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GENERAL INFORMATION

1. Who should use this booklet?

- All insured health plan subscribers should use this booklet throughout the year as a reference. Also, the Uniform Benefits in Section (D) is the benefits certificate for those enrolled in alternate health plans and SMP (but not the Standard plan or Medicare Plus \$1,000,000).
- Currently-insured retirees who, during the October Dual-Choice Enrollment period, are changing to a different plan for the following calendar year.
- Currently-insured retirees who wish to change from single to family coverage without incurring waiting periods or exclusions for pre-existing conditions. This is generally possible only during the Dual-Choice Enrollment period.
- Former employees and/or dependents who are insured under the health insurance continuation option.
- COBRA continuants. Those individuals who are covered for a maximum of 36 months following a qualifying event as defined in the Consolidated Omnibus Reconciliation Act of 1986 (COBRA).

2. Which annuitants are eligible for State of Wisconsin group health insurance?

The State of Wisconsin Group Health Insurance program will cover state retirees who are enrolled at the time of retirement and whose retirement annuity from the Wisconsin Retirement System (WRS) begins within 30 days after employment ends. Insured employees who terminate employment and have 20 years of WRS creditable service are eligible to continue the State Group Health Insurance program even if the annuity is deferred if a timely application is submitted. State employees receiving a WRS disability benefit are also eligible.

The following former state employees whose coverage has been cancelled or has elapsed may apply for coverage under the State Group Health Insurance program:

1. Retired state employees receiving a WRS retirement annuity or a lump sum benefit under Wis. Stat. § 40.25(1); or
2. Terminated state employees with 20 years of WRS creditable service who remain as inactive WRS participants and are not eligible for an immediate annuity.

The health insurance coverage will be effective the first of the seventh month following the application receive date (or the 1st of the 7th month after receiving your 1st annuity

payment or lump sum payment, whichever is later) with no restrictions. You will be responsible for the full amount of the premiums. Contact Employee Trust Funds for additional information.

3. *Where can I get more information?*

Health Plans and Pharmacy Benefit Manager

The best source of information regarding benefits and services is from the plans themselves. You should ask that they provide written clarification on specific benefit questions. **See the inside back cover of this booklet for the addresses and telephone numbers of available plans.**

All state plans have descriptive brochures. These brochures are available by contacting the plans directly. Prior to Dual-Choice each year, many plans will mail new brochures directly to your home.

Dual-Choice Health Fairs

Each year during Dual-Choice, health fairs are scheduled throughout the state. Representatives from the area plans are available to provide you with information about their plans. See the health fair schedule in Section F of this booklet.

4. *Privacy of Social Security Number*

If you prefer that your ID number be different from your Social Security number, you may request that your plan assign a different number to you. This should be done prior to the first of the year when new cards are issued. Please note that your PBM ID number will not be your Social Security number.

Another method to follow, if you have your Social Security number memorized, is to black it out on your ID card and verbally inform your provider of it upon request.

HEALTH INSURANCE COMPLAINT PROCESS

5. *What if I have a complaint about my health plan or Pharmacy Benefit Manager?*

Each of the plans participating in the State of Wisconsin health insurance program is required to have a complaint and grievance resolution procedure in place to help resolve participants' problems. Your plan has information on how to initiate this process. You must exhaust all of your appeal rights through the plan. If the plan upholds its denial, it will state in its final decision letter your options if you wish to proceed further.

Depending on the nature of your complaint, you may be given rights to request an independent review through an outside organization approved by the Office of the

Commissioner of Insurance. This option becomes available when a plan has denied services as either not medically necessary or experimental. **It is important to note that if you choose to have an independent review organization (IRO) review the plan's decision, that decision is binding on both you and your plan and you have no further rights to a review through the Department of Employee Trust Funds.**

6. How can the Department of Employee Trust Funds help me if I disagree with my health plan's grievance decision?

As a member of the State of Wisconsin group health insurance program, you have the right to request an administrative review through ETF if an IRO has not rendered a decision on your grievance. To initiate a ETF review, you may call or send a letter to ETF and request an insurance complaint form (ET-2405). Complete the ETF complaint form and attach all pertinent documentation, including the plan's response to your grievance.

Please note that the ETF review will not be initiated until you have completed the grievance process available to you through the plan. After your complaint is received, your complaint is acknowledged and information is obtained from the health plan. An ombudsperson in the Quality Assurance Services Bureau will review and investigate your complaint and attempt to resolve your dispute with your plan. If the ombudsperson is unable to resolve your complaint in your favor, you will be notified of additional administrative review rights available through the Department.

If you have a dispute with your plan, and have questions concerning the review options available to you, feel free to contact ETF and request to speak with an ombudsperson.

ENROLLING FOR COVERAGE

ANNUITANT ENROLLMENT

7. When can I enroll in health insurance as an annuitant?

When you retire, your health insurance plan will automatically continue if your retirement annuity from the Wisconsin Retirement System (WRS) begins within 30 days after your employment termination date. If you terminate employment after 20 years of creditable service but are not eligible for an immediate annuity, your completed application must be received by Employee Trust Funds within 90 days of your termination of employment to continue coverage. You may switch coverage to any other available plan during the Dual-Choice Enrollment period.

8. What if I didn't have coverage at retirement or if coverage later lapsed?

If you are a former state employee receiving a retirement annuity (or have received a lump sum retirement benefit), you may enroll or re-enroll in the state health insurance program by submitting a health insurance application. This option is not available to survivors or dependents. There is a six-month waiting period before your coverage becomes effective (that is, the first day of the seventh month after the health insurance application is received by Employee Trust Funds (ETF). Contact ETF for details on this process. You would not be eligible to use any sick leave credits to pay premiums if you enroll under this provision.

Please note: Separate enrollment opportunities to re-enroll for coverage apply to those who have escrowed their sick leave. See questions 10 and 11.

9. When must I apply for Medicare?

Enrollment in Medicare Part A is automatic when you turn age 65. The requirement to enroll for Medicare coverage Part B is **deferred for active employees and their dependents** until the subscriber's termination of the WRS-covered employment through which active employee health insurance coverage is provided.

Coverage as offered by any of the state plans is the same for everyone regardless of age or Medicare eligibility.

If you are **retired** or are a surviving spouse or dependent and are eligible for coverage under the federal Medicare program, you must immediately enroll in both Part A and Part B of Medicare unless you are otherwise employed and have health insurance coverage through that employment. **IF YOU DO NOT ENROLL FOR ALL AVAILABLE PORTIONS OF MEDICARE UPON RETIREMENT, YOU MAY BE LIABLE FOR 80% OF YOUR CLAIMS ON THE DATE MEDICARE COVERAGE WOULD HAVE BECOME EFFECTIVE.** However, if you or your insured spouse is also insured as an active employee under a non-state group plan, enrollment in Medicare may be deferred until retirement from that job.

Once you receive your Medicare card, please send a photocopy to the ETF.

Because all plans have coverage options that are coordinated with Medicare, you will remain covered by the plan you selected after you are enrolled in Medicare. HMO coverage does not change. The plan will simply not duplicate benefits paid by Medicare. Prescription drugs will continue to be covered.

If you are enrolled in the Standard Plan, or SMP Plan, your coverage will be changed to the Medicare Plus \$1,000,000

plan when you enroll in Medicare Parts A and B.

OTHER ENROLLMENT INFORMATION

10. What if I lose other coverage?

You can take advantage of a special 30-day enrollment period to become insured under the state health insurance program **without waiting periods or exclusions for pre-existing conditions if:**

1. Your annuity began (or you received a lump sum retirement benefit) within 30 days after your employment termination date; AND,
2. You have escrowed your sick leave account; AND,
3. You and/or your dependents are not insured under the state health program because of being insured under a group health insurance plan elsewhere; AND,
4. Your eligibility for that other coverage is lost; or
5. The employer's premium contribution for the other coverage ceases.

