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GENERAL INFORMATION

1. Who should use this booklet?

Graduate Assistants, Employees-in-Training, Fellows, Scholars, and Short-Term Academic Staff (NOT covered under the Wisconsin Retirement System) of the University of Wisconsin System who are:

- New university appointees who are selecting a health insurance plan for the first time;
- Currently-insured university appointees who, during the October Dual-Choice Enrollment period, are changing to a different plan for the following calendar year;
- Currently-insured university appointees 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.
- Insured health plan subscribers, as a reference throughout the year.

2. Who is eligible for State of Wisconsin group health insurance?

Information about the State of Wisconsin Group Health Insurance program in this booklet applies to the following individuals:

Graduate Assistants (Research, Project/Program, Teaching Assistants) holding a combined one-third (33%) or greater appointment of at least one semester or six months duration.

Employees-in-Training (Research Associates, Post-Doctoral Fellows, Post-Doctoral Trainees, Postgraduate Trainees 1 through 7, Interns Non-Physician, Research Interns, Graduate Interns/Trainees) holding a one-third time (33%) or greater appointment of at least one semester or 6 months duration.

Fellows, Scholars, Trainees, or Advanced Opportunity Fellows receiving monthly stipend payments at or above the one-third time Research Assistant level.

Short-Term Academic Staff who are employed in positions not covered under the Wisconsin Retirement System and are holding a fixed-term terminal appointment of one-third time or more with an expected duration of at least six months (one semester for nine month basis appointees) but less than 12 months (one academic year for nine month basis appointees).

“Visiting” Appointees (e.g., Visiting Professors, Visiting Scientists, Visiting Lecturers) may be eligible for the health insurance benefits described in this booklet. If you hold a “visiting” appointment, contact your benefits/payroll/personnel office for more information. Separate booklets have been prepared for two other categories of eligible individuals:

- Active state and university employees who participate in the Wisconsin Retirement System, elected state officials, members and employees of the legislature, certain visiting faculty members of the University of Wisconsin System, and blind employees of the Workshop for the Blind (WISCRAFT) should refer to booklet ET-2107.
- Retired state and university employees and those retirees receiving a WRS disability benefit should refer to booklet ET-2108.

3. Where can I get more information?

Health Plans and Pharmacy Benefit Manager (PBM)

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.**

The Uniform Benefits, found in Section D, is the benefits certificate for those enrolled in alternate health plans and SMP (but not the Standard Plan).

All participating 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.

University Benefits/Payroll/Personnel offices

Questions regarding eligibility and enrollment, including requests for applications, should be directed to your benefits/payroll/personnel office. They can answer general questions about the health insurance program or can tell you the time and place of any benefits sessions or orientations. **In addition, contact that office to report changes in your subscriber information, family status or primary provider.**

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.

4. Privacy of Social Security Numbers

Social Security numbers are a common form of member/patient identification. 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 call should be done prior to the first of the year when new cards are issued. Some plans may require you to submit your request in writing. Please note that your Pharmacy Benefit Manager (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.

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

HEALTH INSURANCE COMPLAINT PROCESS

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 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 an 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's 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 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 health plan, and have questions concerning the review options available to you, feel free to contact ETF and request to speak with an ombudsperson.

7. What steps do I follow to enroll as a new employee?

ENROLLING FOR COVERAGE

INITIAL ENROLLMENT

- Carefully read the information provided in this booklet.
- Determine which plans have providers in your area.
- Compare plans that interest you. Review and compare the **Health Plan Report Card Information** in Section E and **Plan Descriptions** in Section G.
- Compare premiums for the plans that interest you.
- Contact plans directly for information regarding available physicians, medical facilities, and services.
- File a health application with your benefits/payroll/personnel office within the required enrollment period.

When you are notified of your appointment with the university, immediately contact your benefits/payroll/personnel office for health enrollment information and an application. If eligible, you may enroll for single or family coverage in any of the available health plans without restriction or waiting periods for pre-existing medical conditions. Your application must be received by your benefits/payroll/personnel office within 30 days of the date of your first eligible appointment. Your health coverage will be effective the first day of the month on or following receipt of your application by your benefits/payroll/personnel office.

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 between appointments.

You cannot assume that the month when your first payroll deduction occurs is the month when your coverage begins. Health premiums are deducted two months in advance of coverage. For further information on deductions and coverage effective dates contact your benefits/payroll/personnel office.

