

*Group Health Insurance
Plans & Provisions*

**Dual-Choice
Enrollment Period
October 8-26, 2007**

*Use this as a reference
throughout the year.*

**Important
information on:**

- Plan and Program Information for 2008
- The Pharmacy Benefit Manager (PBM)
- Premiums for 2008
- Eligibility and Other Coverage Information
- Uniform Benefits – Serves as Your Certificate of Coverage for HMOs & SMP for 2008
- Health Plan Report Cards

*It's Your
Choice*

Contains federally required notices of COBRA Health Insurance Continuation Rights for Employees & Covered Spouses, HIPAA Privacy Practices, and others.

2008

FOR STATE OF WISCONSIN EMPLOYEES



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

The Department of Employee Trust Funds does not discriminate on the basis of disability in the provision of programs, services or employment. If you are speech, hearing or visually impaired and need assistance, call our toll free number at 1-877-533-5020 or (608) 266-3285 (local Madison). We will try to find another way to get the information to you in a usable form.

Employee Trust Funds
801 West Badger Road
P. O. Box 7931
Madison, WI 53707-7931

Internet site: etf.wi.gov
Toll Free: 1-877-533-5020
(608) 266-3285 (local Madison)

NOTABLE PLAN AND PROGRAM CHANGES EFFECTIVE JANUARY 1, 2008

All Dual-Choice plan changes and coverage changes take effect on January 1, 2008. To change health plans, your employer must receive your application by 4:30 p.m. on Friday, October 26, 2007.

All plan and provider network changes have been made at the request of the health plan. If you have questions or concerns, all plan telephone numbers, including Nurse Lines where available, and addresses are shown on the inside back cover of this booklet.

→ **HEALTH PLANS NO LONGER AVAILABLE**

- SMP is no longer available in Ashland, Marinette and Pierce counties. Subscribers using providers in these counties must consider selecting another plan or will be limited to the SMP providers remaining in other areas. Subscribers are not required to live or work in an SMP county to be eligible for SMP.

→ **HEALTH PLAN NAME CHANGE**

- **CompcareBlue has changed its name to Anthem Blue Cross & Blue Shield.** The plan will mail out information to current members prior to Dual-Choice and produce new identification cards at the end of this year.
- **WPS Prevea Health Plan has changed its name to Arise Health Plan.** Current members have already received new identification cards and information.

→ **SIGNIFICANT PLAN PROVIDER NETWORK CHANGES**

- A number of health plans have changed their service areas. **Some have made significant changes by adding or terminating contracts with certain provider groups. Humana and Arise Health Plan are examples of plans that have such changes this year.** Please refer to the map on page A-5 and the Plan Descriptions in Section G. *Verify with your health plan* that your provider(s) is still available to you in 2008.
- **Note:** Your current health plan is required to provide you with either a list of all plan providers that will not be available to you or a provider directory listing only those providers available in 2008. You should contact your plan and request this information if you have not received it by October 5.

→ **CHANGES TO PHARMACY BENEFITS**

- For most plans, the annual prescription drug out-of-pocket amount will increase to \$350 per individual and \$700 per family. See page D-2 for further information. The out-of-pocket amount for the Standard Plan will remain at \$1,000 per individual and \$2,000 per family.

→ **CHANGES TO DENTAL COVERAGE** See Section G, the Plan Description Pages for more information.

- **Arise Health Plan (formerly WPS Prevea)** is offering dental coverage in 2008.
- **Dean Health Plan** has changed dental plan administrators from Delta Dental to the Ameritas Group, a Preferred Provider Plan. In addition, certain annual and lifetime benefit maximum amounts are increasing. The plan will mail out

information to current members prior to Dual-Choice and produce new identification cards at the end of this year.

- **Physicians Plus** has changed the criteria for dental exams. The plan will cover '2 cleanings per year' as opposed to '1 cleaning every six months'.
- **Security Health Plan** is implementing a network for benefits. Members should check with the health plan for a list of available providers.

➔ **INFORMATION ON PROVIDER QUALITY**

The Group Insurance Board supports the goals of improving the quality and safety of health care services. Staff at ETF is involved in a number of state and national initiatives focused on reducing medical errors and saving lives through voluntary public reporting. The Plan Descriptions in Section G have notations on the participating hospitals and clinics that have reported information to several quality and safety reporting organizations, including the Leapfrog Group, CheckPoint, the Joint Commission, and the Wisconsin Collaborative for Healthcare Quality. See page G-2 for more information. By providing this information, ETF is recognizing hospitals and providers that make improvements in patient safety and quality. You can visit the results on-line at:

www.leapfroggroup.org

www.jointcommission.org

www.wicheckpoint.org

www.wchq.org

➔ **OTHER INFORMATION ABOUT IT'S YOUR CHOICE**

WEB SITE: The Dual-Choice booklet is available on the ETF Web site at etf.wi.gov. Any known printing discrepancies will be clarified on this site. Additional information about the health insurance program and other insurance programs offered to employees, annuitants and continuants is also available at this site.

IMPORTANT CONSIDERATIONS

Generally, if you are satisfied with your current plan, you do not have to do anything during Dual-Choice. Your current coverage will automatically continue provided your plan is still offered. (Note, coverage for dependents over age 19 must be verified with the plan annually.) However, you should review this checklist and consider the following:

- Is your plan still available next year?** Sometimes HMOs drop out of the State of Wisconsin Group Health Insurance program, merge with other HMOs, or split off to form new HMOs. These changes are listed on page i. If this happens with your plan, you will probably need to take some action to change your coverage. Sections A and G provide information on plan service areas.
- Have your premiums changed?** Premiums change each year and as a result the amount you pay may have increased. Premiums are shown in Section A.
- Is your physician, clinic, or hospital still affiliated with your plan?** Agreements between HMOs and medical providers are subject to change each year. It is not unusual for medical providers to move from one HMO to another or to contract with more than one HMO. Provider listings are available from the plans.
- Have benefits changed with your plan?** If your plan offers dental benefits, you should check whether there are any changes. Changes to the Uniform Benefits are the same for all alternate plans and are described on page D-2.
- How satisfied are other participants with their health plans?** Review and compare the health plan report card and information in Section E.
- Do you want to change health plans or change from single to family coverage for 2008?** If so, your benefits/payroll/personnel office (or Employee Trust Funds if you are an annuitant or are on continuation coverage) must receive your Dual-Choice application on or before October 26, 2007. Coverage changes will be effective on January 1, 2008.
- How do plans compare for disease management and wellness programs?** Plans offer various programs. Two comparison grids are included for your reference. One appears in the introductory portion of section E. The other appears on pages G-4 and G-5. Further detail is available on the plan pages in section G.
- Do you have a dependent over age 19 covered under your family plan?** Your health plan will contact you to check on their status and you must reply or the dependent's coverage may terminate. See the Question and Answer section on dependent children for more information.

If you are considering changing health plans please read through the following checklist and if applicable, call the specific plan you are considering and/or review its materials. This will help ensure that your health care needs are smoothly transitioned from your prior coverage to your new coverage.

- Are there sufficient providers, including specialists, conveniently located to meet your needs?**

- Did you list your primary care physician's *name* on the application?**

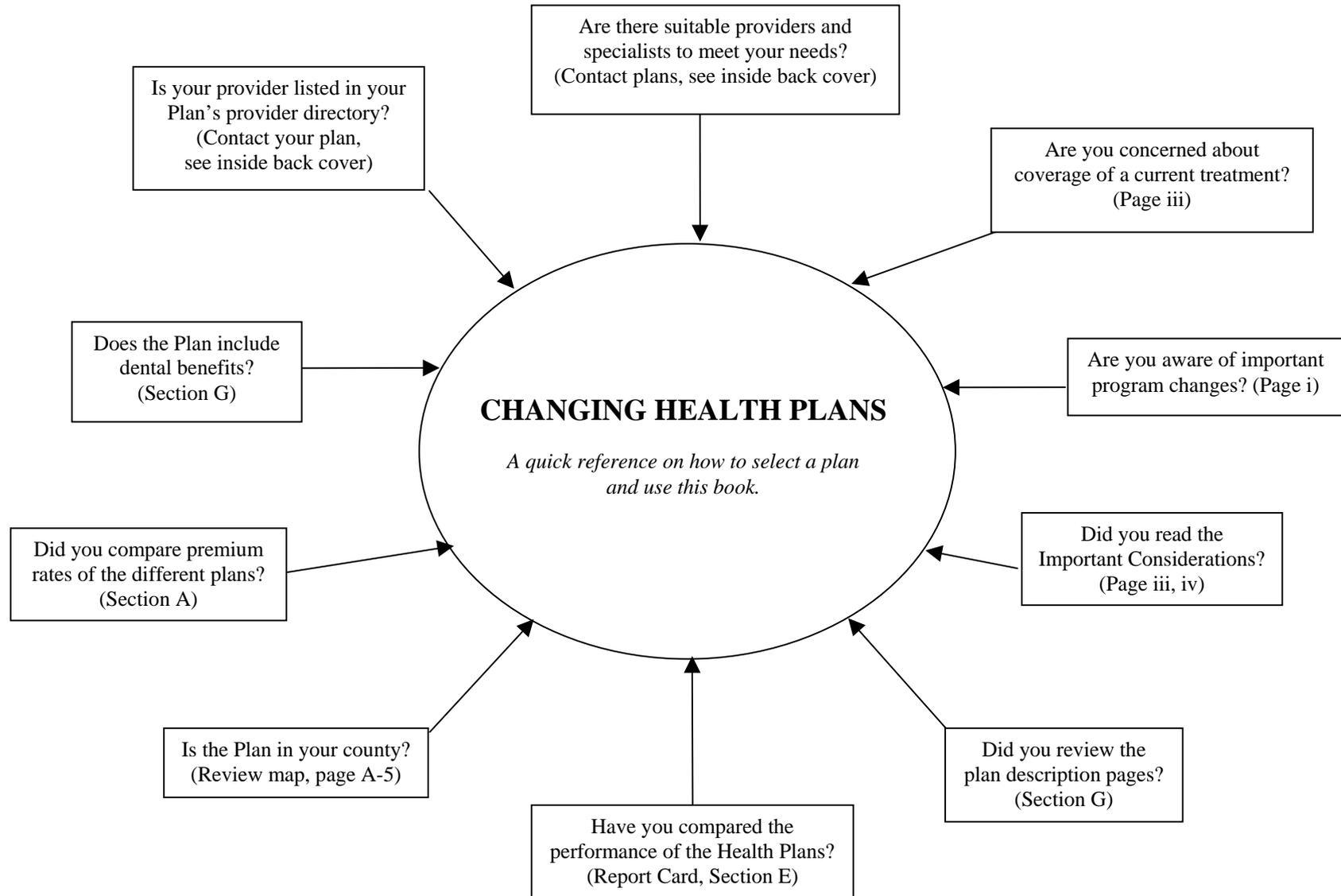
- Are you concerned that a current treatment that you are receiving may not be covered under your new plan?** If so, please make sure to contact customer service of the plan you are considering. If your current provider is not also with your new plan, do not expect to get a referral to that provider. In most cases, you will need to see a provider affiliated with the new plan.