To enroll, submit a health insurance application form and other information documenting the loss of coverage or loss of the employer's premium contribution within 30 days of the date the other coverage ended. The coverage will be effective on the date the other coverage or the employer's premium contribution ends.

This enrollment opportunity is also available to employees and/or dependents who lose medical coverage under medical assistance (Medicaid), as a dependent of a member of the U.S. Armed Forces, or as a citizen of a country with national health care coverage comparable to the Standard Plan.

The enrollment period begins on the date the other group health insurance coverage terminates because of loss of eligibility or the employer's premium contribution toward the other coverage ceases (for example, termination of employment, divorce, etc., but not voluntary cancellation of coverage).

NOTE: If other coverage ends due to voluntary cancellation, you may be eligible for State health coverage with a waiting period before coverage becomes effective. (See **Question 8: What if I didn't have coverage at retirement or if coverage later lapsed?** for further information.)

If you are currently enrolled in the State Group Health Insurance program, but with single coverage because of your spouse being insured under a group health insurance

plan elsewhere, and she/he loses eligibility or the employer contribution for that coverage ends, this special enrollment opportunity would also allow you to change from single to family coverage to insure her/him.

11. Can I delay or initiate use of sick leave credits after I retire?

Yes. Under a new law provision, retirees receiving a WRS annuity or surviving insured dependents may elect to delay use (escrow) or initiate use (unescrow) of sick leave credits annually. In order to escrow, you must certify that you have health coverage comparable to the State of Wisconsin's Standard Plan. You may escrow only once during a calendar year. You may unescrow during Dual-Choice for coverage effective January 1 of the following year or the first of the month in the following year that you select. If you lose your comparable coverage, or the contribution for it (if it is an employer sponsored plan) you may unescrow (re-enroll) by filing an application within 30 days of the loss.

12. When and how must I notify my health plan of various changes?

Always file the approved forms through Employee Trust Funds to notify your plan of changes. Request applications from Employee Trust Funds.

There are two types of changes, which require a health application.

1. Change in plan (for example, from HMO to Standard Plan)
2. Change in plan coverage (for example, from Single to Family)

All changes in coverage are accomplished by completing an approved application **within 30 days after the change occurs.**

Other changes should be accomplished by submitting a *Health Insurance Information Change* form. These other changes would include:

- Name change
- Change of address
- Addition/deletion of a dependent to an existing family plan
- Changing primary physicians within an HMO network

RE-EMPLOYED ANNUITANTS

13. How are my health benefits affected by my return to work (for an employer not under the WRS)?

If you return to work for a non-WRS participating employer after retirement, your WRS annuity and health benefits will not be affected.

14. How are my health benefits and premiums affected by my return to work (for an employer who is under the WRS)?

If you return to work for a WRS participating employer, you may be eligible to once again become an active WRS employee. If you make this election and become an active WRS employee, your annuity will be cancelled and you will no longer be eligible for health insurance as a retiree/annuitant. You will be eligible for health insurance as an active WRS employee through your WRS participating employer if the employer is participating in an ETF health plan. Check with your employer to make sure you have other health insurance coverage available before you elect WRS participation.

As a state annuitant, if you were paying for your health insurance from your converted sick leave credit account, your account will be inactivated if you return to work for a state government employer. Your sick leave credit account will be activated again when you re-retire. Any sick leave credit you accumulate during re-employment with a state government employer will be added to the balance in your account when you re-retire. If your re-employment is with a local government employer, and you have comparable health insurance coverage, you may escrow your sick leave account balance. Contact ETF for an escrow form. Your sick leave credit account balance will be available to you when you re-retire.

You may also waive or terminate enrollment under Medicare until the first Medicare enrollment period after active WRS employment ceases. Your premium rates while covered through active employment will be the active employee rates shown on page A-4, not the Medicare rates.

When you subsequently terminate employment, eligibility for State group health coverage is once again dependent on your meeting the requirements for newly retired employees (that is, you must be insured and you must apply for an immediate annuity from the WRS).

15. What if I'm a disability annuitant who returns to work?

If you are a disability annuitant under § 40.63(1) who is under normal retirement age and return to any employment, you are subject to a flat rate earnings limit. If you exceed your earnings limit, your disability annuity is **suspended**, but you will remain eligible for health insurance as an annuitant.

If you are receiving a disability annuity, you may not actively participate in the WRS until it is determined that you are no longer eligible for a disability annuity because of medical certification. If your disability annuity is **terminated**, and you are employed by a WRS participating employer, you will become eligible for the health insurance offered by your

employer.

- If you return to state employment, you must file a new health application within 30 days after the date you resume active status under WRS.
- If you return to local public employment, you lose eligibility to remain in the state group health program. You may enroll in your public employer's health program (if one is offered), or you may elect continuation coverage of the state health insurance for up to 36 months by applying within 60 days of being notified by Employee Trust Funds of your right to continue.

IMPORTANT CAUTION: Continuation coverage will end after 36 months. It does **NOT** make you eligible to re-enroll in the state plan when you terminate. You will only be eligible for the health insurance your employer offers its retirees, subject to its rules and requirements.

SINGLE/FAMILY ELIGIBILITY

SINGLE VS FAMILY COVERAGE

Single coverage covers you only. Family coverage covers you, your spouse, and your unmarried dependent children, stepchildren, and legal wards. All eligible dependents are covered without exception under a family contract. A subscriber may not choose to exclude an eligible dependent from coverage. Your grandchildren may be covered if the parent is your unmarried dependent and is under age 18. Upon request, you must provide official documentation of dependent eligibility. No other relatives (for example, parents, grandparents, etc.) or domestic partners may be covered under a family contract.

16. When can I change from single to family coverage without restrictions?

You may change from single to family coverage during the Dual-Choice Enrollment period with family coverage becoming effective on the following January 1. In addition, coverage may be changed from single to family coverage without restrictions if an application is received by Employee Trust Funds within **30** days of the following events:

- Marriage
- Birth or adoption of a child (application must be submitted within 60 days of the event)
- A single father declaring paternity
- An unmarried parent whose only eligible child resumes full-time student status or becomes disabled (as defined in Uniform Benefits) and thus is again an eligible dependent

- All eligible dependents lose eligibility for other medical coverage. (See **Question 10: What if I lose other coverage?**)
- Upon order of a Federal Court under a National Medical Support Notice. This can occur when a parent has been ordered to insure his/her eligible child(ren) who are not currently covered.

Coverage becomes effective on the date of the event (for example, date of birth, marriage, etc.). All eligible dependents will then be covered.

If the application is not received during Dual-Choice or within 30 days of the above events (60 days for birth or adoption), or if you wish to change from single to family coverage for any other reason (for example, custody of children is transferred after a divorce), you may still change from single to family coverage. However, you are limited to coverage under the Standard Plan until you are able to select a different plan during a subsequent Dual-Choice Enrollment period. A 180-day waiting period for coverage of pre-existing medical conditions (except pregnancy) will apply to a newly added spouse and dependents. The waiting period for pre-existing conditions will also apply to you (the subscriber) unless you are enrolled in the Standard Plan at the time of the change to family coverage. The waiting period does not apply to children born or adopted after the effective date of the coverage change.

17. When can I change from family to single coverage?

You may change from family to single coverage at any time by submitting an application to Employee Trust Funds. The change will be effective on the first day of the month following receipt of your application.

Switching from family to single coverage is deemed to be a voluntary cancellation of coverage for all covered dependents. Voluntary cancellation is not considered a “qualifying event” for continuation coverage.

18. What if I am a single mother or a father establishing paternity?

An insured single parent may cover his or her dependent child effective with the child’s birth or adoption by submitting a timely application changing from single to family coverage.

Children born outside of marriage become dependents of the father on the date of the court order declaring paternity or on the date the “Voluntary Paternity Acknowledgment” (form HCF 5024) is filed with the Department of Health and Family Services or equivalent if the birth was outside the state of Wisconsin. The effective date of coverage will be the date of birth if a statement of paternity is filed within **60** days

of the birth.