8. What if I miss my enrollment opportunity?

If you do not enroll during a designated enrollment period, **you may still get health insurance coverage if you are otherwise eligible.** However, you (and your insured spouse and/or dependents if you elect family

coverage) will be limited to the Standard Plan and will have a 180-day waiting period for all pre-existing medical conditions except pregnancy. The waiting period applies to all conditions which existed prior to the effective date of coverage under the Standard Plan, including all hospital confinements or inpatient charges related to pre-existing conditions for which confinement begins within the 180-day waiting period. For example, if a hospital confinement for a pre-existing heart condition begins on the 170th day of the waiting period and ends on the 200th day, none of the costs associated with the confinement would be covered. The waiting period does not apply to pregnancy terminated without childbirth. (See **Question 10: What if I lose other coverage?** for exceptions.)

9. Important Notice For Limited Term (LTE) and Less Than Half-Time Employees

The initial enrollment opportunity for most employees begins with their participation under the Wisconsin Retirement System (WRS). However, if you are in a WRS-covered LTE position or are a less than half-time employee, you have another enrollment period when:

- There has been a 30-day termination of employment break; or
- Your hours of employment increase and you qualify for the full share of employer contribution toward health insurance premiums; or
- You are appointed to a permanent position and you now qualify for the full share of employer contributions.

If you apply for coverage within 30 days after one of these events, coverage will be effective on the first of the month following the employer's receipt of the application. Retroactive effective dates are not allowed. This does not provide an opportunity to change from single to family coverage.

You may enroll at any other time, but will be restricted to the Standard Plan with a 180-day waiting period for pre-existing conditions.

OTHER ENROLLMENT INFORMATION

10. What if I lose other coverage?

If you and/or your dependents are not insured under the State Group Health Insurance program because of being insured under a group health insurance plan elsewhere, and eligibility for that coverage is lost or the employer's premium contribution for the other plan ends, you may take advantage of a special 30-day enrollment period to become insured in the State Group Health Insurance program without waiting periods for pre-existing conditions, if otherwise eligible.

This enrollment opportunity is also available to employees and/or dependents who lose medical coverage:

- Under medical assistance (Medicaid); or
- Upon return from active military service with the armed forces. Employees must return to employment within 90 days of release from active duty; 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 coverage terminates because of loss of eligibility (for example, termination of employment, divorce, etc., but not voluntary cancellation of coverage) or the employer's premium contribution ends.

To enroll, submit a health insurance application form and other information documenting your loss of coverage or employer's premium contribution to your benefits/payroll/personnel office within 30 days of the date the other coverage ended. Coverage will be effective on the date the other coverage or the employer's contribution ends.

HIPAA (Health Insurance Portability and Accountability Act) also allows a special enrollment when an employee or dependent is eligible but not enrolled and there is a marriage or a birth, adoption or placement for adoption. By contract, if coverage is elected within 30 days of a marriage or 60 days of the other event, coverage is effective on the date of birth, adoption, placement for adoption, or marriage.

If you do not enroll during these special enrollment opportunities, your coverage will be limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.

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

Always file the approved forms through your benefits/payroll/personnel office to notify your plan of changes. Failure to report changes on time may result in loss of benefits or delay payment of claims.

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

1. Change in plan (for example, from HMO to the 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 can be accomplished by submitting a *Health Insurance Information Change* form (ET-2329). These other changes would include:

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

(See also **Question 17. What family changes need to be reported?**)

12. How are my health benefits affected by changes in employment status?

Permanent Layoff

State contributions toward premium will be up to 5 months. This includes three months of state contribution in addition to any premium prepaid prior to the time of layoff. Arrangements for employee share of premium payment must be made with your benefits/payroll/personnel office prior to the date of layoff.

Unpaid Leave of Absence

State share towards premium includes three months of state contribution in addition to any premium prepaid at the time your leave of absence begins. You can elect coverage for 36 months (or beyond 36 months if the leave is military or union service). Arrangements for all premium payment must be made with your benefits/payroll/personnel office prior to the time your leave of absence begins. If coverage is not continued during leave of absence there are no continuation rights if employment terminates.