- Are there differences between the dental benefits provided, if any, by your current plan and the one(s) you are considering?**

See the inside back cover of this booklet for telephone numbers of the available health plans.

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Plan Addresses/Phone Numbers	inside back cover



Premium Rates for 2008

Some plans have limited provider availability in certain areas. For this reason they appear without underlining or bold type on the map on page A-5. You may select any plan offered through this program. See the Plan Descriptions in Section G for more information about plans in your area. Verify the providers in your selected plan to be sure that you are satisfied with their availability in your county.

All Health Insurance Applications filed during Dual-Choice are for coverage effective January 1, 2008. If you decide to change plans you need to fill out a form. If you want to remain with your current plan, do nothing.

Explanation of Three-Tier Health Insurance Program

Nationally, health insurance costs have been rising at double-digit rates for the last several years, and this trend is expected to continue for more years to come. The State of Wisconsin has implemented changes to the state employee health insurance program that are helping the state to reduce this trend of escalating costs. One of those changes is the 3-Tiered approach to health insurance purchasing.

Prior to the passage and signing of the 2003-2005 biennial budget in July of 2003, state statutes required the state to pay health plan premiums of up to 105% of the lowest-cost health plan in a particular county. Any plan that bid within 5% of the lowest-cost plan was provided at no cost to employees, just like the plan that submitted the lowest bid. The 105% formula had some significant shortcomings. This formula did not create incentives for health plans to hold down their premium costs. Because plans were priced by county, employees in different counties often paid different amounts for the same health plan. Finally, the formula drove up the cost of the Standard Plan to the point that the plan became unaffordable for many state employees.

The 3-Tier model, recommended by the Group Insurance Board and adopted in the 2003-2005 biennial budget, was designed to address these problems while maintaining high-quality, low-cost health care coverage. While still maintaining a uniform medical insurance benefits package, each plan has now been assigned to one of three tiers based on the relative efficiency with which a plan is able to provide the benefits and the quality of care required by the Board. Plans were given extra credit in the tier assignment process if they scored well on measures of quality, patient safety, and customer satisfaction. This approach has created significant incentives for health plans to hold down the costs they charge the state while guaranteeing that all state employees have access to a Tier 1 plan in their area. In addition, monthly premium contributions for the Standard Plan have been capped.

Premium contribution amounts for calendar year 2008 are provided below, and are based on the current budget in effect, subject to change per the 2007-2009 biennial budget. These rates apply to **represented employees** (except UW-Madison and Milwaukee Graduate Assistants) and to **non-represented employees including those at the University of Wisconsin System**. They also apply to **the faculty and academic staff of the University of Wisconsin System**, as established by their respective compensation plans.

January 2008 through December 2008

<u>Tier</u>	<u>Single Rate</u>	<u>Family Rate</u>
Tier – 1	\$27.00	\$68.00
Tier – 2	\$60.00	\$150.00
Tier – 3	\$143.00	\$358.00

For **represented employees**, the employee contribution rates remain subject to collective bargaining. Agency payroll/benefits staff will notify all affected employees of any changes in the employee contribution amounts resulting from collective bargaining.

For **employees of the University of Wisconsin Hospital**, your premium contribution amounts will be provided to you from your benefits/payroll office.

MONTHLY STATE GROUP HEALTH INSURANCE RATES FOR CY 2008*	PLAN TIER	CONTRACT TYPE	
		SINGLE	FAMILY
PLAN NAME			
STANDARD PLAN	3	895.70	2235.60
STATE MAINTENANCE PLAN (SMP)	1	554.30	1382.00
ANTHEM BCBS NORTHWEST	2	658.40	1642.30
ANTHEM BCBS SOUTHEAST	1	618.90	1543.60
ARISE HEALTH PLAN	1	577.50	1440.10
DEAN HEALTH PLAN	1	501.80	1250.80
GHC EAU CLAIRE	1	604.00	1506.30
GHC-SCW	1	494.20	1231.80
GUNDERSEN LUTHERAN HEALTH PLAN	1	591.00	1473.80
HEALTH TRADITION	1	620.60	1547.80
HUMANA EASTERN	1	621.20	1549.30
HUMANA WESTERN	1	625.10	1559.10
MEDICAL ASSOCIATES HEALTH PLAN	1	476.20	1186.80
MERCYCARE HEALTH PLAN	1	480.60	1197.80
NETWORK HEALTH PLAN	1	523.00	1303.80
PHYSICIANS PLUS--MERITER & UW	1	498.10	1241.60
SECURITY HEALTH PLAN	1	621.10	1549.10
UNITEDHEALTHCARE NE	1	543.00	1353.80
UNITEDHEALTHCARE SE	1	602.70	1503.10
UNITY COMMUNITY	1	611.70	1525.60
UNITY UW HEALTH	1	504.60	1257.80
WPS PATIENT CHOICE PLAN 1	1	619.90	1546.10
WPS PATIENT CHOICE PLAN 2	2	650.20	1621.80
*These are the total monthly premium rates. See your benefits and payroll specialist and page A-2 for more information on employee contributions.			

State of Wisconsin Employees

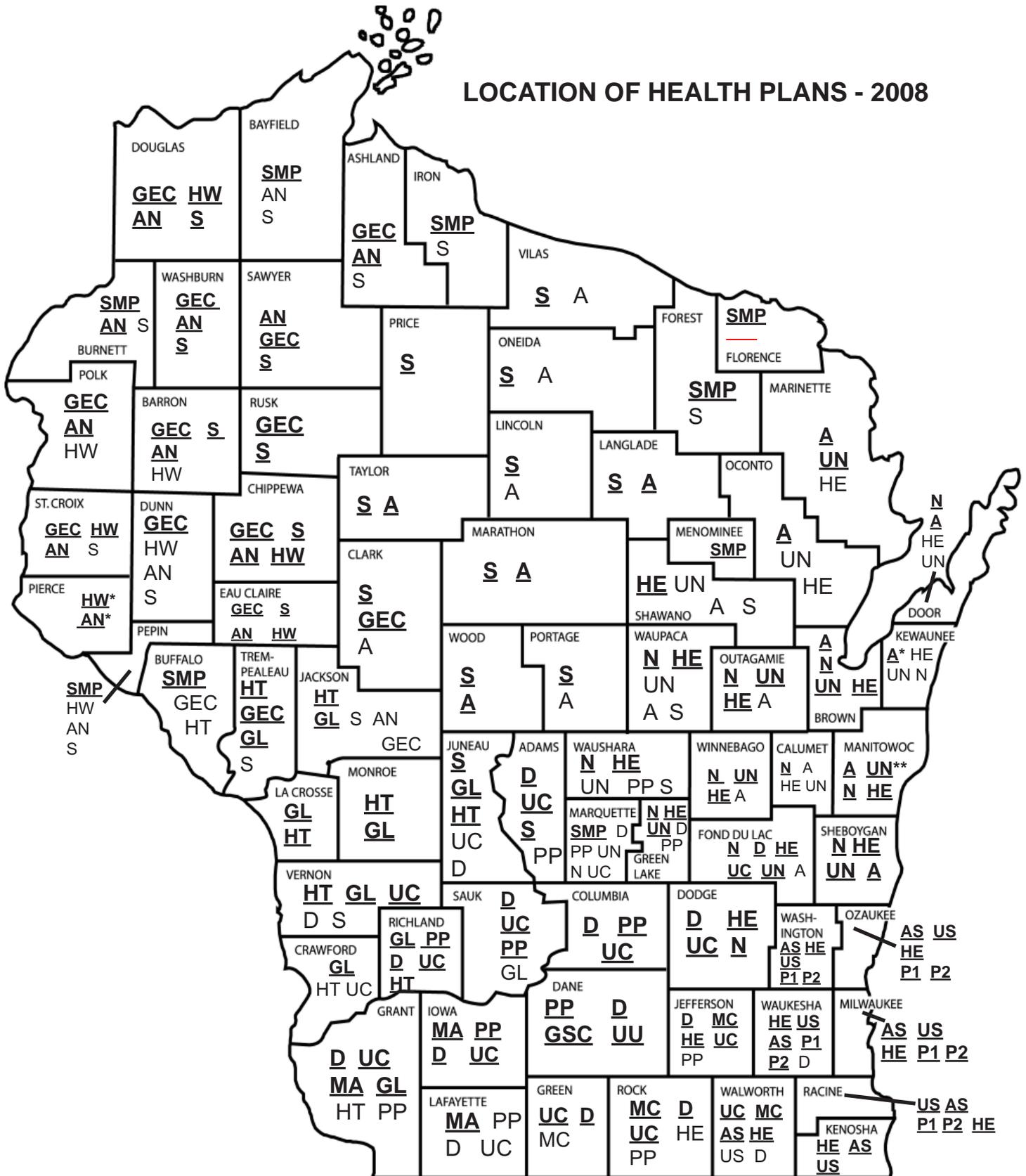
2008 Plans	Plan Code
Anthem BCBS – Northwest (formerly Compcare Blue)	AN
Anthem BCBS – Southeast (formerly Compcare Blue)	AS
Arise Health Plan (formerly WPS Prevea)	A
Dean Health Plan	D
Group Health Cooperative of Eau Claire	GEC
Group Health Cooperative of South Central Wisconsin	GSC
Gundersen Lutheran Health Plan	GL
Health Tradition Health Plan	HT
Humana Eastern	HE
Humana Western	HW
Medical Associates Health Plan	MA
MercyCare Health Plan	MC
Network Health Plan	N
Physicians Plus – Meriter & UW Region	PP
Security Health Plan	S
State Maintenance Plan (WPS Health Insurance)	SMP
Standard Plan (WPS Health Insurance)	None
UnitedHealthcare of Northeast	UN
UnitedHealthcare of Southeast	US
Unity Community	UC
Unity UW Health	UU
WPS Patient Choice Plan 1	P1
WPS Patient Choice Plan 2	P2

HOW TO USE THIS MAP

- See the Plan Codes above to determine which plans are in your county.
- If the plan code is underlined and in **bold** type in a county, it means that the plan is “**qualified**”. To be qualified, a plan must meet minimum provider availability requirements (based on primary care providers, hospital, chiropractor, and dentist if dental is offered by the plan).
- If a Plan Code appears in a county but is not underlined and in bold type, it means that the plan has at least one primary care provider in that county but is not a qualified plan. You may select that plan but make sure that it has sufficient providers in your area to meet your needs.
- You may enroll in any plan regardless of where you live, but if you enroll in an HMO, you must receive care from that plan’s providers.
- SMP is available in counties where there is no qualified tier 1 plan. There may also be non-qualified plans available in those counties.
- Contact the health plan directly if you have questions about the number or location of providers. The plans’ telephone numbers are shown on the inside back cover.