19. What if my spouse is also a state or university employee or annuitant?

If your spouse is also an eligible state or university employee or annuitant:

- you may each retain or select single coverage;
- OR
- one of you may retain or select family coverage, which will cover your spouse and any eligible dependents.

If the husband and wife are each enrolled for single coverage, one of the single contracts may be changed to a family plan at any time without restriction and the other single contract will be cancelled. Family coverage will be effective on the beginning of the month following receipt of a Health Insurance Application.

One family policy can be split into two single plans with the same carrier effective on the beginning of the month following receipt of a Health Insurance Application from both husband and wife. However, if you and your spouse each have single coverage, no dependents are covered and if one of you should die, that individual's sick leave credits will not be available for use by the surviving spouse.

The named subscriber for the family coverage can be changed to the other spouse at any time. Coverage can be effective on the beginning of the month following receipt of a *Health Insurance Application* (ET-2301).

If, at the time of marriage, the employees and/or annuitants each have family coverage or one has family coverage and the other has single coverage, **coverage must be changed to one of the options listed above within 30 days of the marriage**. Failure to comply with this requirement may result in denial of claims for eligible dependents.

Note: Change from single to family coverage due to marriage is effective the date of marriage if the *Health Insurance Application* is postmarked within 30 days of the marriage.

20. What family changes need to be reported?

- Change of name, address, telephone number, and Social Security number, etc.
- Addition of a dependent
- Loss of a dependent's eligibility for coverage
- Marriage
- Divorce
- Death
- Eligibility for Medicare
- Obtaining or losing other health insurance coverage

DEPENDENT CHILDREN

21. Who is eligible as a dependent?

If you select family coverage, your eligible dependents are your spouse and unmarried children. Unmarried children are eligible for coverage to the end of the year in which they turn age 19 or age 25 if they are full-time students and are dependent upon you and/or the other parent for at least 50% of their support, meet the support tests as a dependent for federal income tax purposes (whether or not the dependent is claimed) and are: (See **Question 27 When does health coverage terminate for dependents?**)

- Your natural children
- Adopted children and pre-adoption placements.
Coverage will be effective on the date that a court makes a final order granting adoption by the subscriber or on the date the child is placed for adoption with the subscriber, whichever occurs first. These dates are defined by § 632.896, Wis. Stat. If adoption is not finalized, the insurer may terminate the child's coverage when the adoptive placement ends.
- Legal wards who became permanent wards of the subscriber before age 19. Coverage will be effective on the date that a court order awards permanent guardianship to the subscriber.
- Stepchildren
- Grandchildren born to insured dependent children may be covered until the end of the month in which your insured dependent (your grandchild's parent) turns age 18. Your child's eligibility as a dependent is unaffected by the birth of the grandchild. The grandchild may be eligible for coverage as a continuant. (See **CONTINUATION OF HEALTH COVERAGE.**)

22. What if I don't have custody of my children?

Even though custody of your child may have been transferred to the other parent, you may still insure the child if the other dependency requirements are met.

23. What if I have a child with physical or mental disabilities?

If your unmarried child has a physical or mental disability that is expected to be of long-continued or indefinite duration, and is incapable of self-support, the age limits and student status requirements do not apply. You will be required to verify your dependent's eligibility at least annually. We recommend you contact the plan for pre-approval.

If your child loses eligibility for coverage due to age or loss

of student status, but you are now indicating that the child meets the disabled dependent definition, eligibility as a disabled dependent must be established before coverage can be continued. Electing COBRA continuation coverage should be considered while his or her eligibility is being verified. If it is determined that the individual is not eligible as a disabled dependent, there will not be another opportunity to elect COBRA. If it is determined that the child is eligible for coverage as a disabled dependent, coverage will be retroactive to January 1 or the date of disability, whichever is later, and premiums paid for continuation coverage will be refunded.

24. What does full-time student mean?

Student means a person who is enrolled in and attending an institution that provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. A student is considered to be enrolled on the date that person is recognized as a full-time student by the institution (for example, the first day of class). Student status includes any intervening vacation period if the child continues to be a full-time student. It does not include on-the-job training courses, correspondence schools, intersession courses (for example courses during winter break), night schools, and post-graduation student commitments. You will be required to verify your dependent's eligibility annually.

25. Will an HMO cover dependent children who are living away from home?

Only if the HMO offers services in the community in which the child resides. Emergency or urgent care services are covered wherever they occur. However, non-emergency treatment must be received at a facility approved by the HMO. Outpatient mental health services and treatment of alcohol or drug abuse may be covered. Refer to the **UNIFORM BENEFITS** Section D. Contact your HMO for more information.

26. How is student status monitored for covered dependents?

If there are full-time students covered under a family plan, the plan will annually send a questionnaire to the insured, which asks where the students are attending school and the anticipated date of graduation. If the questionnaire is not completed and returned, the plan may delete the student(s) from the contract. Medical and prescription drug claims would then be rejected. If deleted in error, students can be reinstated to the contract upon documentation of student status, including a *Health Insurance Information Change* form (ET-2329). Charges for services rendered during the period of deletion would then be covered. However, it is

required that you to notify Employee Trust Funds if student status terminates. Failure to do so may result in the loss of continuation rights.

27. When does health coverage terminate for dependents?

Coverage for **dependent children** who are not physically or mentally disabled terminates on the **earliest** of the following dates:

- The end of the month in which the child marries.
- The end of the calendar year in which the child:
 1. Turns 19 while not a full-time student.
 2. Ceases to be a full-time student and is age 19 or older.
 3. Turns 25 while still a full-time student.
 4. Ceases to be dependent on either parent or guardian for support and maintenance.
- The date eligibility for coverage ends either for the dependent or the subscriber.

Coverage for dependent children under 25 who drop out of school during the second semester (January-May) and who have all or most of their tuition refunded, are not eligible for coverage for that year until they are enrolled and attending school again.

Coverage for the grandchild ends at the end of the month in which your child (parent of grandchild) ceases to be an eligible dependent, or becomes age 18, whichever occurs first. The grandchild is then eligible for continuation coverage.

Coverage for a spouse and stepchildren under your plan terminates at the end of the month in which the divorce was granted. See section **CONTINUATION OF HEALTH COVERAGE** for additional information.

REPORTING PERSONAL CHANGES

You need to report the following changes to Employee Trust Funds within 30 days of the change. Failure to report changes on time may result in loss of benefits or delay payment of claims. To report the following changes, contact Employee Trust Funds Self-Service Line at 1-877-383-1888 to obtain the notification form listed below. If the change affects your level of coverage (single to family or family to single), you must complete a *Health Insurance Application*, form number ET-2301.

- Change of name, address, or telephone number
ET-2329, *Health Insurance Information Change* form

- Change of physician ET-2329
- Addition of dependent (report within 60 days)
ET-2329 if presently under family coverage;
ET-2301 if changing to family coverage
- Loss of a dependent's eligibility for coverage
ET-2329 if continuing on family coverage;
ET-2301 if changing to single coverage
- Marriage
ET-2329 if continuing on family coverage;
ET-2329 if continuing on single coverage and
changing your name
- Divorce
ET-2329 if continuing on family coverage;
ET-2301 if changing to single coverage
- Death of dependent
ET-2329 if continuing on family coverage;
ET-2301 if changing to single coverage
Contact Employee Trust Funds if dependent is your
named survivor
- Death of subscriber
Contact Employee Trust Funds to report the death
- Eligibility for Medicare
Contact Employee Trust Funds for the appropriate
Medicare package
- Obtaining or losing other health insurance coverage
Contact Employee Trust Funds regarding the form
required

REPORTING PERSONAL CHANGES

28. What action do I need to take for the following personal events?

Marriage

You can change from single to family coverage to include your spouse (and stepchildren if applicable) without restriction provided your application is received within 30 days after your marriage, with family coverage being effective on the date of your marriage. (See also **Question 16: When can I change from single to family coverage without restrictions?**)

If you were enrolled in family coverage before your marriage, you need to complete a *Health Insurance Information Change* form as soon as possible to report your change in marital status, add your new spouse (and stepchildren) to the coverage, and if applicable, change your name. In most cases, coverage for the newly added dependent(s) will be effective as of the date of the marriage. (See also **Question 19: What if my spouse is also a state or university employee or annuitant?** for

any exceptions.)