If your health coverage lapses during your leave due to non-payment of premiums, you must submit a new application within 30 days of returning to work to reinstate the lapsed coverage. Coverage will be effective the first of the month after the application is received by your payroll office. If a Dual-Choice Enrollment period has occurred while you were on leave, you will be offered a Dual-Choice opportunity upon your return. (See also **Question: 8 What if I miss my enrollment opportunity?**)

A leave of absence is not considered ended until you have terminated employment or have resumed employment for at least 50% of what is considered your normal work time for that employer for 30 consecutive calendar days.

Temporary Layoff

State share towards premium will continue for the first three months after your leave begins. You can elect coverage for 36 months (or beyond 36 months if you are using sick leave to pay premium). Arrangements for all premium payment must be made with your benefits/payroll/personnel office prior to the time your leave of absence begins.

Transfer

If you transfer from one employing state department to another, contact your benefits/payroll/personnel office for information on how to maintain continuous coverage.

Termination of Employment

Coverage will end on the last day for which premiums are paid. See **CONTINUATION OF HEALTH COVERAGE**.

Appealing a Discharge

Coverage may be continued if you have terminated from employment and are appealing discharge. The first premium payment and the appeal must both be filed within 30 days of discharge. Premium payments must be made through your benefits/payroll/personnel office and be received at least 30 days prior to the end of the period for which premiums were previously paid. You must pay the gross amount of premium due until the appeal is resolved. If the appeal is resolved in your favor, the amount normally considered university contribution will be refunded to you.

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. A subscriber may not choose to exclude an eligible dependent from coverage. All eligible dependents are covered without exception under a family contract. Your grandchildren may be covered if the parent is your unmarried dependent and 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.

13. 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 your benefits/payroll/personnel office within **30** days of the following events:

- Marriage
- Birth or adoption of a child (application must be submitted with 60 days of the event - pre-existing condition limitations do not apply for such dependents when added in a timely manner)
- A single father declaring paternity. Children born outside of marriage become DEPENDENTS of the father on the date of the court order declaring paternity or on the date the acknowledgement of paternity 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.
- 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.
- Any 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 coverage change.

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

You may change from family to single coverage at any time with the change being effective on the first day of the month on or following receipt of your application by your benefits/payroll/personnel office.

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.

15. 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.

A single mother may cover the child under her health plan effective with the birth by submitting an application changing from single to family coverage.

16. 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 with your current plan(s);
OR
- One of you may retain or select family coverage under one of your current plans, 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* (ET-2301).

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 will be effective on the beginning of the month following receipt of a Health Insurance Application.

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 to be effective as of the date 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 received by your employer or postmarked within 30 days of the marriage.

17. What family changes need to be reported?

You need to report the following changes to your benefits/payroll/personnel office or Employee Trust Funds (for continuants and retirees) within 30 days of the change. Failure to report changes on time may result in loss of benefits or delay payment of claims.

- Change of name, address, telephone number, and Social Security number, etc.
- Obtaining or losing other health insurance coverage
- Addition of a dependent (within 60 days of birth or adoption)

- Loss of dependent's eligibility
- Marriage
- Divorce
- Death

18. What action do I need to take for the following personal events (marriage, birth, etc.)?

Marriage

You can change from single to family coverage to include your spouse (and stepchildren if applicable) without restriction provided you submit your application to your benefits/payroll/ personnel office within 30 days after your marriage with family coverage being effective on the date of your marriage.

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 marriage.

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, legal guardianship, or when a dependent age 25 or younger becomes a full-time student and otherwise satisfies the dependency requirements. Be prepared to submit documentation of guardianship, paternity, or other information as requested by your employer.

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.

If you are a father first declaring paternity, there may be a different effective date. (See **Question 15: What if I am a single mother or a father establishing paternity?**)

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 your payroll office 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. You can keep your dependent children and adopted stepchildren on your family plan, as long as they are eligible (age, student status, etc.). (See also **CONTINUATION OF HEALTH COVERAGE** for additional information.)

You must file a Health Insurance Application with your benefits/payroll/ personnel office to change from family to single coverage. File a Health Insurance Information Change form to remove ineligible dependents from a family contract.

When both parties in the divorce are state 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,

Eligibility

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 (e.g. county). The application must be received by his or her benefits/payroll/personnel office within 30 days of the date of the divorce. Failure to apply timely will limit available coverage to the Standard Plan with a 180-day waiting period for pre-existing conditions (except pregnancy). (**Question 8: What if I miss my enrollment opportunity?**)

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.