THE STANDARD PLAN IS AVAILABLE ANYWHERE. As such, it does not appear on the map.

LOCATION OF HEALTH PLANS - 2008



* Quali ed in a county with no hospital.

** Hospital 4 miles from major city.

A number of plans have changed their service areas for 2008; some have made signi cant changes. As a result, you may need to change plans for 2008.

“Quali ed plans in each county are underlined and show in **bold** type. “Non-quali ed” plans are not underlined or bolded. Non-quali ed plans have limited provider availability in the indicated county.

Plan designation is based upon the tiering of plans approved by the Group Insurance Board.

2008 HEALTH PLAN OPTIONS AND TIERING BY COUNTY: ACTIVE STATE		Tier
ADAMS		
	DEAN HEALTH PLAN	1
*	PHYSICIANS PLUS--MERITER & UW	1
	SECURITY HEALTH PLAN	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
ASHLAND		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
*	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
BARRON		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
*	HUMANA WESTERN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
BAYFIELD		
*	ANTHEM BCBS NORTHWEST	2
*	SECURITY HEALTH PLAN	1
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3
BROWN		
	ARISE HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
BUFFALO		
*	GHC EAU CLAIRE	1
*	HEALTH TRADITION	1
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3
BURNETT		
	ANTHEM BCBS NORTHWEST	2
*	SECURITY HEALTH PLAN	1
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3
CALUMET		
*	ARISE HEALTH PLAN	1
*	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
*	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
CHIPPEWA		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
	HUMANA WESTERN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
CLARK		
*	ARISE HEALTH PLAN	1
	GHC EAU CLAIRE	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3

* Plan has limited provider availability in the county and is considered "non-qualified." Please see QA #45 on page C-26 for more information on qualification.

2008 HEALTH PLAN OPTIONS AND TIERING BY COUNTY: ACTIVE STATE		Tier
COLUMBIA		
	DEAN HEALTH PLAN	1
	PHYSICIANS PLUS--MERITER & UW	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
CRAWFORD		
	GUNDERSEN LUTHERAN HEALTH PLAN	1
*	HEALTH TRADITION	1
*	UNITY COMMUNITY	1
	STANDARD PLAN	3
DANE		
	DEAN HEALTH PLAN	1
	GHC-SCW	1
	PHYSICIANS PLUS--MERITER & UW	1
	UNITY UW HEALTH	1
	STANDARD PLAN	3
DODGE		
	DEAN HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
DOOR		
	ARISE HEALTH PLAN	1
*	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
*	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
DOUGLAS		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
	HUMANA WESTERN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
DUNN		
*	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
*	HUMANA WESTERN	1
*	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
EAU CLAIRE		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
	HUMANA WESTERN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
FLORENCE		
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3

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2008 HEALTH PLAN OPTIONS AND TIERING BY COUNTY: ACTIVE STATE		Tier
FOND DU LAC		
*	ARISE HEALTH PLAN	1
	DEAN HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
	UNITEDHEALTHCARE NE	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
FOREST		
*	SECURITY HEALTH PLAN	1
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3
GRANT		
	DEAN HEALTH PLAN	1
	GUNDERSEN LUTHERAN HEALTH PLAN	1
*	HEALTH TRADITION	1
	MEDICAL ASSOCIATES HEALTH PLAN	1
*	PHYSICIANS PLUS--MERITER & UW	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
GREEN		
	DEAN HEALTH PLAN	1
*	MERCYCARE HEALTH PLAN	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
GREEN LAKE		
*	DEAN HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
*	PHYSICIANS PLUS--MERITER & UW	1
	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
IOWA		
	DEAN HEALTH PLAN	1
	MEDICAL ASSOCIATES HEALTH PLAN	1
	PHYSICIANS PLUS--MERITER & UW	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
IRON		
*	SECURITY HEALTH PLAN	1
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3
JACKSON		
*	ANTHEM BCBS NORTHWEST	2
*	GHC EAU CLAIRE	1
	GUNDERSEN LUTHERAN HEALTH PLAN	1
	HEALTH TRADITION	1
*	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
JEFFERSON		
	DEAN HEALTH PLAN	1
	HUMANA EASTERN	1
	MERCYCARE HEALTH PLAN	1
*	PHYSICIANS PLUS--MERITER & UW	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3

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2008 HEALTH PLAN OPTIONS AND TIERING BY COUNTY: ACTIVE STATE		Tier
JUNEAU		
*	DEAN HEALTH PLAN	1
	GUNDERSEN LUTHERAN HEALTH PLAN	1
	HEALTH TRADITION	1
	SECURITY HEALTH PLAN	1
*	UNITY COMMUNITY	1
	STANDARD PLAN	3
KENOSHA		
	ANTHEM BCBS SOUTHEAST	1
	HUMANA EASTERN	1
	UNITEDHEALTHCARE SE	1
	STANDARD PLAN	3
KEWAUNEE		
	ARISE HEALTH PLAN	1
*	HUMANA EASTERN	1
*	NETWORK HEALTH PLAN	1
*	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
LACROSSE		
	GUNDERSEN LUTHERAN HEALTH PLAN	1
	HEALTH TRADITION	1
	STANDARD PLAN	3
LAFAYETTE		
*	DEAN HEALTH PLAN	1
	MEDICAL ASSOCIATES HEALTH PLAN	1
*	PHYSICIANS PLUS--MERITER & UW	1
*	UNITY COMMUNITY	1
	STANDARD PLAN	3
LANGLADE		
	ARISE HEALTH PLAN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
LINCOLN		
*	ARISE HEALTH PLAN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
MANITOWOC		
	ARISE HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
MARATHON		
	ARISE HEALTH PLAN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
MARINETTE		
	ARISE HEALTH PLAN	1
*	HUMANA EASTERN	1
	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3

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2008 HEALTH PLAN OPTIONS AND TIERING BY COUNTY: ACTIVE STATE		Tier
MARQUETTE		
*	DEAN HEALTH PLAN	1
*	NETWORK HEALTH PLAN	1
*	PHYSICIANS PLUS--MERITER & UW	1
*	UNITEDHEALTHCARE NE	1
*	UNITY COMMUNITY	1
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3
MENOMINEE		
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3
MILWAUKEE		
	ANTHEM BCBS SOUTHEAST	1
	HUMANA EASTERN	1
	UNITEDHEALTHCARE SE	1
	WPS PATIENT CHOICE PLAN 1	1
	WPS PATIENT CHOICE PLAN 2	2
	STANDARD PLAN	3
MONROE		
	GUNDERSEN LUTHERAN HEALTH PLAN	1
	HEALTH TRADITION	1
	STANDARD PLAN	3
OCONTO		
	ARISE HEALTH PLAN	1
*	HUMANA EASTERN	1
*	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
ONEIDA		
*	ARISE HEALTH PLAN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
OUTAGAMIE		
*	ARISE HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
OZAUKEE		
	ANTHEM BCBS SOUTHEAST	1
	HUMANA EASTERN	1
	UNITEDHEALTHCARE SE	1
	WPS PATIENT CHOICE PLAN 1	1
	WPS PATIENT CHOICE PLAN 2	2
	STANDARD PLAN	3
PEPIN		
*	ANTHEM BCBS NORTHWEST	2
*	HUMANA WESTERN	1
*	SECURITY HEALTH PLAN	1
	STATE MAINTENANCE PLAN	1
	STANDARD PLAN	3
PIERCE		
	ANTHEM BCBS NORTHWEST	2
	HUMANA WESTERN	1
	STANDARD PLAN	3

* Plan has limited provider availability in the county and is considered "non-qualified." Please see QA #45 on page C-26 for more information on qualification.

2008 HEALTH PLAN OPTIONS AND TIERING BY COUNTY: ACTIVE STATE		Tier
POLK		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
*	HUMANA WESTERN	1
	STANDARD PLAN	3
PORTAGE		
*	ARISE HEALTH PLAN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
PRICE		
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
RACINE		
	ANTHEM BCBS SOUTHEAST	1
	HUMANA EASTERN	1
	UNITEDHEALTHCARE SE	1
	WPS PATIENT CHOICE PLAN 1	1
	WPS PATIENT CHOICE PLAN 2	2
	STANDARD PLAN	3
RICHLAND		
	DEAN HEALTH PLAN	1
	GUNDERSEN LUTHERAN HEALTH PLAN	1
	HEALTH TRADITION	1
	PHYSICIANS PLUS--MERITER & UW	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
ROCK		
	DEAN HEALTH PLAN	1
*	HUMANA EASTERN	1
	MERCYCARE HEALTH PLAN	1
*	PHYSICIANS PLUS--MERITER & UW	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
RUSK		
	GHC EAU CLAIRE	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
SAUK		
	DEAN HEALTH PLAN	1
*	GUNDERSEN LUTHERAN HEALTH PLAN	1
	PHYSICIANS PLUS--MERITER & UW	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
SAWYER		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
SHAWANO		
*	ARISE HEALTH PLAN	1
	HUMANA EASTERN	1
*	SECURITY HEALTH PLAN	1
*	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3

* Plan has limited provider availability in the county and is considered "non-qualified." Please see QA #45 on page C-26 for more information on qualification.