Birth/Adoption/Dependent Becoming Eligible

If you already have family coverage, you need to submit a *Health Insurance Information Change* form to add the new dependent. Coverage is effective from the date of birth, adoption, or legal guardianship or when a dependent age 25 or younger becomes a full-time student if otherwise satisfies the dependency requirements. Be prepared to submit documentation of guardianship, paternity, or other information as required by ETF.

If you have single coverage, you can change to family coverage by submitting an application within 30 days of the date a dependent becomes eligible or within 60 days of birth or adoption. (See **Question 16: When can I change from single to family coverage without restrictions?**)

Divorce

Your ex-spouse (and stepchildren) can remain covered under your family plan only until the end of the month in which divorce is entered. The divorce is usually entered on the hearing date regardless of when the judge files papers or papers are signed by the parties. You should notify Employee Trust Funds prior to the divorce hearing date. **If you fail to provide notice of divorce timely, you may be responsible for premiums paid in error which covered your ineligible ex-spouse and stepchildren.** Your ex-spouse and stepchildren are then eligible to continue coverage under a separate contract with the group plan for 36 additional months. Conversion coverage would then be available. (See also **CONTINUATION OF HEALTH COVERAGE.**) You can keep your dependent children and adopted stepchildren on your family plan for as long as they are eligible (age, student status, etc.).

You must file a Health Insurance Application with Employee Trust Funds to change from family to single coverage. File a *Health Insurance Information Change* form with Employee Trust Funds to remove ineligible dependents from a family contract.

When both parties in the divorce are state or university employees or annuitants and each party is eligible for state health insurance in his or her own right, and is insured under the state plan at the time of the divorce, each retains the right to continue state health insurance

coverage regardless of the divorce.

The participant who is the subscriber of the insurance coverage at the time of the divorce must submit a health application to remove the ex-spouse from his or her coverage and may also elect to change to single coverage.

The participant insured as a dependent under his or her ex-spouse's insurance must submit a health application to establish coverage in his or her own name. The ex-spouse must continue coverage with the same plan unless he or she moves out of the service area. The application must be received by Employee Trust Funds within 30 days of the date of the divorce. Failure to apply timely will delay the effective date of coverage.

Each participant may cover any eligible dependent children (not former stepchildren) under a family contract. Coverage of the same dependents by both parents would be subject to Coordination of Benefits provisions. Refer to the **UNIFORM BENEFITS** in Section D (your plan benefit certificate) or contact your health plan directly for information on Coordination of Benefits policies and procedures.

Death

Surviving Spouse/Dependents

If an active or retired employee with family coverage dies, the surviving insured spouse and insured dependent(s) who are enrolled at the time of the death may continue coverage for life under the state program at group rates but without state contribution toward the premium. If the surviving spouse is eligible for coverage under the federal Medicare program, he or she must enroll in Medicare Part A & B. The dependents may continue coverage until eligibility ceases. A health insurance application for continuation of single or family coverage must be filed with Employee Trust Funds within 90 days after the death occurs. The new contract is effective the first of the month following the date of death. The survivors may not add persons to the policy who were not insured at the time of the death unless the survivor was also a state employee and eligible for the insurance in his or her own right.

If family coverage was in force at the time of death, any unused sick leave credits in the deceased employee's account are available to the surviving spouse/dependents for premium payments. If the surviving dependents

terminate coverage for any reason they may not re-enroll later. If sick leave credits are escrowed, the surviving dependents may continue to escrow the credits or may apply to convert the credits to pay health insurance premiums.

If single coverage was in force at the time of death, the full monthly premiums collected for coverage months following the date of death will be refunded. No partial month's premium is refunded for the month of coverage in which the death occurred. Remaining sick leave credits are not refundable. In this case, surviving dependents are not eligible for coverage.

Medicare Eligibility

If you and/or your insured dependents are eligible for coverage under the federal Medicare program and you are retired, you must immediately enroll in both Part A and Part B of Medicare. (See **Question 9: When must I apply for Medicare?**)

SELECTING A HEALTH PLAN

29. How do I select a health plan?

See Chart on Page iii.

30. What types of health plans are available?

The State Group Health Insurance program consists of plans that fall into the following broad categories:

Self-insured plans

Medicare Plus \$1,000,000 (administered by Blue Cross & Blue Shield United of Wisconsin [BCBSWi]) is a fee-for-service indemnity plan available to those eligible for and enrolled in Medicare Parts A & B. Medicare Plus \$1,000,000 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.

The Standard Plan (administered by BCBSWi) was redesigned to contain in-network and out-of-network services effective January 1, 2004. This type of arrangement is often called a Preferred Provider Plan (PPP). This allows you to see any provider of your choice, but there are differences in reimbursements depending on whether you go to an in-network or an out-of-network provider. If you receive services from an in-network provider you will have lower out-of-pocket costs. If you choose an out-of-network provider, you contribute

more toward your health care costs by incurring additional deductible costs, and coinsurance.

State Maintenance Plan (SMP)

This is another self-insured plan that is available in those counties that lack a qualified Health Maintenance Organization (HMO). Effective January 1, 2005 the plan design has been altered to match Uniform Benefits, as offered by the HMOs. See Section D of this booklet for benefit information. Please note that SMP has physician, hospital and specialty care networks and referral processes.

The Standard Plan, and SMP plans contain **Managed Care** and **Pre-admission Certification** provisions. Managed care utilizes various programs to evaluate each patient's medical needs and identify the appropriate treatments. Pre-admission Certification requires members to notify BCBSWi prior to admission to a hospital for non-emergency care. Admission will be authorized after the plan has had an opportunity to explore treatment alternatives with the admitting physician. The primary goal with both of these features is to provide cost-effective health care without sacrificing quality of care or access. Managed Care and Pre-admission Certification are not features of Medicare Plus \$1,000,000.

Health Maintenance Organizations (HMOs)

An HMO is an association of hospitals, physicians, and other health professionals who contract or collectively agree to provide all medically necessary covered services to the HMO participants in return for a prepaid fee. Each HMO offers service only in specific areas of the state.

The HMO concept is not new. The State of Wisconsin has been offering HMOs for more than 15 years with almost 90% of current state employees electing coverage under an HMO plan. For many people, HMOs provide high quality care at a lower cost than the fee-for-service plans. However, HMOs are not for everyone.

All insured members of an HMO are expected to receive their health care only through physicians, health professionals, and hospitals affiliated with that HMO. **Don't expect to join an HMO and get a referral to a non-HMO physician.**

HMOs generally refer outside their networks only if they are unable to provide needed care within the HMO. **If you go to a non-HMO provider for non-emergency care without an approved referral, you will not be reimbursed by the HMO.** If you have questions

regarding the availability of physicians, hospitals, or other medical professionals, you should contact the HMO directly.

Often HMOs will contract with several **Independent Physician Associations (IPAs)** for medical services. Generally, referrals between IPAs are restricted. Consequently, even though a physician may be listed as an HMO affiliate, that physician may not be readily available to you unless you have selected him/her as your primary care physician.

Medicare Coordinated Plans

Since all state health plans have coverage options which are coordinated with Medicare, you will remain covered by the plan you selected after you are enrolled in Medicare Parts A and B. Coverage for participants enrolled in the Standard Plan, or the SMP Plan, will be changed to the Medicare Plus \$1,000,000 plan on the participant's Medicare effective date. Your health coverage will remain substantially the same as before Medicare coverage became effective, but the state health plans are designed to supplement, not duplicate, the benefits you receive under Medicare. Prescription drugs will continue to be covered. Because of this coordination with Medicare, your monthly premiums for state health insurance may be less.