Medicare Eligibility

Coverage as offered by any of the state plans is the same for everyone regardless of age or Medicare eligibility. Employees who are eligible for Medicare by reason of age or disability who would rather have Medicare as primary coverage may do so by simply discontinuing group coverage. The federal government requires us to inform you that you may drop your group coverage in order to obtain Medicare as primary coverage although that action is probably not in your best interest.

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 death may continue coverage for life under the state program at group rates but without the University contribution toward the premium. The dependents may continue coverage until eligibility ceases. An enrollment 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.

If the surviving dependents terminate coverage for any reason, they may not re-enroll later.

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. Surviving dependents are not eligible for coverage.

DEPENDENT CHILDREN

19. 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:

- Your natural children (see **Question 25: When does health coverage terminate for dependents?**).
- 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 Wis. Stat. § 632.896. If the adoption of a child 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 awards 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.**)

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

Even though custody of your children may have been transferred to the other parent, you may still insure the children if the other dependency requirements are met. (See **Question 15: What if I am a single mother or a father establishing paternity?**)

21. What if I have a child with physical or mental disabilities or my adult child becomes disabled?

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. We recommend you contact the plan to obtain pre-approval. You will be required to verify your dependent's eligibility at least annually.

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. If you are providing at least 50% support, you must file a *Health Insurance Change* form (ET-2329) with your employer to initiate the disabilities review process by the health plan.

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.

For adult children who become disabled, they must have been previously covered under the State of Wisconsin group insurance program to be considered for disabled dependent status. Contact ETF for more information.

22. What does full-time student mean?

Student means a person who is enrolled in and attending an accredited 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 classes). The determination of the date should be discussed with the institution. 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 student commitments after the semester ends, such as student teaching. You will be required to verify your dependent's eligibility annually.

23. How is student status monitored for covered dependents?

If there are full-time students over age 19 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 terminate the student(s) from the contract as of December 31st. Medical and prescription drug claims will reject.)** If terminated in error, students can be reinstated after the termination date with documentation of student status including *Health Insurance Information Change* form (ET-2329). Charges for services rendered during the period of termination would then be covered. However, it is required that you notify your benefits/payroll/personnel office if student status terminates. Failure to do so may result in the loss of continuation rights.

24. 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.

25. 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 entered.

See section **CONTINUATION OF HEALTH COVERAGE** for additional information on continuing coverage after eligibility terminates.

SELECTING A HEALTH PLAN

26. How do I select a health plan?

See chart on Page iii.

27. 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

The Standard Plan (administered by WPS Health Insurance (WPS)) was redesigned in 2004 to contain in-network and out-of-network services. This type of arrangement is 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 was 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 and prior authorization 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 WPS Health Insurance 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 pre-paid 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.

NOTE: ALL HMOs OFFER UNIFORM BENEFITS WHEN SERVICES ARE PROVIDED IN-NETWORK. SEE UNIFORM BENEFITS IN SECTION D OF THIS BOOKLET.

28. Which plans are actually available to me?

All health plans listed in this booklet, (except SMP that is available if you live in an SMP county as illustrated on the map on page A-5) are available to you. 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 map in the Premium Section A and the Plan Description Section G of this booklet to see which plans serve your area.** Coverage under the Standard Plan is available worldwide.

29. Are there differences between alternate health care plans?

Alternate health care plans (HMOs) 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 and the employee's share of premiums, if any
- 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 plan, do not hesitate to ask questions, especially if you have unique requirements or know you will be requiring medical care in the near future.

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

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

31. 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 after an emergency be received from a plan provider. Only the Standard Plan allows you the flexibility to seek routine care outside a particular service area. (See "Proof of Claim" in UNIFORM BENEFITS, Section D. VI, I, item I for information on submitting claims for non-plan providers.) (See also Question 24: Will an HMO cover dependent children who are living away from home?)

32. 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.

PROVIDER QUALITY INFORMATION

33. Why is ETF including information about Leapfrog, CheckPoint and Healthclick Wisconsin in the It's Your Choice book?

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.

34. 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 hospitals for voluntarily reporting their progress in fully



adopting the standards. The three key standards urban hospitals have been asked 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. Updates occur monthly. The most up-to-date information is available at http://www.leapfroggroup.org/consumer_intro.htm.