2008 HEALTH PLAN OPTIONS AND TIERING BY COUNTY: ACTIVE STATE		Tier
SHEBOYGAN		
	ARISE HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
ST. CROIX		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
	HUMANA WESTERN	1
*	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
TAYLOR		
	ARISE HEALTH PLAN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
TREMPEALEAU		
	GHC EAU CLAIRE	1
	GUNDERSEN LUTHERAN HEALTH PLAN	1
	HEALTH TRADITION	1
*	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
VERNON		
*	DEAN HEALTH PLAN	1
	GUNDERSEN LUTHERAN HEALTH PLAN	1
	HEALTH TRADITION	1
*	SECURITY HEALTH PLAN	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
VILAS		
*	ARISE HEALTH PLAN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
WALWORTH		
	ANTHEM BCBS SOUTHEAST	1
*	DEAN HEALTH PLAN	1
	HUMANA EASTERN	1
	MERCYCARE HEALTH PLAN	1
*	UNITEDHEALTHCARE SE	1
	UNITY COMMUNITY	1
	STANDARD PLAN	3
WASHBURN		
	ANTHEM BCBS NORTHWEST	2
	GHC EAU CLAIRE	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
WASHINGTON		
	ANTHEM BCBS SOUTHEAST	1
	HUMANA EASTERN	1
	UNITEDHEALTHCARE SE	1
	WPS PATIENT CHOICE PLAN 1	1
	WPS PATIENT CHOICE PLAN 2	2
	STANDARD PLAN	3

* Plan has limited provider availability in the county and is considered "non-qualified." Please see QA #45 on page C-26 for more information on qualification.

2008 HEALTH PLAN OPTIONS AND TIERING BY COUNTY: ACTIVE STATE		Tier
WAUKESHA		
	ANTHEM BCBS SOUTHEAST	1
*	DEAN HEALTH PLAN	1
	HUMANA EASTERN	1
	UNITEDHEALTHCARE SE	1
	WPS PATIENT CHOICE PLAN 1	1
	WPS PATIENT CHOICE PLAN 2	2
	STANDARD PLAN	3
WAUPACA		
*	ARISE HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
*	SECURITY HEALTH PLAN	1
*	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
WAUSHARA		
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
*	PHYSICIANS PLUS--MERITER & UW	1
*	SECURITY HEALTH PLAN	1
*	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
WINNEBAGO		
*	ARISE HEALTH PLAN	1
	HUMANA EASTERN	1
	NETWORK HEALTH PLAN	1
	UNITEDHEALTHCARE NE	1
	STANDARD PLAN	3
WOOD		
	ARISE HEALTH PLAN	1
	SECURITY HEALTH PLAN	1
	STANDARD PLAN	3
OUT OF STATE		
*	ARISE HEALTH PLAN	1
*	DEAN HEALTH PLAN	1
*	GHC EAU CLAIRE	1
*	GUNDERSEN LUTHERAN HEALTH PLAN	1
*	HEALTH TRADITION	1
*	HUMANA EASTERN	1
*	MEDICAL ASSOCIATES HEALTH PLAN	1
*	MERCYCARE HEALTH PLAN	1
*	SECURITY HEALTH PLAN	1
*	UNITY COMMUNITY	1
	¹ STANDARD PLAN	2

¹Out of State residents receive the Standard Plan at the tier-2 level.

* Plan has limited provider availability in the county and is considered “non-qualified.” Please see QA #45 on page C-26 for more information on qualification.

2008 Health Plans by Tier for Active State Employees

TIER 1

ANTHEM BCBS SOUTHEAST
ARISE HEALTH PLAN
DEAN HEALTH PLAN
GHC EAU CLAIRE
GHC-SCW
GUNDERSEN LUTHERAN HEALTH PLAN
HEALTH TRADITION
HUMANA EASTERN
HUMANA WESTERN
MEDICAL ASSOCIATES HEALTH PLAN
MERCYCARE HEALTH PLAN
NETWORK HEALTH PLAN
PHYSICIANS PLUS--MERITER & UW
SECURITY HEALTH PLAN
UNITEDHEALTHCARE NE
UNITEDHEALTHCARE SE
UNITY COMMUNITY
UNITY UW HEALTH
WPS PATIENT CHOICE PLAN 1
STATE MAINTENANCE PLAN

TIER 2

ANTHEM BCBS NORTHWEST
WPS PATIENT CHOICE PLAN 2

TIER 3

STANDARD PLAN

State and Federal Notifications/ Patients' Rights and Responsibilities

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for the Group Health Insurance Program..... B-5

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Section B - State and Federal Notifications/ Patients' Rights and Responsibilities

NOTICE OF PRIVACY PRACTICES

for the
Standard Plan and State Maintenance Plan
(currently administered by WPS Health Insurance)
and the
Prescription Drug Benefit Plan
(currently administered by Navitus Health Solutions)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR INFORMATION IS IMPORTANT TO US. PLEASE REVIEW IT CAREFULLY.

You do not need to do anything regarding this notice. It is intended to make you aware of your rights under the privacy rule of the federal Health Insurance Portability and Accountability Act (HIPAA) and to inform you how the Wisconsin Department of Employee Trust Funds (ETF) uses and discloses your protected health information. Protected health information is information about you, including demographic data collected from you, that can reasonably be used to identify you and relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the payment for that care.

Please note that while ETF administers many benefit programs for state and local government employees, this notice applies to only the plans listed above. Different policies and regulations apply to records associated with other benefit programs.

OUR RESPONSIBILITIES

ETF receives some protected health information as a necessary part of administering health benefits for members. ETF is required by law to maintain the privacy of your protected health information and to provide you with a notice of the above plans' duties and privacy practices. The term "we" in this notice means ETF and our business associates. Business associates are companies and individuals with whom ETF contracts for services, including but not limited to: claim processing, utilization review, actuarial services, claim appeals services and participant surveys. In order to perform their respective functions for ETF, ETF's business associates sometimes must receive your protected health information. ETF requires a contractual commitment from all business associates to protect the privacy of any health information received in the course of providing services.

WPS Health Insurance (WPS) is the current third-party plan administrator for the Standard Plan and State Maintenance Plan. Navitus Health Solutions (Navitus) is the pharmacy benefit manager (PBM) for the prescription drug benefit program. WPS and Navitus are business associates and are required to safeguard your health information according to HIPAA's privacy regulation and their respective contracts with the State of Wisconsin.

If you have health insurance with a health maintenance organization (HMO) or a preferred provider plan (PPP), you should receive a notice from your HMO or PPP regarding its privacy practices relating to your health insurance benefit.

We reserve the right to change the terms of this notice and to make the new notice provisions apply to information we already have about you as well as to any information we may receive in the future. We are required by law to comply with the privacy notice that is currently in effect. We will notify you of any material changes to this notice by distributing a new notice to you and posting the new notice on our Web site (<http://etf.wi.gov>).

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your protected health information for treatment purposes. Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, we may share your health information with a pharmacy in order to verify your eligibility for benefits.

Payment: We may use or disclose your protected health information for the payment of covered services that you receive under your benefit plan or to otherwise manage your account or benefits. Payment includes activities by ETF or by organizations hired by ETF to obtain premiums, to make coverage determinations and to provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing. We may also use and disclose your protected health information to determine premium costs, underwriting, rates and cost-sharing amounts. For example, we may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate the payment of your benefits.

Health Care Operations: We may use or disclose your protected health information to administer the plans covered by this notice and to coordinate coverage and services on your behalf. We may also use or disclose your health information during the grievance or claim review process in resolving your insurance complaints. Other examples of health care operations include:

- Quality assessment and improvement activities;
- Activities designed to improve the health plan or reduce costs;
- Reviewing and evaluating health plans, including participant satisfaction surveys;
- Training of ETF personnel and contractors;
- Transfer of eligibility and plan information to business associates (for example, to the PBM for the management of pharmacy benefits);
- Reviews and auditing, including compliance reviews, ombudsperson services, legal services, and audit services;
- Business management and general administrative activities, including customer service; and
- Fraud and abuse detection and compliance programs.

As Permitted or Required By Law: We may share your protected health information as permitted or required by state and federal law, including but not limited to disclosures to comply with Workers' Compensation laws or similar legal programs; for U.S. Department of Health and Human Services investigations, in judicial and administrative proceedings and as required under Wisconsin law for state auditing purposes.

Organized Health Care Arrangement: We may participate in an Organized Health Care Arrangement (OHCA). An OHCA can take several forms under HIPAA, including offering health benefits under a combination of group health plans and HMOs. We may share your protected health information to coordinate the operations of the plans and to better serve you as a participant in the plans.

For Distribution of Information Related to Health Benefits and Services: We may use and disclose your protected health information to inform you of treatment alternatives or of other health related services and benefits that may be of interest to you.

Plan Sponsors: Your employer is not permitted to receive your protected health information related to the plans covered by this notice for any purpose other than the administration and coordination of your benefit plan. For example, we may disclose to your employer whether an employee is participating in the plans or has enrolled or disenrolled in any available option offered by the plans. We may disclose summary health information to your employer, or someone acting on your employer's behalf, so that it can monitor, audit or otherwise administer the employee health benefit plan that the employer sponsors and in which you participate. Summary health information is data that combines information from many participants and does not include information on the individual level.

Special Circumstances: If you are unavailable to communicate, such as in a medical emergency or other situation in which you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.

Authorization: We will obtain your written permission before we use or disclose your protected health information for any other purpose, unless otherwise stated in this notice. If you grant such permission, you may later withdraw your consent at any time, in writing, using the contact information listed at the end of this notice. We will then stop using your information for that purpose. However, if we have already used or disclosed your information based on your authorization, we cannot undo any actions we took before you withdrew your permission.

YOUR HEALTH INFORMATION RIGHTS

You have rights under federal privacy laws relating to your protected health information. If you wish to exercise any of the following rights, please submit your request in writing to the ETF Privacy Officer using the contact information provided at the end of this notice. We are not required to agree to every request. We will notify you if we approve your request or explain the reason(s) for our decision if we deny your request. We may charge you a fee to cover the costs of processing your request. If so, we will inform you of the fee before proceeding.

Restrictions/Confidential Communications: You may request that we not use your protected health information for certain treatment, payment or health care operations or that we communicate with you using reasonable alternative means or locations.

