventive	100%	100% ⁵	Deductible and coinsurance	100% covered by Medicare only
Hospital Days	As medically necessary, plan providers only. No day limit.	Deductible, as medically necessary. No day limit.	Deductible and coinsurance, as medically necessary. No day limit.	100% 120 days; semi-private room
Emergency Room	\$60 copay per visit	\$75 copay per visit, deductible thereafter	\$75 copay per visit, Preferred Provider deductible and coinsurance thereafter	100%, no copay
Ambulance	100%	Deductible	Deductible and coinsurance	100%
Transplants (May cover these and others listed)	Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney with pancreas, heart with lung, and lung	Deductible bone marrow, musculoskeletal, corneal, and kidney	Deductible and coinsurance bone marrow, musculoskeletal, corneal, and kidney	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, outpatient, and transitional, 100%	Deductible	Deductible and coinsurance	Inpatient 100%, up to 120 days. Outpatient and transitional 100%
Hearing Exam	100%	Benefit for illness or disease to deductible	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease 100%

Footnotes are explained on Page 22.

2015 Comparison of Benefit Options

BENEFIT	TRADITIONAL UNIFORM BENEFITS	STANDARD PLAN (If under Medicare Age)		MEDICARE Plus (and Medicare Part A, B and D ⁸)
		Preferred Provider	Non-Preferred Provider	
Hearing Aid (per ear)	Every 3 years: Adults, 80%/20%, up to \$1,000 (not to OOP). Dependents younger than 18 years, 100%, maximum does not apply.	For dependents younger than 18 years only, every 3 years—deductible	For dependents younger than 18 years only, every 3 years—deductible and coinsurance	For dependents younger than 18 years only, every 3 years—100%
Cochlear Implants	Adults, 80%/20% for device, surgery, follow-up sessions (not to OOP); 100% hospital charge for surgery. Dependents under 18, 100%.	Dependents under 18, deductible for device, surgery, follow-up sessions	Dependents under 18, deductible and coinsurance for device, surgery, follow-up sessions	Dependents under 18, 100% for device, surgery, follow-up sessions
Routine Vision Exam	One per year	100% for children; illness or disease only, deductible	No benefit for routine; illness or disease only, deductible and coinsurance	No benefit for routine; illness or disease only, 100%
Skilled Nursing Facility (non custodial care)	120 days per benefit period	Deductible, as Medically Necessary, 120 days per benefit period	Deductible and coinsurance, as Medically Necessary, 120 days per benefit period	100% 120 days/ benefit period at Medicare-approved facility. At non-Medicare-approved facility, if transferred within 24 hours of hospital release, benefits payable up to 30 days/ confinement
Home Health (non custodial)	50 visits per year; plan may approve an additional 50 visits	Deductible, 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	100%
Physical/Speech/ Occupational Therapy	50 visits per year; plan may approve an additional 50 visits	Deductible, 50 visits per plan year; plan may approve an additional 50 visits	Deductible, 50 visits per plan year; plan may approve an additional 50 visits	100%
Durable Medical Equipment	80%/20% coinsurance, \$500 OOP	Deductible	Deductible and coinsurance	100%

Footnotes are explained on Page 22.

2015 Comparison of Benefit Options

BENEFIT	TRADITIONAL UNIFORM BENEFITS	STANDARD PLAN (If under Medicare Age)		MEDICARE Plus (and Medicare Part A, B and D ⁸)
		Preferred Provider	Non-Preferred Provider	
Hospital Pre-Certification	Varies by plan	WPS Medical Management for inpatient stays	WPS Medical Management for inpatient stays	Not required
Referrals	In-network varies by plan; out-of-network required.	Not required	Not required	Not required
Treatment for Morbid Obesity	Excluded	Deductible in-network provider. Surgical treatment requires prior authorization.	Non-preferred provider deductible and coinsurance. Surgical treatment requires prior authorization.	100% for Medicare-covered service
Oral Surgery	11 procedures	23 procedures—deductible	23 procedures—deductible and coinsurance	100%
Dental Care (if offered)	Uniform Dental Benefit	No benefit	No benefit	No benefit
Drug Copays and OOPL ⁶ (non-specialty)	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$410 individual/\$820 family	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 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	Preferred drugs \$15 to OOPL \$1,000 individual/\$2,000 family; Non-preferred drugs \$50, no OOPL	Not applicable	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	Not applicable	Preferred drugs \$50 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

Footnotes are explained on Page 22.