35. What is CheckPoint?



CheckPoint is a statewide program sponsored by the Wisconsin Hospital Association that reports results from Wisconsin hospitals who have agreed to share 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.

36. 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.

37. Are there other resources available to consumers for information on provider safety and quality?



HealthclickWisconsin.org is a single web site that links consumers to the most current and extensive public report on quality, safety and service performance for 122 Wisconsin hospitals and clinic care in over 21 major metropolitan areas in the State. This resource is jointly sponsored the Wisconsin Collaborative for Healthcare Quality and the Wisconsin Hospital Association.

By clicking on www.healthclickwisconsin.org, consumers will find information on such things as:

- Appointment wait times in clinics
- Clinical measures on how well patients with diabetic are managed
- Hospital measures on the treatment of heart attack, pneumonia, chronic heart failure, high-risk births, surgical interventions and medical error prevention

PROVIDER INFORMATION

- 38. How can I get a listing of the physicians participating in each plan?** Contact the plan directly. Neither ETF nor your benefits/payroll/ personnel office maintains a current list of this information.
- 39. 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
- 40. How do I choose a primary physician or pharmacy who's right for me?** If you're not sure a provider holds the same beliefs as you do, call the clinic or pharmacy and ask about your concerns. For example, you may want to ask the provider's opinion about dispensing a prescription for oral contraceptives.
- 41. 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 your benefits/payroll/personnel office indicating the effective date of your change as specified by the plan.
- 42. 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.
- 43. What happens if my provider leaves the plan mid-year?** 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 (excluding 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.

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

As an HMO or SMP participant, you may need to designate a primary physician or clinic. 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 HMOs or SMPs 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.

In case of an injury that may fall under workers compensation, you should utilize only providers in your health plan, in case Workers Compensation denies your claim.

PREMIUM CONTRIBUTION TIERING

45 How are health premium contributions determined and why was a tiered premium contribution structure implemented?

For eligible employees listed in question 2, the employer contribution is determined either through collective bargaining or through the applicable compensation plan. For additional information see Page A-2 or contact your payroll representative. The 3-tier health insurance program was implemented because:

- the cost of State employee health insurance is rising by over 10% of every year and.
- in the past there was a wide and sometimes inequitable variation in what employees paid,
- in addition to a lack of incentives for health plans to control costs.

The 3-tier health insurance program is an innovative approach that holds costs down as it creates incentives for health plans to reduce their costs to the State, and encourages State employees to choose the plans that are most efficient in providing quality health care.

It also significantly reduces the employee contribution for certain plans, such as the Standard Plan, by capping the monthly premium contributions. Each plan is rated and placed in a tier based on efficiency. Plans in the same tier have been determined to be within certain thresholds in their level of efficiency.

For additional information see page A-2 or contact your payroll representative.

46 What is a “Qualified Plan?”

“Qualified” simply means that the Board has determined that a plan meets its requirements for providers in the service area in question. This distinction is used by the Board to ensure that each county has at least one tier-one health plan option in each county that has adequate providers available in the service area.

To be qualified in a county, a plan must meet minimum provider availability requirements, consisting of a minimum of five primary care providers, a hospital (if one exists in the county), a chiropractor, and a dentist if dental is offered in the county.

Note that the Group Insurance Board allows health plans to qualify in counties where there are no hospitals, provided the plans have met all other minimum provider availability requirements, and hospitals are

available in surrounding counties.

The distinction between qualified and non-qualified plans should only be used as a guide and members should refer to plan provider directories before making a plan selection. The most appropriate plan for a member may be a non-qualified plan.

Plans cannot be qualified in the first year they participate in this program.

47 Does a plan with a higher premium or a higher tier offer more benefits?

No, all alternate plans (HMOs) are required to offer the Uniform Benefits. Premium rates and tier placement 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. (The Standard Plan will continue to offer benefits that differ from Uniform Benefits.)

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 How do I pay my portion of the premium?

Premiums are paid two months in advance. Therefore, initial deductions from your salary probably will occur about two months before coverage begins. If the initial deduction cannot occur that far in advance, double or triple deductions may be required initially to make premium payments current. **NOTE:** If eligible, your premium will automatically be deducted from your payroll check on a pre-tax basis.