NOTE: ALL HMOs OFFER UNIFORM BENEFITS WHEN SERVICES ARE PROVIDED IN-NETWORK EVEN IF NOT COVERED BY MEDICARE. SEE UNIFORM BENEFITS IN SECTION D OF THIS BOOKLET.

31. Which plans are actually available to me?

All health plans listed in this booklet are available to you, but of course some are more suitable because of the location of their providers. Since HMOs require you to seek non-emergency medical care from physicians, clinics, and hospitals associated with that HMO, you should consider the distance you will have to travel to receive care when making your selection. **See the list of locations and the map in Section A of this booklet to see which plans serve your area.** Coverage under the Standard Plan, and Medicare Plus \$1,000,000 is available worldwide.

32. Are there differences between alternate health care plans?

Alternate health care plans are offered to help hold down health care costs and to give individuals some latitude in selecting their health care benefits. There is standardization in benefit levels and some areas such as the definition of eligible dependents and the determination of when coverage

is effective. There are also distinct differences.

Uniform Benefits are intended to simplify the plan selection process for participants. However, in choosing an alternate plan, you should consider the following:

- Monthly premium amount
- Quantity, quality and availability of participating health care providers
- Location and convenience of affiliated clinics, hospitals, emergency/urgent care centers and other medical facilities
- Dental coverage (if offered), including the location and availability of dental providers
- Requirements/restrictions on receiving a referral to another provider within or outside of the plan's provider network
- Other plan rules/restrictions/limitations covering such issues as:
 - changing primary care physicians
 - allowing covered family members to have primary care
 - physicians from different clinics
 - receiving emergency/urgent care outside of the plan's service area

In addition, remember that Uniform Benefits does not mean that all plans will treat all illnesses or injuries in an identical manner. Treatment will vary depending on the needs of the patient, the methodologies employed by the physicians involved, and the managed care policies and procedures of the plan.

When considering an alternate health benefit plan, do not hesitate to ask questions about the program, especially if you have unique requirements or know you will be requiring medical care in the near future. Contact the health plan directly.

33. Can family members have different health plans from the subscriber?

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

34. What if I have covered dependent children who live elsewhere or if I travel frequently?

While HMOs provide reimbursement for emergency care outside of their service areas, routine care must be received from the HMO's own physicians. Some HMOs also require that follow-up care following an emergency be received from a plan provider. Only the Standard Plan, and Medicare Plus

\$1,000,000 allow you the flexibility to seek routine care outside a particular service area. (See “Proof of Claim” in **Uniform Benefits, Section D., VI, item I** for information on submitting claims for non-plan providers. See also **Question 25: Will an HMO cover dependent children who are living away from home?**)

35. Will an HMO cover non-emergency care from physicians who are not affiliated with the plan?

Most HMO plans will pay nothing when non-emergency treatment is provided by physicians outside of the plan unless there is an authorized referral. Contact the plans directly regarding their policies on referrals. See Section C of this booklet.

36. Why is ETF including information about Leapfrog and CheckPoint in the It's Your Choice book?

PROVIDER QUALITY INFORMATION

Wisconsin hospitals are demonstrating their willingness to share information with the public about the steps they are taking to improve the safety of care for their patients. Medical errors result in over 98,000 preventable deaths each year, yet there is little information with which to compare and choose health care providers based on safety and quality. This information is a starting point to help us begin to assess healthcare options and to ask more informed questions about what doctors and hospitals are doing to reduce medical errors and improve quality.

37. What is Leapfrog?



The ETF has endorsed a nationwide effort taking aim at improving the quality and safety of hospital care. The “Leapfrog” effort raises consumer awareness of three hospital safety practices or standards proven to reduce medical errors and save lives. At the same time, insurance program administrators (like the ETF) are publicly recognizing and rewarding their urban hospitals for voluntarily reporting their progress in fully adopting the standards. The three key standards the State has asked urban hospitals to adopt are: Computerized Prescription Order Entry (CPOE); Intensive Care Unit Physician Staffing; and Evidence-Based Hospital Referral. Urban and rural hospitals have also been asked to complete a survey based upon 30 National Quality Forum practices call the Leapfrog Quality Index. These practices, if used universally in applicable clinical settings, would reduce risk of harm to patients.

As of August 2004, almost 50% of all Wisconsin hospitals (58 out of 123) have publicly reported their progress on these standards and/or survey. Updates occur monthly. The most up-to-date information is available to at

http://www.leapfroggroup.org/consumer_intro.htm.

38. What is CheckPoint?



CheckPoint is a program sponsored by the Wisconsin Hospital Association that reports results from Wisconsin hospitals who have shared information about the quality and safety of health care services delivered to patients in their communities.

CheckPoint provides data on five error prevention measures and ten clinical interventions that medical experts agree should be taken to treat heart attacks, heart failure and pneumonia; three of the most common causes of hospitalization.

Additional quality measures, as well as consumer-focused educational information, will be added to the CheckPoint program over time. Visit their web site for the most up-to-date information at www.wicheckpoint.org.

39. Why are some hospitals noted with check marks, and some hospitals and plans noted with frog symbols on the Plan Description pages?

Hospitals who have completed the Leapfrog and/or CheckPoint survey are noted with a frog and/or a check mark, to recognize them for reporting on their attainment, or work toward improvements in patient safety and quality.

ETF is also noting those plans who have written to their plan hospitals to educate them about Leapfrog, to request them to participate in these safety and quality initiatives.

PHYSICIAN INFORMATION

40. How can I get a listing of the physicians participating in each plan?

Contact the plan directly. Employee Trust Funds does not maintain a current list of this information.

41. What is a primary provider?

When you select a health plan, each covered family member typically selects a primary provider who provides entry into the plan's health care system and evaluates your total health needs. Depending upon the requirements of your plan, the primary provider exercises a greater or lesser degree of control to your access of other providers. He/she responds to your health questions and concerns, recommends and coordinates treatment and initiates referrals to specialists, when necessary. It is important to establish a relationship with your primary provider, through annual physical exams for example, to ensure that if there is a serious health problem you will be comfortable seeking care from a

physician who knows you and your health history.

Generally, primary providers are family practice, general practice or internal medicine physicians. Some plans also permit participants to select an OB/GYN or pediatrician as the primary provider.

42. Can I change primary physicians within my HMO?

Plans differ in their policies. First contact your plan to find out when your change will become effective. Then file a *Health Insurance Information Change* form available from Employee Trust Funds indicating the effective date of your change as specified by the plan.

43. If my physician or other health care professionals are listed with an HMO, can I continue seeing him or her if I enroll in that HMO?

If you want to continue seeing a particular physician (or psychologist, dentist, optometrist, etc.), contact that physician to see which HMO, if any, he or she is affiliated with and if he or she will be available to you under that HMO. Confirm this with the HMO. Even though your current physician may join an HMO, he or she may not be available as your primary physician just because you join that HMO.

44. What happens if my provider leaves the plan midyear?

Health care providers appearing in any published health plan provider listing or directory remain available for the entire calendar year except in cases of normal attrition (that is, death, retirement or relocation) or termination due to formal disciplinary action. A participant who is in her second or third trimester of pregnancy may continue to have access to her provider until the completion of post-partum care for herself and the infant.

If a provider contract terminates during the year (if not due to normal attrition or formal disciplinary action), the plan is required to pay charges for covered services from these providers on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the member is held harmless. Health plans will individually notify members of terminating providers (prior to the Dual-Choice period) and will allow them an opportunity to select another provider within the plan's network.

Your provider leaving the plan does not give you an opportunity to change plans mid-year.