Choose Your Health Plan

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_Local_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 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 website.

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.

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.

We are excited to offer the uniform dental coverage to enrolled WPE plan employees and their families in 2015! Please refer to your Uniform Benefits Reference Guide for the specific benefits available under the plan.

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



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.

We are excited to offer the uniform dental coverage to enrolled WPE plan employees and their families in 2015! Please refer to your Uniform Benefits Reference Guide for the specific benefits available under the plan.

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 2 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.

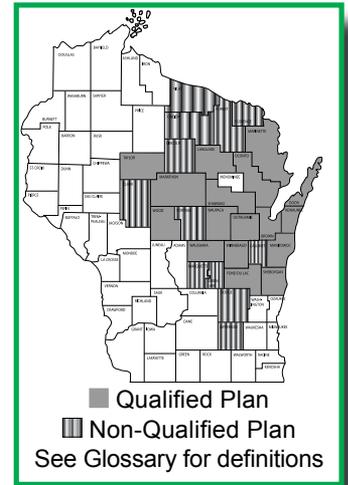
Dental Benefits

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 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.



Dean Health Insurance

1-800-279-1301

deancare.com/wi-employees



Overall Performance Rating

What's New for 2015

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

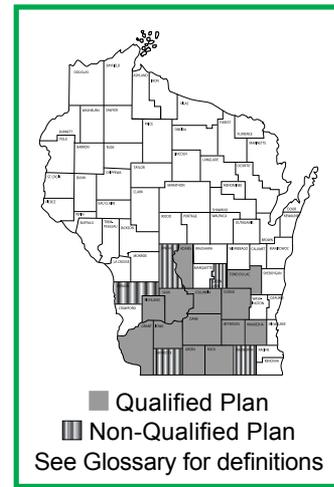
Referrals are not needed when receiving care from in-network providers. Prior authorization is required for certain services, procedures and for out-of-network providers before you receive care. You will receive written notification of the approval or denial for the prior authorization. You may check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

No dental coverage is provided under this plan.

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



Overall Performance Rating

What's New for 2015

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" to search for providers online, or Select "Printable Provider Directory" for a static 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

No dental coverage is provided under this plan.

24-Hour Nurseline

Prevea Care After Hours 1-888-277-3832



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

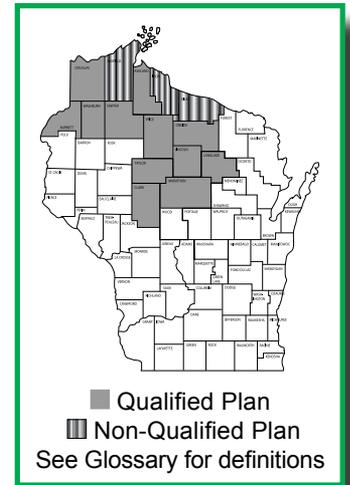
No referral is needed to see a provider in the Cooperative's network. Prior authorization guidelines may apply for certain services; please contact Member Services at 1-888-203-7770 for additional information. Please refer to the provider directory for a listing of mental health providers in the Cooperative's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

Dental Benefits

No dental coverage is provided under this plan.

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

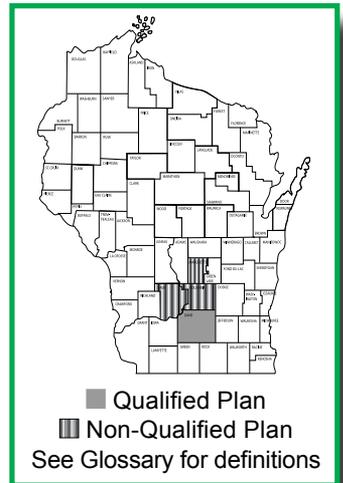
When you need mental health services, contact GHC-SCW mental health triage at 608-441-3290. Please refer to the GHC-SCW Provider Directory. A referral is not required for services provided in a GHC-SCW clinic. A referral is needed for transitional, outpatient and/or inpatient care.