If you are paid on an annual basis (12 monthly checks), your health premiums will be deducted each month of the year.

If you are paid on an academic year basis (9 monthly checks), you will have multiple premium deductions taken from your last check of the academic year (May payroll) to ensure continuous health coverage during the summer if you are expected to hold a summer or fall appointment.

50. If a plan is not in Tier 1, does that mean it provides lower quality health care?

No. The Group Insurance Board will not allow such a plan into the program. This is verified by our collection of data from the Consumer Assessment of Health Plans (CAHPS) survey, the Health Plan Employer Data and Information Set (HEDIS), and other quality measures. Plans that do not make Tier 1 placement are those that are less cost effective in managing care, costs, and quality.

CHANGING HEALTH PLANS

DUAL-CHOICE ENROLLMENT

During the Dual-Choice Enrollment period all subscribers currently 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 the next year provided the plan is still offered.

- 51. 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
- 52. When is a coverage change made during Dual-Choice effective?** Dual-Choice coverage changes are effective January 1 of the following year.
- 53. Is the Dual-Choice Enrollment available to everyone?** No, the Dual-Choice Enrollment period is offered only to subscribers who are presently insured under the State Group Health Insurance program. This includes employees who enroll in the Standard Plan with 180-day waiting period for pre-existing conditions if their coverage is effective on or before October 1.
- 54. 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 13: When can I change from single to family coverage without restrictions?**
- 55. How do I change plans during Dual-Choice?** If you decide to change to a different plan, **complete a health application and submit it to your benefits/payroll/personnel office by the last day of the Dual-Choice Enrollment period.** Applications postmarked after the deadline will not be accepted. Health applications are available from your benefits/payroll/ personnel office unless you are a continuant. If you are a continuant who wants to make a Dual-Choice election, complete and return the application (see Section H) to ETF.
- 56. 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 your benefits/payroll/personnel office **in writing before December 31.**

CHANGING HEALTH PLANS

Yes, but only if you, the subscriber:

- 57. Can I change from one plan to another during the year?**
- Move from your plan's service area (e.g. county) for a period of at least 3 months. An application must be received by your benefits/payroll/personnel office within 30 days 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 for three months by submitting another application within 30 days after you return. **(Also see Question 60: What if I have a temporary or permanent move from the service area?)**
 - OR**
 - Are actively employed and voluntarily cancel your existing coverage and enroll in the Standard Plan with a 180-day waiting period for any pre-existing condition.

You may change to the Standard Plan at any time by canceling your existing coverage and submitting an application for the Standard Plan. Coverage will be effective the first of the month on or following the receipt of the application by your employer. However, there will be a 180-day waiting period for any pre-existing conditions (except pregnancy) for all

participants. There is no waiting period for any children born after the effective date of the Standard Plan coverage. **Pre-existing condition** means a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date.

Otherwise, you can only change health plans without restriction during each Dual-Choice Enrollment period.

58. If I change plans, what happens to any benefit maximums 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 maximums 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.

59. 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.

60. 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.

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 your employer 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 with a 180-day waiting period for pre-existing conditions (except pregnancy). Your contribution rate may change because the University's contribution toward the premium varies by county. (See **Question 44: How are health premium contributions determined?**)

If your relocation is temporary, you may again change plans by submitting an application to change plans within 30 days after your return. The change will be effective of the first of the month on or after

your application is received by your employer or by the Department if you have terminated employment.

61. What if I change plans but am hospitalized

If you are confined as an inpatient (in a hospital, an Alcohol and Other Drug Abuse (AODA) residential center, a skilled nursing center); or

before the new coverage becomes effective and am confined as an inpatient on the date the change occurs (such as January 1)?

require 24 hour home care on the effective date of the coverage with the new plan, you will begin to receive benefits from your new plan unless the facility you are confined in is not in your new plan's network. If you are confined in such a facility, your claims will continue to be processed by your prior plan as provided by contract until that confinement ends and you are discharged from the non-network hospital or other facility, 12 months have passed, or the contract maximum is reached. If you are transferred or discharged to another facility for treatment of the same or related condition, it is considered one confinement.

In all other instances, the new plan assumes liability immediately on the effective date of your coverage, such as 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 (WPS) before you are admitted to a hospital or you will be subject to a penalty. 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.