View or Receive a Copy of Your Health Information: You have the right to review or obtain a copy of the protected health information that is used to make decisions about you. We are not required to give you certain information, including information prepared for use in legal actions or proceedings.

Amendment of Your Records: If you believe that your protected health information is incorrect or incomplete, you may request that your information be changed. Your request must include the reason(s) why you believe the change should be made. In certain situations we will not amend records, such as when we did not create the records that you want amended.

Request a Listing of Who Was Given Your Information and Why: Upon request we will provide you with a list of certain disclosures that we have made since April 14, 2003. The list will not include disclosures you authorized, or disclosures we made for treatment, payment, or health care operations or disclosures for which a listing is otherwise restricted by law.

Copy of the Privacy Notice: You have a right to obtain a paper copy of this notice at any time.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint by contacting ETF's Privacy Officer using the information provided below. Federal law prohibits any retaliation against you for filing a complaint. You may also file a complaint with the federal Office of Civil Rights.

<u>Privacy Rights Contact Information</u>	
Voice: 1-877-533-5020	FAX: (608) 267-0633
Send written correspondence: Department of Employee Trust Funds Privacy Officer P.O. Box 7931 Madison, WI 53707-7931	Send secure e-mail correspondence: access our Internet site at http://etf.wi.gov/contact.htm and click on the "Email Us" link.

EFFECTIVE DATE: OCTOBER 9, 2006

NOTIFICATION OF STATE AND OTHER FEDERAL REQUIREMENTS

→ COBRA: CONTINUATION OF COVERAGE PROVISIONS FOR THE GROUP HEALTH INSURANCE PROGRAM

This notice is provided to meet Federally required notification for continuing your health insurance in the event that you or a covered dependent lose eligibility for coverage. Both you and your spouse should take the time to read this information carefully.

If active coverage is lost, the State Employees and Wisconsin Public Employers (local government) Group Health Insurance Programs have routinely permitted continuation of coverage for a:

- Retired employee
- Surviving spouse of an active or retired employee
- Surviving dependent child of an active or retired employee

The coverage for a retired employee and surviving spouse may be continued for life; the children may continue coverage for only as long as they meet the definition of a dependent child. This is not considered to be continuation of coverage as discussed below.

Current federal law, known as COBRA, is somewhat more broad and requires that this notification, regarding additional continuation rights, be given to you and your spouse at the time group health insurance coverage begins. Your employer will provide you with the necessary forms. If you choose COBRA, complete and return the forms to ETF. Do not send a check. Your health plan will bill you.

If you are the actively employed subscriber, you have the right to apply for continuation of coverage if you lose coverage because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct).

If you are the spouse of the subscriber (active or retired), you have the right to apply for continuation if you lose coverage for any of the following reasons:

1. The death of your spouse
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment
3. Divorce from your spouse

Dependent children have the right to continuation if coverage is lost for any of the following reasons:

1. The death of a parent
2. A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment
3. Parents' divorce; or
4. The dependent child loses dependent status.

The employee or a family member has the responsibility to inform the employer of a divorce or a child losing dependent status. Under the law, Employee Trust Funds must receive your application to continue coverage, postmarked within 60 days from the termination of your current coverage or within 60 days of the date you were notified by your employer, of the right to choose continuation coverage, whichever is later. If ETF is not notified within 60 days of the date of these two events, the right to continuation coverage is lost.

Continuation coverage is identical to the former coverage, and you have the right to continue this coverage for up to three years from the date of the qualifying event (for example, divorce or a dependent reaching the limiting age) that caused the loss of eligibility. However, your continuation coverage may be cut short for any of the following reasons:

1. The premium for your continuation coverage is not paid
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 or
3. You were divorced from a covered employee, subsequently remarry, and are covered under your new spouse's group health plan.

If you do not choose continuation coverage, your group health insurance coverage will end. You do not have to show that you are insurable to choose continuation coverage. However, you will be required to pay all of the premium (both your share and any portion previously paid by your employer). At the end of the three-year continuation coverage period, you will be allowed to enroll in an individual conversion health plan. Contact your health plan directly to make application for conversion coverage.

If you are an active employee, you or your dependents should contact your employer regarding continuation (including any changes to your marital status or addresses). If you are a retired employee, you or your dependents should contact our office regarding continuation, at toll free 1-877-533-5020 or (608) 266-3285 (local Madison).

Additional information may be found under **Continuation of Health Coverage** in Section C of this booklet.

- **HIPAA/PRIVACY, ELECTRONIC TRANSACTIONS STANDARDS, AND SECURITY:** HIPAA's administrative simplification rules are intended to simplify and streamline the healthcare claims and payment process through the implementation of national standards. The rules also require that your health information be protected from unauthorized use or disclosure. The three components of the rules are privacy, electronic data transaction standards, and security. The privacy rule came into effect on April 14, 2003, and establishes limits on how your health information can be used and disclosed. The transaction standards rule, which sets out uniform methods for conducting electronic transactions, is effective on October 16, 2003. The security rule requires safeguards for health information maintained in electronic form, and is effective on April 21, 2005.

If you have any questions about HIPAA and need further information, please contact the Department's Privacy Officer at 1-877-533-5020.

- **HIPAA/PRE-EXISTING CONDITIONS:** The federal Health Insurance Portability and Accountability Act (HIPAA), effective January 1, 1998, is intended to make it easier for employees to change jobs by limiting waiting periods for coverage of pre-existing health conditions.

Under this health insurance program, employees who did not enroll for coverage when first offered but later enroll are limited to coverage under the Standard Plan with a 180-day waiting period for pre-existing conditions. As a non-federal, self-insured governmental plan, HIPAA allows this policy to continue. The Group Insurance Board has determined that this is necessary to avoid potential anti-selection.

- **HIPAA/SPECIAL ENROLLMENT OPPORTUNITIES:** There are certain situations where the employee may enroll as a late enrollee without pre-existing condition restrictions, such as loss of other coverage, marriage and birth or adoption of a child. (See **Other Enrollment Opportunities** in Section C.)

- **INDEPENDENT REVIEW:** In addition to the internal grievance process that all health plans are required to provide, 1999 Wisconsin Act 155 requires all health plans to have an independent review procedure for review of certain decisions. These include denial of, or refusal to pay, for treatment that the insurer considers to be experimental, not medically necessary or appropriate or not the proper level of care or health care setting. The amount or expected cost of treatment must exceed \$274 and a \$25 fee is required with the request for independent review. The fee will be refunded when the participant prevails.

The Office of the Commissioner of Insurance (OCI) oversees this process, which has been in place since 2002. Contact OCI at (800) 236-8517 or your plan if you have questions about the independent review law.

- **NATIONAL MEDICAL SUPPORT NOTICE:** State and Federal law provides for a special enrollment opportunity for children in certain cases when ordered by a court. The enrollment opportunity is for eligible children who are not currently covered, and may provide for an enrollment opportunity not otherwise available. When the court orders such coverage for a child or children, a copy of the National Medical Support Notice should be attached to the application.

If the parent named in the notice is currently enrolled, the child(ren) will be added to his/her current plan. If the parent is not enrolled, in most circumstances the issuing agency will select the plan for family coverage. If the issuing agency does not, the employee will be enrolled in our program's default plan, the Standard Plan.

- **WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998** requires annual notification of coverage under this program for the following treatments in connection with a mastectomy:

Reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.



***Important Notice From
The Department of Employee Trust Funds
About Your Prescription Drug
Coverage and Medicare***

**Certificate of Creditable Coverage for Medicare Part D
KEEP THIS NOTICE – DO NOT DISCARD**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State of Wisconsin Group Health Insurance program (State) and prescription drug coverage for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

- 1. Medicare prescription drug coverage is available to everyone with Medicare in 2007.**
- 2. The Department of Employee Trust Funds (ETF) has determined that the prescription drug coverage offered by the State is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage.**
- 3. Read this notice carefully. It explains the options you have under Medicare prescription drug coverage, and can help you decide if you want to enroll.**

You may have wondered how Medicare's prescription drug coverage might affect you. ETF has determined that your prescription drug coverage with the State of Wisconsin Group Health Insurance program is, on average for all plan participants, similar to if not better than the standard Medicare prescription drug coverage. This is referred to as "**Creditable Coverage**".

For 2008 prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because the existing prescription drug coverage administered by Navitus Health Solutions (Navitus) is "Creditable Coverage", it is not necessary to enroll in a Medicare Part D prescription drug plan (Medicare PDP). You will not be penalized and pay extra if you later decide to enroll in a Medicare PDP.

People with Medicare can enroll in a Medicare PDP from November 15, 2007 to December 31, 2007. However, because you have "**Creditable Coverage**", you can choose to join a Medicare PDP, but you are not required to. Each year, you will have the opportunity to enroll in a Medicare PDP between November 15 through December 31.

Important note: If you drop or lose your prescription drug coverage with the State, you may not be able to get this coverage back later.

You should also know that if you drop or lose your coverage with the State and do not enroll in Medicare prescription drug coverage after your current coverage ends, you might pay more to enroll in Medicare PDP later. If you are Medicare eligible, and go without creditable prescription drug coverage for 63 days or longer after you are initially eligible, you may have to pay a late enrollment penalty. The penalty will be a Medicare PDP premium increase of at least 1% of the national average premium per month, for every month after you were initially eligible that you did not have that coverage. For more information about your Medicare premium, please contact Medicare directly.

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Certificate of Creditable Coverage for Medicare Part D
KEEP THIS NOTICE – DO NOT DISCARD

This notice may be sent to you at various points in the future, such as prior to the next Medicare prescription drug coverage enrollment period or whenever coverage changes. For more information about this notice, your current prescription drug coverage, or your options under the Medicare prescription drug coverage, please **contact Navitus or ETF.**

Navitus Customer Service

Phone toll free: 1-866-333-2757
Regular Hours: 7 a.m. - 9 p.m. CST, Monday through Friday
Holiday Hours: 8:30 a.m. - 5p.m. CST, (Closed Thanksgiving and Christmas Day)

Department of Employee Trust Funds

Phone (toll free)	1-877-533-5020	Mailing Address:
Local to Madison.....	(608) 266-3285	P.O. Box 7931
TTY to Madison.....	(608) 267-0676	Madison, WI 53707-7931
Web site	http://etf.wi.gov	

In addition, more detailed information about Medicare plans that offer prescription drug coverage is available in the “Medicare & You” handbook, which is updated annually. You will get a copy of the handbook in the mail from Medicare when you become eligible. While you may also be contacted directly by Medicare prescription drug plans, you can also get more information about Medicare prescription drug plans from the following sources:

Call 1-800-MEDICARE (800) 633-4227. TTY users should call (877) 486-2048.