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



Overall Performance Rating

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

No dental coverage is provided under this plan.

24-Hour Nurseline

Careline 1-800-551-0859

Humana – Eastern

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.

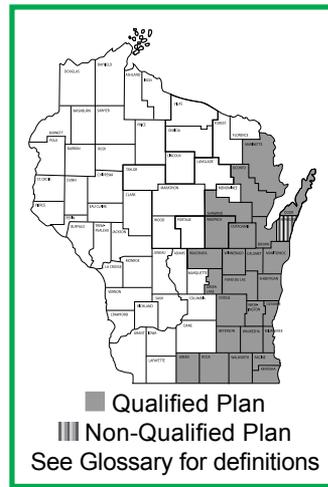
To request a printed directory be mailed to you, call 1-855-786-3944.

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

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 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

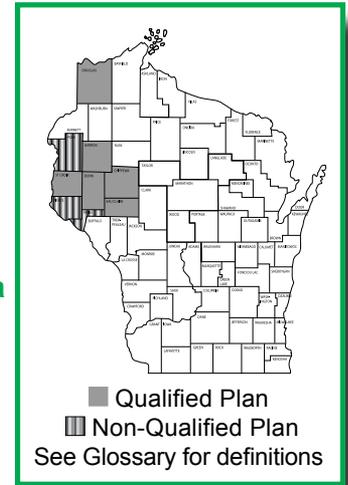
Prior to seeking mental, behavioral health or substance abuse services, contact 1-855-STOFWIH or 1-855-786-3944 between 8 a.m. and 5:30 p.m. for assistance from a behavioral health specialist.

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 healthcare. 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



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

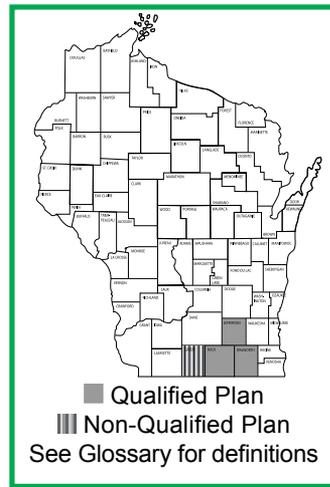
No prior authorization or referral is required for outpatient services from an in-network provider. Prior authorization and referral is required for inpatient services and transitional care out-of-network. For other services, contact 1-800-895-2421.

Dental Benefits

No dental coverage is provided under this plan.

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



Overall Performance Rating

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

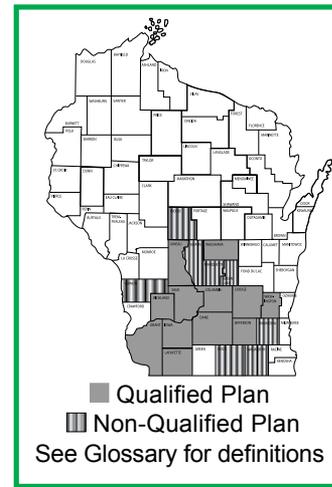
Contact UW Behavioral Health at 608-417-4709 for prior authorization or provider information, Monday through Friday, 8 a.m. to 5 p.m. A mental health professional will assess your situation and refer you to the appropriate provider. For emergencies, please contact your therapist directly or call 911.

Dental Benefits

No dental coverage is provided under this plan.

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

No dental coverage is provided under this plan.

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 booklet* (ET-2112).

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

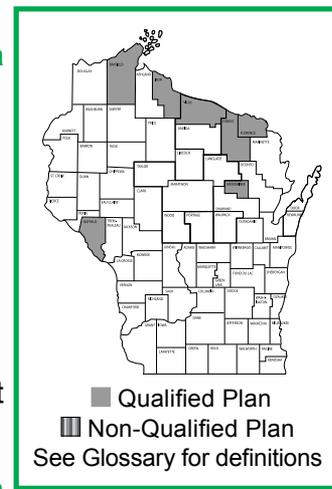
Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their licenses and processed based on the provider's network status.