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 or services. The Standard Plan requires claims incurred in any calendar year to be received by the Administrator no later than the end of the next calendar year. Alternate plans (HMOs) require claims be filed within 12 months of the date of service, or if later, as soon as reasonably possible.

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

When you are covered under two or more group health insurance policies 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.**)

STANDARD PLAN

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

This plan, often called a Preferred Provider Plan (PPP), offers you 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. The in-network deductible will be \$100

single/\$200 family. After the deductible, the plan pays 100% of in-network, covered services.

If you choose an out-of-network provider, you contribute more toward your health care costs by incurring additional deductible costs, and coinsurance. You will have a \$500 single/\$1,000 family deductible and co-insurance costs. (See in section G, the Standard Plan description page for more information.)

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.

Note that 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-payments is \$1,000 single/\$2,000 family.

A PPP 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 have the option to enroll in this plan.

66. 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.

67. How does the change in administrator for the Standard Plan and SMP from BCBSWI to WPS affect me?

- You will receive a new identification card that you will need to show to your providers as you see them on or after January 1st, so that they will begin sending claims to WPS Health Insurance (WPS) for processing. If you don't show your card, the processing of your claims may be delayed.
- You should check the WPS provider list to determine if your providers are in network. You can call WPS at (800) 634-6448, check their web site www.wpsic.com/state and/or request a directory to be sent to you. (See last bullet below.)
- If you are enrolled in the Standard Plan or SMP in 2005 and/or plan to enroll effective January 1, 2006, watch your mailbox for materials sent to you from WPS for more information. WPS will mail out information in September and December to current members, and (in December) to those who enroll during Dual-Choice.
- If you are enrolled in SMP, and have referrals that were approved for services in 2006, those will be honored but future referrals must follow WPS guidelines. See your SMP provider directory, Section G Plan Descriptions, or call WPS for more information.

PHARMACY BENEFIT MANAGER

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

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.

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

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 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.

70. How does a three-level drug co-payment system work?

Under a three-level prescription drug benefit, you have three different co-payment amounts for covered prescription drugs. By having to pay a lower co-payment 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 co-payment, which is the Level 3 co-payment. 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.

71. 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.

EMPLOYEE REIMBURSEMENT ACCOUNT (ERA) PROGRAM

72. How can I decrease my taxes by using the ERA program?

Most state employees have an opportunity to lower their taxes by paying certain medical and dependent care expenses with pre-tax dollars through the ERA program. Enrollment information is provided to eligible employees each fall. Newly eligible employees should receive a packet from their benefits/payroll/personnel office when they are hired.

The ERA program has two parts.

1. **Automatic Premium Conversion.** Unless you have filed a waiver, group health insurance premiums are taken from your pre-tax salary automatically. This reduces your taxable gross pay which in turn will reduce your income tax withholding and Social Security deductions. Group life insurance and EPIC dental and excess medical insurance and Spectera Vision Care premiums are also taken from pre-tax salary. You need to file a waiver only once. It will remain in effect until you revoke it. To file a waiver, or revoke a previously filed waiver, complete an *Automatic Premium Conversion Waiver/Revocation of Waiver* form (ET-2340) and return it to your benefits/payroll/personnel office during the enrollment period, to be effective at the beginning of the next plan year.
2. **Medical Reimbursement and Dependent Care Accounts.** Employee Reimbursement Accounts (ERA) allow you to reduce your taxable income by an agreed-upon amount each pay period and to

have these amounts set aside to pay dependent care and/or certain medical expenses.

- A medical reimbursement account is used to pay medical expenses for you, your spouse, and dependents that are not paid by insurance. This would include deductibles and co-insurance amounts; drugs; dental, vision and hearing care; orthodontia; and other uncovered medical procedures or supplies. Certain over-the-counter drugs such as antacids, allergy, pain and cold remedies may also be paid through a medical expense reimbursement account. A more complete list of eligible expenses may be found in the ERA plan booklet.
- A dependent care reimbursement account pays for day care expenses for your children or other eligible dependents if such care is necessary to enable you and your spouse to work.

Enrollment. Participation in the Employee Reimbursement Account Program is entirely optional. It is administered by Fringe Benefits Management Company, a public employer benefit administrator. You are given an opportunity each fall to enroll for the following calendar year. Newly eligible employees may enroll during the year by applying within 30 days of their initial date of hire.