45. What if I need medical care that my primary physician cannot provide?

As an HMO or SMP participant, you must designate a primary physician. Your primary physician is responsible for managing your health care. Under most circumstances, he or she may refer you to other medical specialists within the

HMO's or SMP's provider network as he or she feels is appropriate. However, referrals outside of the network are strictly regulated. Check with your plan for their referral requirements and procedures.

PREMIUM CONTRIBUTION

46. How will my health premiums be paid?

Premium rates for retired employees are the same as for active employees (except that your premium will decrease when you or a dependent becomes covered by Medicare). However, the state does not pay any portion. Your monthly premiums will be paid in one of the following ways:

- **From your Accumulated Sick Leave Conversion Credits until those credits are exhausted.** If you have accumulated sick leave at the time of your retirement or death (and your applicable compensation plan or collective bargaining agreement provides for sick leave conversion), the credits can be converted to a dollar amount to pay your health premiums for the State Group Health Insurance Program. (Sick leave credits can only be converted for payment of State Group Health Insurance program premiums; they cannot be used for other insurances; they have no cash value and accrue no interest.) If you choose to escrow your sick leave, this can be done at the time of retirement or a later date. Contact ETF for the escrow form.

NOTE: If you qualify for a Wisconsin Retirement System disability benefit, you have the option of being paid your sick leave hours or having them converted to pay your health premiums while you are receiving your disability annuity.

If you have no sick leave credits available, or your credits are exhausted, then monthly premiums will be paid:

- **From deductions from your monthly retirement, disability, or beneficiary annuity payment.** Premiums will be automatically deducted a month in advance of coverage. If there is no annuity or your annuity is not large enough to take premiums, then they will be paid:
- **From direct billings to you.** Your health plan will bill you directly for premiums.

WARNING: Your coverage will be cancelled if you fail to timely pay your premium when billed. If you re-enroll, coverage will be effective the first of the seventh month following the application receive date. If you are a surviving spouse or dependent, you are not eligible for re-enrollment.

- **From your converted life insurance.** If you are retired

and have life insurance coverage through the State of Wisconsin, are at least 66, and **have used up all your sick leave credits**, you may elect to convert your life insurance to pay health insurance premiums. If you make this election, your life insurance coverage will cease and you will receive credits in a conversion account equal to the present value of your life insurance. The present value ranges from about 44% to 80% of the face amount, depending on your age. The life insurance company, Minnesota Life, will pay health insurance premiums on your behalf from your conversion account until the account is exhausted. You will NOT receive any direct cash payment. You may file the election at any time, and it will be effective at the beginning of the third full month after ETF receives it. For more information, contact ETF.

47. Does a plan with a higher premium offer more benefits?

No, all alternate plans are required to offer Uniform Benefits. Premium rates may vary because of many factors: how efficiently the plan is able to provide services and process benefit payments; the fees charged in the area in which service is being rendered; the manner in which the health care providers deliver care and are compensated within the service area; and how frequently individuals covered by the plan use the health plan. Also, plans offering optional dental coverage may have slightly higher premiums.

48. How often will premium rates change?

All group premium rates change at the same time — January 1 of each year. The monthly cost of all plans will be announced during the Dual-Choice Enrollment period.

49. Do I have to use my sick leave credits to pay my health premiums?

You do not have to use your sick leave credits to pay your health premiums if:

➤ **You escrow your sick leave.** When you retire, you may escrow your sick leave credits indefinitely after your retirement date if you are currently insured in the state program and are covered under comparable health coverage. Annually, you may also elect to escrow if you later become covered by a comparable health coverage. You may elect coverage under any plan in the state program without waiting periods or exclusions for pre-existing conditions when timely re-enrolled.

OR

➤ **You are covered under your spouse's State Group Health Insurance Program plan.** If you retire and are also a dependent on your spouse's state group health insurance plan, you will have your sick leave credits inactivated until your spouse retires and depletes his or

her own sick leave credits.

NOTE: You can unescrow your sick leave once a year at Dual-Choice.

CHANGING HEALTH PLANS

DUAL-CHOICE ENROLLMENT

During the Dual-Choice Enrollment period all subscribers currently continuants, and retirees insured by the State Group Health Insurance program are allowed to change from one plan to another, or from single to family coverage, for the following calendar year without a waiting period or exclusions for pre-existing medical conditions. You will receive a new *It's Your Choice* booklet prior to the enrollment period. You do not need to submit a completed application to continue coverage in your current plan for next year provided the plan is still offered.

50. What does Dual-Choice mean?

Dual-Choice refers to the annual opportunity insured subscribers have to select one of many health care plans offered. The name originated many years ago when the choice of health care plans was very limited. Today, eligible subscribers have over 15 different health plans from which to choose.

51. When is a coverage change made during Dual-Choice effective?

Dual-Choice coverage changes are effective January 1 of the following year.

52. Is the Dual-Choice Enrollment available to everyone?

No, the Dual-Choice Enrollment is offered only to subscribers presently insured under the State Group Health Insurance program.

53. May I change from single to family coverage during Dual-Choice?

Yes, if you change from single to family coverage during Dual-Choice, coverage will include all eligible dependents effective January 1 of the following year. (See also **Question 16: When can I change from single to family coverage without restrictions?**)

54. How do I change plans during Dual-Choice?

If you decide a different plan is for you, **complete the enclosed health application and mail it to Employee Trust Funds P.O. Box 7931, Madison, WI 53707-7931 by the last day of the Dual-Choice Enrollment period.** Applications postmarked after the deadline will not be accepted. Instructions for filling out the application are in Section H of this booklet.

55. What if I change my mind about the plan I selected during Dual-Choice?

You may submit or change an application at any time during the Dual-Choice period. After that time, you may withdraw your application (and keep your current coverage) by notifying Employee Trust Funds **in writing before December 31.**

CHANGING HEALTH PLANS

56. Can I change from one plan to another during the year?

Only if you, the subscriber, move from your plan's service area for a period of at least 3 months. An application must be received by Employee Trust Funds within 30 days after the date of your move. Your new coverage will be effective the first of the month on or following the receipt of your application. You may again change plans when you return to the service area by submitting another application within 30 days after your return.

You may change to the Standard Plan/Medicare Plus \$1,000,000 at any time by canceling your existing coverage and submitting an application for the Standard Plan/Medicare Plus \$1,000,000. Coverage will be effective the first of the month on or following the receipt of the application by Employee Trust Funds. However, there will be a 180-day waiting period for any pre-existing conditions (except pregnancy) for all participants. Otherwise, you can only change health plans without restriction during the Dual-Choice Enrollment period. (Also see **Question 59: What if I have a temporary or permanent move from the service area?**)

57. If I change plans, what happens to any benefit maximum that may apply to services I've received?

When you change plans for any reason (for example, Dual-Choice or a move from a plan's service area), any health insurance benefit maximum under Uniform Benefits will start over at \$0 with your new plan, even if you change plans mid-year. Examples are the lifetime benefit maximum or durable medical equipment and the mental health/alcohol/drug abuse benefit. However, orthodontia benefit maximums typically carry over from one plan to the next. They are optional and not part of the Uniform Benefits medical plan.

58. If I leave a plan and later re-enroll in that plan, does my lifetime benefit Maximum start over?

The lifetime benefit maximum is per participant per plan. When you change from one health plan to another, your lifetime maximum with the new plan will start over at \$0. If you later return to a plan under which you were previously covered, the plan may count any benefits paid during all periods of coverage toward the lifetime benefit maximum for that plan. The only exception is if you are covered by a plan

under the State program and then under the Wisconsin Public Employers' Group Health Insurance program, or vice versa. In that situation, the lifetime benefit maximums accumulate separately, as these are separate insurance programs.

59. What if I have a temporary or permanent move from the service area?

A subscriber who moves out of a service area (for example, out of the county) either permanently, or temporarily for 3 months or more will be permitted to enroll in the Standard Plan, or an available alternate plan, provided an application for such plan is submitted within 30 days after relocation. You will be required to document the fact that your application is being submitted due to a change of residence out of a service area.