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
1-800-846-4678 myuhc.com


Overall Performance Rating

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

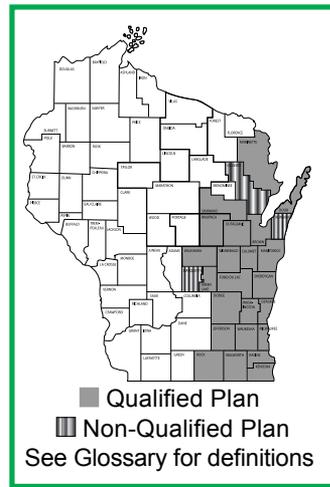
You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception." You are responsible for notifying 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



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

No dental coverage is provided under this plan.

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

No dental coverage is provided under this plan.

24-Hour Nurseline

Not available.



WEA Trust – East

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.

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

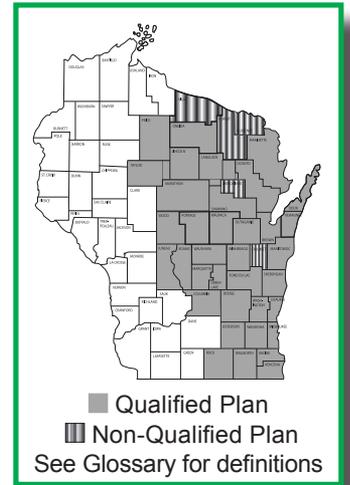
Dental services are provided through Delta Dental of Wisconsin. Go to deltadentalwi.com or call 1-800-236-3712 for a provider directory.

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



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-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.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions



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

Notes

Other Benefits



Pharmacy—NAVITUS HEALTH SOLUTIONS™

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

www.navitus.com

Formulary Information

The four-level formulary requires copayments of \$5 (Level 1), \$15 (Level 2), \$35 (Level 3) and \$50 (Level 4). 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 Navigate 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), 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 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.

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



NAVITUS HEALTH SOLUTIONS™—Pharmacy

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

www.navitus.com

copayments will apply. More detailed information can be found on the Navitus website; the WellDyneRx website (<https://www.welldynex.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 Wisconsin Public Employers plan. Coordination of benefits does not guarantee that all of your out-of-pocket costs will be covered.

Pharmacy—NAVITUS MedicareRx (PDP)

Underwritten by 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 Wisconsin Public Employers 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 NOTICE 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 Wisconsin Public Employers 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

Underwritten by 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 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 local government employees coverage of up to five times annual earnings—the Basic, Supplemental and Additional plan each base earnings on your highest prior calendar year’s earnings with your current employer, rounded up to the next thousand. The amount of coverage available depends on which plans are offered by your employer.

- **Basic Plan** coverage will continue in a reduced amount for your lifetime, without cost, for eligible retirees over age 65 and for active employees over age 70.
- **Supplemental Plan** provides coverage up to age 65, if retired, or age 70 if an active employee.
- **Additional Plan** provides up to three units of coverage. Depending on how many levels of coverage are offered by your employer, you may choose one, two or three units of Additional coverage. Coverage 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 Insurance Premiums**
Retirees who have WPE life insurance and reached age 66 or 67—depending on the post-retirement benefit selected by your employer—may be eligible to convert the present value of their life insurance to pay ETF-administered health 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 for more information.

• Eligibility and Enrollment

You have an open enrollment opportunity for life insurance coverage if you:

- are under age 70, and
- 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 before becoming eligible for the coverage may be insured under the Additional Plan only, 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 or 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

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 and 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 www.wdc457.org

Notes

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 6 through 9), 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.



Department of Employee Trust Funds
Health Insurance Application/Change Form

801 W. Badger Road
 PO Box 7931
 Madison, WI 53707-7931
 1-877-533-5020 (toll-free)
 Fax: 608-267-4549
etf.wi.gov

- Please complete the requested information and return to your employer (or ETF for Retirees/Continuants) as soon as possible. Only complete if you are the employee/retiree/continuant applying for coverage.
- Read the Terms and Conditions accompanying this application **prior** to signing and submitting to your employer (or ETF for Retirees/Continuants).
- HDHP is a High Deductible Health Plan as explained in the Information pages under Section 4.
- For detailed information regarding eligibility requirements, please read the informational pages attached.
- For information on required documentation (☺), please see the included chart “Documentation Requirements” on Page 10.
- Contact your employer (or ETF for Retirees/Continuants) with any questions not answered here.