Additional Information. If you would like more information about the ERA program, or if you did not receive your fall enrollment materials, contact Fringe Benefits Management Customer Service directly at 1-800-342-8017. ERA information may also be found on the Employee Trust Funds web site at etf.wi.gov.

73. How much should I contribute to my ERA medical expense account?

Review the Dual-Choice book and benefit information for other dental, vision or supplemental medical coverage that you may have to determine the benefits, co-payments, and/or deductibles. Also review the Navitus formulary to determine your drug co-payments. Keep in mind the out-of-pocket maximums for drug coverage apply to only Level 1 and Level 2 drugs. Certain over-the-counter drugs are also eligible for reimbursement through a medical expense account.

Plan carefully before you enroll in the ERA program. Your account may not be changed or terminated during the plan year unless you experience a qualifying "change in status." Unused funds cannot be refunded. Consult the ERA enrollment booklet for more information about eligible medical expenses and qualifying change in status events.

TERMINATION/LEAVING YOUR HEALTH PLAN

CANCELLATION / TERMINATION OF COVERAGE

74. How do I cancel coverage?

Voluntary cancellation (or switching from family to single coverage that is deemed voluntary cancellation for all insured dependents) requires written notification to your benefits/payroll/personnel office and the completion of a Health Insurance Application denoting a cancellation of coverage. 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**. Cancellation affects both medical and prescription drug coverage.

No **REFUNDS** are made for premiums paid in advance unless your benefits/payroll/personnel office (or, if you are no longer a University

employee, 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.

75. When can an employee's health insurance coverage be terminated?

Your coverage can only be terminated because:

1. Premiums are not paid.
2. Coverage is voluntarily cancelled.
3. Eligibility for coverage ceases (for example, terminate employment).
4. 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.
5. Death of subscriber.

Contact your benefits/payroll/personnel office for the date coverage will end.

CONTINUATION OF HEALTH COVERAGE

Your COBRA continuation rights are described in Section B. of this booklet. **Both you and your spouse should take the time to read that section carefully.** This section provides additional information about continuation coverage.

You do not have to provide evidence of insurability to enroll in continuation coverage. However, coverage is limited to the plan you had as an active employee or covered dependent. (For example, if you change plans January 1st and your dependent loses eligibility December 31st, that dependent would be eligible for COBRA from the plan you were enrolled in on December 31st. An exception is made when the participant resides in a county that does not include a primary physician for the subscriber's plan at the time continuation is elected. In that case, the participant may elect a different plan that is offered in the county where the participant resides.) You may select another plan during the Dual-Choice Enrollment period or if you move from the service area. If family coverage is not elected when continuation is first offered, each dependent may independently elect single continuation coverage. A family of two may select two single contracts at a lower cost than the premium for a family contract. The plan will bill you directly. There can be no lapse in coverage so multiple premiums may be required.

If you terminate employment and have less than 20 years of creditable service, you will be offered a 36-month continuation coverage period. **A second qualifying event while on continuation will not serve to extend your period of continuation. Coverage will be limited to the original 36 months.** At the end of the continuation period you will be allowed to enroll in an individual conversion health plan.

NOTE: Continuation coverage time limits do not apply to state and University employees who terminate with 20 years of WRS creditable service and remain a WRS participant. They can continue the group health insurance for life even if they don't take an immediate annuity. To continue, an application must be received before coverage lapses.

76. Who is eligible for continuation?

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

77. When do I notify my employer if a dependent loses eligibility for coverage?

Under Federal Law, if the employer 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. You have the responsibility to inform the employing agency 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. A voluntary change in coverage from a family plan to a single plan does not create a continuation opportunity.

78. 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.

79. Will my premium change under continuation?

It may change as you will pay the total premium amount which includes both the employee and employer share. Contact your employer to obtain the total amount.

80. 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 ETF receives the request to cancel coverage.

81. When is conversion coverage available?

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.

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.

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 30 days after termination of group coverage. If you have questions regarding conversion, write or call the plan in which you are enrolled.

82. How is my continuation coverage affected if 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 **Question 60: What if I have a temporary or permanent move from the service area?** for additional information.)

Your application to change plans must be postmarked within 30 days after your move. Because you are on continuation coverage, call the 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.