Prescription Drug Helpline

Phone toll free: 1-866-456-8211, Monday through Friday

Medigap Helpline

Phone toll free: 1-800-242-1060 (leave a message)

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS NOTICE.

If you enroll in one of the Medicare prescription drug plans approved by Medicare which offer prescription drug coverage after May 15, 2006, or after you are first eligible, you may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount. Additional copies of this notice can be requested from ETF.

PATIENT'S RIGHTS AND RESPONSIBILITIES

As a participant in this health insurance program, you have certain rights and responsibilities. By becoming familiar with them, you will be able to make the most of your health care. Our goals are to strengthen your confidence in a fair, responsive and high quality health care system, to provide effective mechanisms to address your concerns and to encourage you to take an active role in improving your health and health care.

The following is a summary of your rights and responsibilities.

You have the following rights:

- Considerate, respectful care from all members of the health care system.
- Non-discrimination consistent with state and federal law.
- To change plans annually.
- To a description of benefits presented in an understandable manner. Uniform Benefits are described in Section D of this booklet. Outlines of coverage for the Standard plans are found in Section G of this booklet. If you select one of the Standard plans, you will receive a certificate of coverage that describes your benefits. Your plan may also provide additional information regarding referral requirements, etc.
- To select a primary care physician and to have access to appropriate specialty care. You have the right to a referral to a non-plan specialist for covered services if there is not a plan specialist who is reasonably available to treat your condition.
- A woman has the right to have access to an OB/GYN provider.
- A woman has the right to a minimum hospital stay of 48 hours following a normal delivery of a child or 96 hours following a cesarean delivery. The physician, in consultation with the mother, may discharge the mother and baby prior to the expiration of the minimum stay.
- To have continuous, appropriate access to a provider for the remainder of that calendar year if the provider leaves the plan (other than for misconduct, retirement or a move from the service area). A woman in her second or third trimester of pregnancy has access to that provider until the completion of postpartum care. This right only applies to providers that are listed in the available plan's provider directory available during the Dual-Choice Enrollment period.
- To have access to emergency care without prior-authorization from the plan. If it is not reasonably possible to use a plan hospital or facility, you have the right to obtain treatment at the nearest facility and have those charges covered by the plan as if you did use the plan hospital or facility (however, be aware of your responsibilities when emergency care is received).
- To participate with your provider in treatment decisions.
- To confidentiality of medical information.
- To execute a living will or durable power of attorney for health care if you are 18 years of age or older. These documents tell others what your wishes are in the event that you are physically or mentally unable to make medical decisions or choices yourself.
- To appeal any referral or claim denial through the plan's grievance process. This review will be conducted in a timely manner. Grievances related to care which is urgently needed must be reviewed by the plan within four working days. If you have exhausted all levels of appeal available through the plan you may submit a complaint to the Department of Employee Trust Funds, in care of the Quality Assurance Services Bureau. You will need to submit a complaint form (ET-2405). You also have the right to request a departmental determination if you believe that a plan did not comply with its contractual obligations.

In a health care system that protects patients' rights, it is reasonable to expect and encourage patients to assume certain basic responsibilities. Greater personal involvement in your care increases the likelihood of achieving the best outcomes and helps support quality improvement and a cost conscious environment.

You have the following responsibilities:

- During the Dual-Choice Enrollment period, to review the *It's Your Choice* book and information provided by your plan. This information is important to determine if your plan and/or your providers

will continue to be available and whether your current plan continues to best meet your needs for the following calendar year.

- To submit your application for coverage prior to the end of the enrollment period if you select a different plan during the Dual-Choice Enrollment period.
- To select a primary care physician who will oversee your total health care and to make a reasonable effort to establish a satisfactory patient/physician relationship.
- To become involved in your treatment options and/or treatment plan.
- To become knowledgeable about your health insurance coverage and your health plan, including covered benefits, limitations and exclusions and the process to appeal coverage decisions. If you are covered under an HMO or preferred provider plan, to also become knowledgeable about the plan's rules regarding use of network providers, prior authorizations and referrals.
- To authorize the release of relevant personal or medical information necessary to determine appropriate medical care, to process a claim or to resolve a dispute.
- To notify your plan by the next business day, or as soon as reasonably possible, if you receive emergency or urgent care from a non-plan provider.
- To promptly report any family status changes to your payroll representative (or ETF if you are an annuitant or continuant). These changes include marriage, divorce, death, a birth or adoption or a dependent child losing eligibility. You should also report address or name changes, a change in your primary care provider and Medicare eligibility.
- To respond to the plan's annual questionnaire on dependent eligibility if you have a dependent child who is at least 19 years of age and is a full-time student or is disabled. Coverage for dependents could be lost if the questionnaire is not returned to the plan.
- To notify your plan if you obtain or lose other health insurance – including Medicare.
- To submit claims to the plan in a timely manner, if applicable.
- To use the plan's internal grievance process to address concerns that may arise.

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Common Questions & Answers

If you need additional information regarding:

Benefits
Exclusions
Limitations
Participating Providers



Contact the plan or Pharmacy Benefits Manager (PBM) directly. Address and telephone numbers are listed on the inside back cover

Applications
Eligibility
Enrollment
General Information



Contact your benefits/payroll/personnel office

All changes in your subscriber information, family status, or providers must be made through your benefits/payroll/personnel office. Changes must be submitted on Employee Trust Funds approved forms. Please fill out the forms completely and submit them in a timely manner.

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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. The Uniform Benefits 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).
- New employees who are selecting a health insurance plan for the first time.
- Currently insured employees who, during the October Dual-Choice Enrollment period, are changing to a different plan for the following calendar year.
- Currently insured employees 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.

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:

- Active state and university employees participating in the Wisconsin Retirement System (WRS).
- Elected state officials.
- Members or employees of the legislature.
- Certain visiting faculty members in the University of Wisconsin System.
- Blind employees of the Workshop for the Blind (Wiscraft) with at least 1,000 hours of services.

Separate booklets have been prepared for two other categories of eligible individuals:

- Graduate assistants, employees-in-training (includes scholars, fellows, trainees, etc.), and short-term academic staff (not covered under the WRS) employed at least one-third full-time by the University of Wisconsin System should refer to booklet ET-2127.
- Retired state and university employees, those receiving a duty disability benefit, and those on health continuation (including surviving spouses and dependents) 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.

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 Booklet (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.

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 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.

ENROLLING FOR COVERAGE

INITIAL ENROLLMENT

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

- Carefully read the information 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 booklet Section E, and **Plan Descriptions** in Section G.
- Compare premiums for the health plans that interest you.
- Contact health 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 begin employment with the state or 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, provided you enroll within your initial enrollment period as follows:

- Within 30 days of your date of hire (to be effective on the first day of the month on or following receipt of the application by your employer). For most employees, premiums will be paid entirely by you for the first six months (check with your payroll person to see your employer contribution begins);

OR

- Prior to becoming eligible for employer contributions toward premium as defined in Wis. Stat. § 40.05 (4) (a) (2), with coverage to be effective when you become eligible for employer contribution. For most state and university employees, this means prior to the beginning of the seventh month after hire. However, if you were previously covered under the Wisconsin Retirement System for at least 6 months as a state or university employee and have not since taken a WRS benefit (local government service does not apply), you must apply for health coverage within 30 calendar days of your first day of employment. Coverage will be effective on the first day of the month on or following receipt of the application by your employer.

THERE ARE NO INTERIM EFFECTIVE DATES except as required by law. If you do not submit a completed application within 30 days of your date of hire, your coverage cannot be effective before the month you become eligible for the employer contribution toward health insurance premiums. However, you may enroll for single coverage within 30 days of your date of hire and change to family coverage if your application is received prior to the date the employer contributions begin.

If you cancel your policy prior to the date that the state contribution starts, you may re-enroll in health insurance with the new coverage becoming effective on the first day of the month state contribution begins.

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. Important note for limited term employees (LTE) and other employees eligible for less than full-time contribution

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 an employee who is eligible for less than full-time contribution, you have another enrollment period if:

- There has been a 30-day termination of employment break; or
- Your hours of employment increase and you qualify for a higher 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 OPPORTUNITIES

9. Are there other enrollment opportunities available to me after my initial one has expired?

You may be able to get health insurance coverage if you are otherwise eligible under specific circumstances as described below:

1. If you and/or your dependent(s) 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.

An enrollment opportunity is also available to employees and/or dependents who have lost medical coverage:

- Under medical assistance (Medicaid); or
- Upon return from active military service with the armed forces. Employees must return to employment within 180 days of release from active duty. You are entitled to enroll regardless of the coverage in effect. Coverage is effective on the date of your re-employment, 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 (for example, termination of employment, divorce, etc., but not voluntary cancellation of coverage) or the employer's premium contribution ends. If you are currently enrolled and need to change from single

to family coverage, at least one eligible family member must have lost the other coverage in order to qualify.

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 or the employer's premium contribution ended. Coverage will be effective on the date the other coverage or the employer's premium contribution ends.

2. HIPAA (Health Insurance Portability and Accountability Act) 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, the employee who deferred coverage may enroll if coverage is elected within 30 days of marriage or 60 days of the other event, coverage is effective on the date of birth, adoption, placement for adoption, or marriage.
3. 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.

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

All changes in coverage are accomplished by completing an approved Health Insurance Application (ET-2301) **within 30 days after the change occurs.**

Always file an application 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. The changes to be reported are:

1. Change in plan (for example, from HMO to Standard Plan)
2. Change in plan coverage (for example, from Single to Family)
3. Name change
4. Change of address or telephone number
5. Addition/deletion of a dependent to an existing family plan
6. Changing primary physicians within an HMO network

(See also **Question 16. What family changes need to be reported?**)

11. 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.

Accumulated sick leave credits may be used to pay premium for up to 5 years. A written request to use sick leave credit must be submitted to your benefits/ payroll/personnel office before the date of layoff.