***Indicates required field**

ICY = Annual It's Your Choice

1. APPLICANT INFORMATION Please print		ETF Member ID*		SSN*					
First name*		M.I.	Last name*		Previous name				
Home mailing address*—street and No.			City*	State*	ZIP code* <input type="checkbox"/> Check here if updating address, name, phone, e-mail or marital status.				
Primary phone No.* ()		Country (if not USA)		Applicant e-mail					
Birth date*		Gender* <input type="checkbox"/> M <input type="checkbox"/> F		Physician/Clinic*					
Marital or domestic partnership (DP) status* <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> DP <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed									
Event Date* _____ (not required for single)									
2.SPOUSE/DOMESTIC PARTNER (DP) INFORMATION <input type="checkbox"/> Check here if <i>only updating</i> spouse/DP information				SSN*					
Name* (First, M.I., Last)			Previous name		Birth date*				
Physician/Clinic*			Tax dependent <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender* <input type="checkbox"/> M <input type="checkbox"/> F				
3.DEPENDENT INFORMATION: (Excludes spouse/DP) Add Coverage, Add Dependent, Remove Dependent <input type="checkbox"/> Check here if <i>only updating</i> dependent information									
Social Security number*	First name*	M.I.	Last name*	Birth date*	Gender*	Rel. code*	Tax dep?	Disabled?	Enter Clinic/Physician* or Provide Dependent Address for COBRA, if removing (may attach separate sheet).



4. ENROLLMENT INFORMATION	New Hire or Return from Leave and Coverage has Lapsed —I want my coverage to be effective:	
	<input type="checkbox"/> When employer contributes to premiums <input type="checkbox"/> As soon as possible (employee will pay entire monthly premium until eligible for employer contribution)	<input type="checkbox"/> I Decline/Waive Coverage <input type="checkbox"/> I Decline coverage because I have other coverage

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

Coverage desired* <input type="checkbox"/> Single <input type="checkbox"/> Family	Are you selecting an HDHP health plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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.
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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 <input type="checkbox"/> Spouse/DP to spouse/DP transfer <input type="checkbox"/> Transfer from one employer to another employer Previous Employer* _____ <input type="checkbox"/> HIPAA (birth, adoption, marriage, DP, divorce) <input type="checkbox"/> LTE new hire (state only) <input type="checkbox"/> Loss of Other Coverage/Employer Contributions <input type="checkbox"/> IYC (eff. Jan. 1) <input type="checkbox"/> COBRA (ET-2311 required) <input type="checkbox"/> State retiree re-enroll Effective date* _____ <input type="checkbox"/> Other _____	Add dependent <input type="checkbox"/> HIPAA (birth, adoption, marriage, DP, divorce) <input type="checkbox"/> National medical support notice <input type="checkbox"/> Paternity acknowledgment <input type="checkbox"/> Legal ward/guardianship <input type="checkbox"/> Eligible dependent not on initial enrollment (excludes DP and adult dependents) <input type="checkbox"/> Loss of other coverage/ employer contributions <input type="checkbox"/> Disabled, age 26+ <input type="checkbox"/> IYC (eff. Jan. 1) <input type="checkbox"/> Other _____	Remove dependent <input type="checkbox"/> Divorce/DP terminated <input type="checkbox"/> Death of dependent <input type="checkbox"/> Legal ward/guardianship ends <input type="checkbox"/> Disabled dependent: Disability ends or support and maintenance less than 50%. <input type="checkbox"/> Grandchild's parent turns age 18 <input type="checkbox"/> Adult dependent eligible for other coverage <input type="checkbox"/> IYC (eff. Jan 1) <input type="checkbox"/> Other _____
Event date* _____	Event date* _____	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.

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

Stay Informed

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