It is important that your application to change coverage be submitted as soon as possible and no later than 30 days after the change of residence to maintain coverage for non-emergency services. The change in plans will be effective on the first day of the month on or after your application is received by Employee Trust Funds but not prior to the date of your move. If your application is received after the 30-day deadline, you are only eligible for the Standard Plan or Medicare Plus \$1,000,000 with a 180-day waiting period for pre-existing conditions. If your relocation is temporary, you may again change to another plan upon return by submitting an application within 30 days of your return. The change will be effective on the first day of the month on or after your application is received by Employee Trust Funds but not prior to your return.

60. What if I change plans due to a move from the service area but am hospitalized before the date the new coverage becomes effective?

If you continue to be confined as an inpatient (or require 24 hour home care) on the effective date of the coverage with the new plan, you will continue to receive benefits from the prior plan as provided by contract until that confinement ends, 12 months have passed, or the contract maximums is reached. If a participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one confinement.

61. What if I select another plan, but am confined as an inpatient on January 1?

If you are admitted to a hospital, Alcohol and Other Drug Abuse (AODA) residential center or a skilled nursing facility prior to the effective date of change in plans, and are still confined on that date, you will continue to receive benefits from the prior plan. If transferred to another hospital or other facility for continued treatment of the same or related illness or injury, it is still considered under the original confinement. The new plan assumes liability for you on the earliest of the following: discharge from the hospital or other facility; after

12 months; or the contract maximum is reached. In all other instances, the new plan assumes liability immediately on January 1.

BENEFITS AND SERVICES

62. How do I receive health care benefits and services?

You will receive identification cards from the plan you select. If you lose these cards or need additional cards for other family members, you may request them directly from the plan.

Alternate plans are not required to provide you with a certificate describing your benefits. The Uniform Benefits section of this booklet provides this information and will serve as your certificate.

Present your identification card to the hospital or physician who is providing the service. Identification numbers are necessary for any claim to be processed or service provided.

Under the Standard Plan, and SMP, you or your physician must contact the Administrative Services Only (ASO) contract Administrator Blue Cross & Blue Shield United of Wisconsin before you are admitted to a hospital. In addition, any ongoing confinement will be monitored by the Administrator. The Administrator's role is to ensure that only care which is appropriate for your medical condition is provided. The Administrator can suggest alternatives to the treatment scheduled by your physician.

Most of the alternate plans also require that non-emergency hospitalizations be prior authorized.

63. How do I file claims?

Most of the services provided by an HMO do not require filing of claim forms. However, you may be required to file claims for some items and services. The Standard Plan, for example, requires claims incurred in any calendar year to be received by the Administrator no later than the end of the next calendar year.

64. How are my benefits coordinated with other health insurance coverage?

When you are covered under two or more group health insurance policies (other than Medicare) at the same time, and both contain coordination of benefit provisions, insurance regulations require the primary carrier be determined by an established sequence. This means that the primary carrier will pay its full benefits first; then the secondary carrier would consider the remaining expenses. See the Coordination of Benefits Provision found in the **UNIFORM BENEFITS** in Section D.

65. How do I file claims if Medicare coverage is in effect?

Alternate Plans. Most alternate plans will take care of submitting claims to Medicare on your behalf and you will probably not notice changes in the claims handling process. However, because each plan may handle the process differently, you should contact your plan directly for specific instructions.

Medicare Plus \$1,000,000. Your responsibilities in the claims process will depend on the policies and practices of the medical facility from which you receive care and whether you have elected the **Medicare Crossover Option** from Blue Cross & Blue Shield of Wisconsin (BCBSWi). You may be required to submit the claims to Medicare and then submit the proper forms to BCBSWi for supplemental payments. Refer to the brochure, "State Medicare Plus \$1,000,000" available from Employee Trust Funds for more information, and contact your health care provider or facility regarding their particular Medicare claims procedures.

66. What is the Medicare Cross-over Option?

An optional claims processing system for services received under Medicare Part B in the State of Wisconsin is available to you at no additional cost. It is designed to eliminate some of the paperwork involved in filing claims.

For services you receive in the State of Wisconsin, you can authorize Medicare Part B to automatically forward your Explanation of Medicare Benefits (EOMBs) to BCBSWi. You will not need to send copies of your Medicare Part B EOMBs to BCBSWi to receive benefits under the Medicare Plus \$1,000,000 plan.

To take advantage of this simplified claim service, contact BCBSWi for information and an authorization form.

Although automatic claim forwarding is free of charge, an authorization form must be submitted with the signature of each person covered under Medicare to receive the service for each person. If you do not wish to use the simplified claim service, you can send copies of your Medicare Part B EOMBs (Explanation of Medicare Benefits) to BCBSWi for processing as usual.

67. If I have Medicare as my primary coverage, how are my benefits coordinated?

Since all state health plans have coverage options that are coordinated with Medicare, you will remain covered by the plan you selected after you are enrolled in Medicare. However, if you are enrolled in the Standard Plan, or SMP, your coverage will be changed to the Medicare Plus \$1,000,000 plan. There are some benefit differences between these plans. Medicare Plus \$1,000,000 is

designed to supplement, not duplicate, the benefits you receive under Medicare.

If you are enrolled in an HMO, your health coverage will remain the same as before Medicare coverage became effective. Your HMO is also designed to supplement, not duplicate, the benefits you receive under Medicare.

In both cases, because of this coordination with Medicare, your monthly premiums for state health insurance will be less.

68. How does the change to the Medicare Plus \$1,000,000's maximum affect those participants who are enrolled in it?

MEDICARE PLUS \$1,000,000 UPDATE

Effective January 1, 2005 the plan's current per illness or injury maximum is changing to a lifetime maximum, similar to all other state plans. In addition, the maximum dollar amount is increasing to \$1,000,000. The reasons for the change are to make the plan easier to understand and administer. Even with this benefit change, your premium rates will be lower in 2005 due to the favorable claims experience for the prescription drug program.

Note that the benefits for the Medicare Plus \$1,000,000 plan are designed to be a supplement to Medicare. Medicare would pay first on any claims you incur, and then the Medicare plus \$1,000,000 plan would pay its portion. Therefore, the maximum of \$1,000,000 per lifetime is expected to meet the needs of our members in today's health care environment, and in the future.

STANDARD PLAN

69. What is the Standard Plan with the Preferred Provider Network?

This plan, often called a Preferred Provider Plan (PPP), offers participants under 65 the choice to see any provider, but there are differences in reimbursements depending on whether you go to an in-network or an out-of-network provider. If you receive services from an in-network provider you will have lower out-of-pocket costs. If you choose an out-of-network provider, you contribute more toward your health costs by incurring additional deductible costs, and coinsurance.

This arrangement can be attractive to persons, who for the most part, are comfortable with the plan's providers, but occasionally feel the need to utilize a particular specialist or desire coverage for routine care while traveling. All eligible State employees and annuitants or other dependent(s) under 65 have the option to enroll in this plan.

70. How do I know which providers are in-network providers?

See the plan description page in Section G for more information on how to access or receive a provider directory. You may also contact the health plan administrator to receive a printed copy.

71. How is the Standard Plan with a preferred provider network different from the old Standard plan and Standard Plan II?

Beginning January 1, 2004, under the Standard Plan, when you receive services from in-network providers, you will need to meet an up-front deductible. The in-network deductible will be \$100 single/\$200 family. However you will not have to pay the 80% co-insurance under the old major medical portion of the plan. All benefits will be paid at 100% of charges, after the deductible.

If you use out-of-network providers, you will have a \$500 single/\$1,000 family deductible and co-insurance costs. Please keep in mind that these deductibles accumulate separately, so the in-network deductible does not apply to the out-of-network deductible, and vice versa.