After sick leave credits are exhausted, or if you have no sick leave credits and State share of premium is no longer available, COBRA continuation will be offered which will allow you to purchase at your own expense an additional 36 months of coverage.

If you have 20 years of WRS service at the time of the layoff, but were not eligible for an immediate annuity at the time of layoff, any sick leave remaining after paying premium during layoff is available upon retirement. You can not use your sick leave after 5 years from the layoff date until you retire. If you had 20 years of WRS service and were eligible for an immediate annuity at the time of layoff you may continue to use it after 5 years or begin using the sick leave at anytime.

Unpaid Leave of Absence

State share towards premium will be up to five months, including three months of state contribution and 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 in whole or only for your dependents during your leave due to non-payment of premiums, you must submit a new application within 30 days of returning to work to reinstate prospectively the coverage that lapsed. 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: 9 Are there other enrollment opportunities available to me after my initial one has expired?**)

Lapsed coverage can also be reinstated for an employee who has been on a leave of absence and who is entitled to, and applies for, an immediate annuity. Coverage shall be effective the first day of the calendar month which occurs on or after the date the annuity application is approved by Employee Trust Funds, provided an application for health insurance has been received by that date. 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.

Military Leave of Absence

Under Wisconsin state law § 45.50, Wis. Stat., health insurance coverage may be continued under our program with employer contribution as long as you are on active duty, your employee premium contribution continues to be paid, and you elect coverage within 60 days of military activation. For more information on this option and the steps you need to take, contact your benefits/payroll/personnel office.

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.

Accumulated sick leave credits may be used to pay premium for up to 5 years. A written request to use sick leave credit must be submitted to your benefits/ payroll/ personnel office before the date of layoff. Other provisions regarding reinstatement of lapsed coverage are the same as those for under permanent layoff.

Seasonal or Teaching Positions. If you occupy a seasonal or teaching position and do not receive pay between the end of one term of service and the beginning of another, your coverage may continue if you authorize a payroll deduction before your earnings are interrupted or make other provisions to pay premiums in advance.

Transfer

If you transfer from one employing state department to another, you are required to file a new enrollment application within 30 days of the date you transfer to maintain continuous coverage. If an application is not filed within 30 days, coverage may be reinstated retroactively by submitting an application and paying back premiums. However, an employee in active pay status whose employee portion of premiums has not been deducted from salary by the employer for a period of 12 months, shall be deemed to have waived coverage. Waived coverage cannot be reinstated retroactively.

You may not select a new plan when you submit your insurance application due to a transfer, unless it coincides with one of the other designated enrollment opportunities. (See **Question 9: Are there other enrollment opportunities available to me after my initial one has expired?**).

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 employing agency 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 state contribution will be refunded to you.

Retirement

If you are covered under our health insurance when you retire, the health benefit plan will automatically continue if your retirement annuity from the WRS begins within 30 days after employment ends. If you are eligible for Medicare, effective dates must be provided before coverage continues. If you do not want your plan to

continue because you are covered under a comparable non-state plan at the time of retirement, you may escrow your sick leave credits to pay health premiums indefinitely. Contact Employee Trust Funds for further information.

You may be eligible for supplemental sick leave credits if you have at least 15 full years of adjusted continuous service with the State of Wisconsin at the time of retirement. (Continuous service means the number of full years the employee has worked for the state without a break in service. Local service does not apply.) Your employer will determine whether you are eligible for supplemental sick leave credits and submit the certification to Employee Trust Funds. If you have questions regarding your eligibility for supplemental sick leave credits, contact your payroll office.

Keep in mind you are already paying for and receiving comprehensive prescription drug coverage through the state's group health insurance program. Your current drug coverage, administered through Navitus Health Solutions, is considered creditable coverage in comparison to the Medicare Part D prescription drug benefit. This will allow you to defer enrollment in Part D without penalty. Nevertheless, you should carefully consider all options before making any kind of enrollment decision. Participation in Medicare Part D is voluntary and requires a premium payment. If you would like to maintain your current level of prescription drug benefits under our program, it is not necessary to enroll in Medicare Part D at this time.

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 cannot 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.

12. 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, there are other opportunities for coverage to be changed from single to family without restrictions described below.

1. If a health insurance application is received by your benefits/payroll/personnel office within **30 days** of the following events, coverage becomes effective on the date of the event. All eligible dependents will then be covered :
 - Marriage
 - Your or any eligible dependents involuntarily lose other medical coverage or lose the employer contribution for the other coverage. (See **Question 9: Are there other enrollment opportunities available to me after my initial one has expired?**)
 - Legal guardianship is granted.

- 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. Coverage will be effective the date eligibility was regained.
 - 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.
 - The effective date of coverage will be the first of the month following receipt of the application by the employer unless otherwise specified on the Medical Support Notice.
2. If an application is received by your benefits/payroll/personnel office within **60 days** of the following events, coverage becomes effective on the date of the event. All eligible dependents will then be covered.
- Birth, adoption of a child or placement for adoption (timely application prevents claim payment delays for such dependents).
 - 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 of 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. If filed more than 60 days after the birth, coverage will be effective on the 1st of the month following receipt of application.

If the application is not received during Dual-Choice or within 30 days for most 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.

13. 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.

Note that if you have single coverage and you should die, your sick leave credits will not be available for use by your surviving dependents.

14. 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. If more than 60 days after the birth, coverage is effective on the 1st of the month following receipt of the application.

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.

15. 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. Under a family plan, sick leave credits are preserved for the surviving spouse regardless of which should die first.

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 marriage to be effective as of the date of 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 if required that the form be mailed) within 30 days of the marriage.

16. What family changes need to be reported?

You need to report the following changes to your benefits/payroll/personnel office 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
- Eligibility for Medicare

17. 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 your application is received 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 Application* 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 Application* 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 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 14: 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 the marriage is terminated by divorce or annulment, or to the end of the month in which the continuation notice (ET-2311) is provided to the divorced spouse, whichever is later. (In Wisconsin, a legal separation is unlike divorce in that it does not affect coverage under the State group health insurance program.) 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 for as long as they are eligible (age, student status, etc.). (See also **CONTINUATION OF HEALTH COVERAGE.**)

You must file a health application with your employer to change from family to single coverage. File a *Health Insurance Application* form with your employer 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 (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 day period for pre-existing medical conditions (except pregnancy). (See **Question 9: Are there other enrollment opportunities available to me after my initial one has expired?**)

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

Active Employees. The requirement to enroll for Medicare Part B coverage is deferred for active employees and their dependents until the subscriber's termination of the WRS-covered employment through which active employee coverage is being provided. 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; however, that action is probably not in your best interest.

Retired Employees. 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. **IF YOU DO NOT ENROLL FOR ALL AVAILABLE PORTIONS OF MEDICARE UPON RETIREMENT, YOU MAY BE LIABLE FOR THE PORTION OF YOUR CLAIMS THAT MEDICARE WOULD HAVE PAID ON THE DATE MEDICARE COVERAGE WOULD HAVE BECOME EFFECTIVE.** However, if you or your insured spouse is an active employee under a non-state group plan, enrollment in Medicare may be deferred until retirement from that job. The reduced Medicare rates will not apply unless coverage as an active employee ceases.

Because all plans have coverage options, which are coordinated with Medicare, you will remain covered by the plan you selected

after you are enrolled in Medicare. Your health benefits will not change; the plan will simply not duplicate benefits paid by Medicare.

Your drug coverage is considered creditable coverage in comparison to the Medicare Part D benefit. This allows you to defer enrollment in Part D without penalty. To maintain your current level of prescription drug benefits under our program, it is not necessary to enroll in Part D at this time. If you do, this plan will pay secondary.

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.

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 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. The survivors may not add persons to the policy who were not insured at the time of death unless the survivor is 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 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 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

18. 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 test as a dependent for federal income tax purposes within IRS publication 501 (whether or not the dependent is claimed) and are (see **Question 25: 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 Wis. Stat. § 632.896. If the adoption of a child is not

finalized, the insurer may terminate coverage of the child when the adoptive placement ends.

- Legal wards that became permanent wards of the subscriber before age 19. Coverage will be effective on the date that a court 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.**)

19. 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?**)

20. What if I have a child who is, or who becomes physically or mentally 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 and he or she may be eligible to be covered under your health insurance through our program.

You must work with your health plan to determine if your child meets the eligibility criteria. If disabled dependent status is approved by the plan, you will be contacted annually to verify the dependent's continued eligibility. 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.

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 Application* form (ET-2301) with your employer to initiate the disability review process by the health plan. Your dependent will be offered COBRA continuation*.

If your disabled dependent child, who has been covered due to disability, is determined by the health plan to no longer meet their disability criteria, the plan will notify you in writing of their decision. They will inform you of the effective date of cancellation, usually the first of the month following notification and your dependent will be offered COBRA continuation*. If you would like to appeal the plan's decision, you must first complete the plan's grievance procedure. If the plan continues to deny disabled dependent status for your child, you may appeal the plan's grievance decision to ETF by filing an Insurance Complaint form (ET-2405).

***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 later determined that the child was eligible for coverage as a disabled dependent, coverage will be retroactive to the date they were last covered, and premiums paid for COBRA continuation coverage will be refunded.

21. 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 and similar on-line programs, intersession courses (for example, courses during winter breaks), night school, and student commitments after the semester ends, such as student teaching. You will be required to verify your dependent's eligibility annually.

22. 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 after the termination date.** If terminated in error, students can be reinstated with documentation of student status including a *Health Insurance Application* form (ET-2301). 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.

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

Only if the HMO offers service 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.

24. 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:
 1. 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.

Full-time student status is determined by the educational institution in which the student is enrolled. Coverage for full-time students over age 19 but under 25 who are recognized as being a full-time student by the institution during the previous calendar year, but who do not return to school in January, will have their coverage end as of December 31. Students who return to school in January but who shortly thereafter drop out, may not be recognized as a full-time student for that semester

by the educational institution. Check with your child's school to determine full-time student status in these cases. If the educational institution indicates that the student will not be recognized as full-time, you will need to consider COBRA coverage retroactive to January 1st. You will have until at least March 1 to apply for COBRA.

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

SELECTING A HEALTH PLAN

25. How do I select a health plan?

See chart on booklet page iii.