A few other benefits were adjusted to keep the overall benefit level comparable and to fit in with the preferred provider network concept. The lifetime maximum benefit increased to \$2,000,000 to more closely match Uniform Benefits. Prescription drug coverage is administered by the PBM so the drug co-payments align with those of Uniform Benefits, except the annual prescription out-of-pocket maximum for drug co-payment is \$1,000 single/\$2,000 family. The Standard Plan and Standard Plan II did not have an out-of-pocket drug maximum before. These out-of-pocket maximums are separate from your medical out-of-pocket costs.

72. What is a Pharmacy Benefit Manager (PBM)?

PHARMACY BENEFIT MANAGER

A PBM is a third party administrator of a prescription drug program that is primarily responsible for processing and paying prescription drug claims. In addition, they typically negotiate discounts and rebates with drug manufacturers, contract with pharmacies, and develop and maintain the formulary. The State's PBM will negotiate rebates and discounts on behalf of the State and pass the savings back. Many health plans currently provide their drug benefit through a PBM.

73. What is a drug formulary, how is it developed, and how will I know if my prescription drug is on

A formulary is a list of prescription drugs established by a committee of physicians and pharmacists that are determined to be medically-effective and cost-effective. The formulary is developed by a Pharmacy and Therapeutics Committee, which includes a statewide group of physicians

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and pharmacists.

Drugs are evaluated on the basis of effectiveness, side effects, drug interactions, and then cost. On a continuous basis new drugs are reviewed to make sure the formulary is kept up-to-date and that patient needs are being met.

The complete formulary is listed on Navitus' Web site, www.navitus.com. You may also contact Navitus customer service toll free at 1-866-333-2757 with questions about the formulary.

74. How does a three-level drug copayment system work?

Under a three-level prescription drug benefit, you have three different copayment amounts for covered prescription drugs. By having to pay a lower copayment for those drugs on the formulary, which are Level 1 and Level 2, you are encouraged to use formulary drugs. However, if you prefer a drug that is not on the formulary (and for which coverage is not excluded), you can get that drug for a higher copayment, which is the Level 3 copayment. This gives you more freedom of choice with the drugs that you use.

Under the three-level prescription drug benefit, it will still be necessary to get a prior authorization before some formulary and non-formulary drugs will be covered.

75. Will I have to use a different ID card when I go to the pharmacy?

Yes. You will have two identification cards, one from your health plan and one from Navitus. Your member identification number will be different on each card, so it is important that you show the correct card when getting services. When filling prescriptions, you **must** present your Navitus ID card to the pharmacist.

TERMINATION/LEAVING YOUR HEALTH PLAN

CANCELLATION / TERMINATION OF COVERAGE

76. How do I cancel coverage?

Voluntary cancellation (or switching from family to single coverage which is deemed voluntary cancellation for all insured dependents) requires written notification to Employee Trust Funds and the completion of a cancellation request form. Be aware that voluntary cancellation of coverage does not provide an opportunity to continue coverage for previously covered dependents as described in section **CONTINUATION OF HEALTH COVERAGE**.

No **REFUNDS** are made for premiums paid in advance unless Employee Trust Funds receives your written request on or before the last day of the month preceding the month for which you request the refund. Under no circumstances are partial month's premiums refunded.

77. When can an annuitant's health coverage be terminated?

Your coverage can only be terminated because:

- Premiums are not paid.
- Coverage is voluntarily cancelled.
- Failure to apply for both Medicare Part A and Part B when first eligible. The Medicare enrollment requirement is deferred while you or your spouse are employed and covered under a group health insurance plan from that employment. (See also **Question 9: When must I apply for Medicare?**)
- Ineligible for coverage as an annuitant because of becoming an active WRS employee. (See also **Question 14: How are my health benefits affected by my return to work (for an employer who is under the WRS)?**)
- Fraud is committed in obtaining benefits or inability to establish a physician/patient relationship. Termination of coverage for this reason requires Group Insurance Board approval.
- Death of subscriber.

Contact Employee Trust Funds for the date coverage will terminate.

78. Is it possible to re-enroll in this health insurance program after I terminate state employment?

If you terminated state employment and you were not enrolled for health insurance or subsequently terminated coverage, you may enroll for single or family coverage if you are:

1. A retired employee of the state who is receiving a retirement annuity or has received a lump sum payment under Wis. Stat. § 40.25 (1);
OR
2. An employee of the state who terminates creditable service after attaining 20 years of creditable service, remains a WRS participant and is not eligible for an immediate annuity.

Once you are retired and received your annuity, you may submit an application to enroll and may select any offered health plan. Coverage will be effective on the first day of the *seventh* month following the Department's receipt of the application. Surviving dependents are not eligible to re-enroll.

CONTINUATION OF HEALTH COVERAGE

79. Who is eligible for continuation?

See **COBRA: Continuation of Coverage Provisions for the Group Health Insurance Program** in Section B of this booklet.

80. Who do I notify when a dependent loses eligibility for coverage?

You have the responsibility to inform Employee Trust Funds of a spouse or dependent losing eligibility for coverage under the State Group Health Insurance program. If you have changed marital status, or you or your spouse have changed addresses, complete a new application as notification of this change. **Under Federal Law, if ETF is not notified within 60 days of the later of (1) the event that caused the loss of coverage, or (2) the end of the period of coverage, the right to continuation coverage is lost.** A voluntary change in coverage from a family plan to a single plan does not create a continuation opportunity.

If the dependent does not choose continuation coverage within 60 days of loss of eligibility for coverage, his or her group health insurance coverage will end as of the date eligibility was lost.

81. Does my coverage change under continuation?

No, continuation coverage is identical to the active employee coverage. In most cases, you are eligible to maintain continuation coverage for 36 months from the month of the qualifying event and are allowed to change plans during the annual Dual-Choice Enrollment period or if the subscriber moves from the service area. However, your continuation coverage may be cut short for any of the following reasons:

1. The premium for your continuation coverage is not paid when due.
2. You or a covered family member become covered under another group health plan that does not have a pre-existing conditions clause which applies to you or your covered family member.
3. You were divorced from an insured employee and subsequently remarry and are insured through your new spouse's group health plan.

82. Will my premium change under continuation?

No. See page A-4, in the premium rate section of this booklet.

83. How do I cancel continuation coverage?

To cancel continuation coverage, notify ETF in writing. Include your name, Social Security number, date of birth and address. ETF will forward your request to the plan. Your

coverage will be cancelled at the end of the month in which Employee Trust Funds receives the request to cancel coverage.

84. When is conversion coverage available?

Conversion coverage is available without providing evidence of insurability, and with no waiting period for pre-existing conditions, provided state group coverage has been in effect for at least three months prior to termination. As required by law, you are eligible to apply for conversion coverage when group continuation coverage terminates. Contact the plan directly to make application for conversion coverage. If the plan automatically bills you for conversion coverage that you do not want, simply do not pay the premium for the coverage. The coverage offered will be the conversion contract (not the state plan) available at the time, subject to the rates and regulations then in effect. The coverage and premium amount may vary greatly from plan to plan.

If you reside outside of the HMO service area at the time you apply for conversion coverage, you may only be eligible for an out-of-area conversion policy through another insurance carrier. The benefits and rates of the out-of-area conversion plan are subject to the regulations in effect in the state in which you reside.

The conversion privilege is also available to dependents when they cease to be eligible under the subscriber's family contract. Request for conversion must be received by the plan within 31 days after termination of group coverage. If you have questions regarding conversion, write or call the plan in which you are enrolled.

85. How is my continuation coverage affected if I move from the service area?

If you move out of the service area (either permanently, or temporarily for three months or more) you are eligible to change plans. (See chart on **Page iii** for additional information.)

Your application to change plans must be postmarked within 30 days after your move.

Contact the ETF Employer Communication Center at (608) 264-7900 to obtain a *Health Insurance Application*. Complete and submit the application to the Department of Employee Trust Funds, P. O. Box 7931, Madison, WI 53707-7931.