26. 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)) is a Preferred Provider Plan (PPP). A PPP 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 tier 1 Health Maintenance Organization (HMO). It offers Uniform Benefits, such as the HMOs. See Section D of this booklet for the certificate of coverage. Please note that SMP has physician, hospital and specialty care networks and referral and prior authorization processes.

The Standard Plan and SMP plans contain **Care Management** 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 or her as your primary care physician.

Preferred Provider Plan (PPP)

These are organizations which pay a specific level of benefits if certain providers are utilized, and a lesser amount for other providers. 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 need additional protection while traveling. Currently, Uniform Benefit PPPs are only available through Patient Choice.

NOTE: ALL HMOS AND PATIENT CHOICE OFFER UNIFORM BENEFITS WHEN SERVICES ARE PROVIDED IN-NETWORK EVEN IF NOT COVERED BY MEDICARE. SEE SECTION D ON UNIFORM BENEFITS IN THIS BOOKLET.

27. Which plans are actually available to me?

All health plans listed in this booklet 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 list of locations and the map in Section A and the Plan Description Section G of this booklet to see which plans serve your area.** Coverage under the Standard Plan, and the Medicare Plus \$1,000,000 (if retired) are available worldwide.

28. Are there differences between alternate health plans?

Alternate health plans (HMOs and Patient Choice's PPPs) 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.

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

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

30. 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. A Preferred Provider Plan such as a Patient Choice or the Standard Plan allows you the flexibility to seek care outside a particular service area. Note that out of network or care system care is subject to higher deductible and coinsurance amounts. (See "**Proof of Claim**" in **Uniform Benefits, Booklet Section D. VI, 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?**)

31. 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

32. Why is ETF including information about Leapfrog, CheckPoint and the Wisconsin Collaborative for Healthcare Quality in the

Wisconsin healthcare providers are demonstrating their willingness to share information with the public about the steps they are taking to improve the quality and 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

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questions about what doctors and hospitals are doing to reduce medical errors and improve quality.

33. 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 four 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 on their efforts in adopting the 27 National Quality Forum safety practices called the Leapfrog quality index. These practices, if used universally in applicable clinical settings, would reduce risk of harm to patients. Provider progress on these measures is updated monthly with information available at http://www.leapfroggroup.org/consumer_intro.htm.

34. 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, 14 clinical interventions that medical experts agree should occur when treating heart attacks, heart failure, pneumonia and eight measures related to surgical site infection prevention. In addition, summary measures called indexes are reported for heart attack, heart failure, pneumonia, and surgical infection prevention care.

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.

35. 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.

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



- 1) The Wisconsin Collaborative for Healthcare Quality website links consumers to an extensive public report comparing the performance of Wisconsin providers on health care effectiveness, safety and service performance, reports on over 22 clinical interventions that medical experts agree should be taken to better treat heart attacks, heart failure, pneumonia and surgical infections are available for review.

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

- Appointment wait times in clinics
 - Clinical measures on how well patients with chronic diseases, like diabetes are managed
 - Physician group results on how well they screened for colorectal, cervical, and breast cancers.
- 2) MedlinePlus contains health information from the world's largest medical library, the National Library of Medicine. Health professionals and consumers alike can depend on it for information that is authoritative and up to date. MedlinePlus has extensive information on over 700 diseases and conditions, a medical encyclopedia and a medical dictionary, health information in Spanish, information on prescription and nonprescription drugs, and links to thousands of clinical trials. MedlinePlus is updated daily and can be bookmarked at: www.medlineplus.gov.
- 3) Wisconsin Health Reports simplifies your search for information on the quality, safety, service, and price provided by Wisconsin medical clinics and hospitals. It's located at www.wisconsinhealthreports.org and provides links to WCHQ, CheckPoint, and PricePoint.

PROVIDER INFORMATION

37. 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.

38. 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.

39. 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 about the provider's opinion about dispensing a prescription for oral contraceptives.

40. Can I change primary physicians within my alternate health plan?

Alternate plans (HMO's and Patient Choice's PPPs) differ in their policies. First contact your health plan to find out when your change will become effective. Then file a *Health Insurance Application* form available from your benefits/payroll/personnel office indicating the

effective date of your change as specified by the plan.

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

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.

42. 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.

43. 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 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.

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

44. 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 info 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% 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.

45. 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.

46. Does a health plan with a higher premium or a higher tier offer more benefits?

No, all alternate plans (HMOs and Patient Choice's PPPs) 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.

47. 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.

48. How do I pay my portion of the premium?

Active Employees. 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 premiums will automatically be deducted from your payroll check on a pre-tax basis. (See also **Question 73 & 74: regarding the Employee Reimbursement Account (ERA) Program.**)

Retired Employees. 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.

If you were insured in the State plan when you retired, you may be able to pay your health insurance premium from your accumulated sick leave credits until those credits are exhausted. If no sick leave credits are available, or when the credits are exhausted, the premium will be deducted from your monthly annuity check. If there is no annuity or the annuity is not sufficient to allow a premium deduction, you will be billed directly on a quarterly basis. (See also **Question 12: How are my health benefits affected by changes in employment status?**)
WARNING: Your coverage will be cancelled if you fail to pay your premium in a timely manner.

If you choose to escrow your sick leave, this must be done at the time of retirement. Annually thereafter you must certify that you have comparable coverage.

49. If a plan is not in the 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.

50. What does Dual-Choice mean?

Dual-Choice refers to the annual opportunity insured subscribers have to select one of the 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 period is offered only to subscribers 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.

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 13: When can I change from single to family coverage without restrictions?**)

54. 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 received after the deadline will not be accepted. Health applications are available from your benefits/payroll/personnel office.

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 your benefits/payroll/personnel office **in writing before December 31.**

CHANGING HEALTH PLANS

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

Yes, but only if you, the subscriber file an application within 30 days for the following events:

1. Move from your plan's service area (for example, out of the county) for a period of at least 3 months. Your new coverage will be effective subsequent to your move on 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 your return. (See also **Questions 60: What if I have a temporary or permanent move from the service area?**)
2. You or a dependent incurs a claim that would meet or exceed the lifetime maximum benefit amount on all benefits. An application must be filed during the 30-day period after a claim is denied due to the operation of the lifetime limit on all benefits with coverage effective on the first day of the month on or following receipt of the application.
3. You involuntarily lose other coverage or lose the employer contribution for it.
4. You add one or more dependants due to marriage, birth, adoption, or placement for adoption.

OR

5. 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.

57. If I change plans, what happens to any benefit maximums that may

When you change plans for any reason (for example, Dual-Choice or a move from a plan's service area), any annual health insurance benefit maximums under Uniform Benefits will start over at \$0 with your new

apply to services I've received?

plan, even if you change plans mid-year. Examples are the 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 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 state's contribution toward the premium varies by tier. (See **Question 45: How are health premium contributions determined?**)

If your relocation is temporary, you may again change plans by submitting an application within 30 days after your return. The change will be effective on the first of the month on or after your application is received by your employer or by the Department if you have terminated employment.

60. What if I change plans but am hospitalized before the date the new coverage becomes effective and am confined as an inpatient on the date the change occurs (such as January 1)?

If you are confined as an inpatient (in a hospital, an Alcohol and Other Drug Abuse (AODA) residential center, a skilled nursing facility) or require 24 hours home care on the effective date of 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 continued 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

61. 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 Health Insurance) 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.

62. 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 (HMO's) require claims be filed within 12 months of the date of service, or if later, as soon as reasonably possible.

63. 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 **Booklet Section D**.

64. What do I need to do when my spouse or I become eligible for Medicare?

Most people become eligible for Medicare at age 65. For some, it occurs earlier due to disability or End Stage Renal Disease.

If your or your insured spouse are covered by health insurance due to active employment, you may wish to enroll in Medicare Part A when you first become eligible at age 65. There is no premium for Medicare Part A, and it may cover some hospital services if they are not covered by your health plan.

When you or your spouse subsequently terminate employment and/or health insurance coverage from active employment is lost, you have a special enrollment opportunity for enroll in Medicare Part A and B, and D.

To enroll in Medicare Part A and B, or if you have questions about enrollment and eligibility, please contact your local social security office.

IF YOU DO NOT ENROLL FOR ALL AVAILABLE PORTIONS OF MEDICARE UPON RETIREMENT, YOU MAY BE LIABLE FOR THE PORTION OF YOUR CLAIMS THAT MEDICARE WOULD HAVE PAID BEGINNING ON THE DATE MEDICARE COVERAGE WOULD HAVE BECOME EFFECTIVE.

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 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.

PHARMACY BENEFIT MANAGER (PBM)

67. 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 drug 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.

68. 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.

69. 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.

70. 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

71. 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.** 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, EPIC dental and excess medical insurance and Spectera Vision Care and DentacareBlue dental plan premiums are also taken from pre-tax salary. If you do not want your insurance premiums deducted on a pre-tax basis you must file a waiver. 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 daycare 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 <http://etf.wi.gov>.

72. 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

73. 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 the employer 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 employer (or Employee Trust Funds if you are no longer a state employee) 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. Once coverage terminates, you will be responsible for any claims inadvertently paid beyond your coverage effective dates.

74. 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 the subscriber.

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

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

If you terminate state employment and you are not enrolled for health insurance or subsequently terminate 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.

You must 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 for this enrollment.

76. Is there any state contribution for health insurance after I terminate coverage?

Yes. Under certain circumstances your accumulated unused sick leave can be converted to credits to pay for health insurance premium if you are:

- retiring,
- terminating after accumulating 20 years of creditable WRS service,
- or a surviving spouse or dependent who is insured under our program at the time of the active subscriber's death.

The rules governing your eligibility are described in ETF publications (ET-4112, ET-4116, & ET-2119).

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 1 and your dependent loses eligibility December 31, that dependent would be eligible for COBRA from the plan you were enrolled in on December 31. 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.

77. Who is eligible for continuation?

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

78. 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.

79. 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.

80. 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.

81. 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.

82. 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.

83. *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 3 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.

Uniform Benefits Certificate of Coverage

THIS IS YOUR DESCRIPTION OF BENEFITS FOR HMOs, SMP AND PATIENT CHOICE'S PPP (ALTERNATE PLANS)

The Group Insurance Board adopted a uniform medical insurance benefits package for alternate health plans. This affects State of Wisconsin employees and annuitants, and local government employees whose employers participate in the Department of Employee Trust Funds (ETF) health insurance programs.

The purpose of Uniform Benefits is to help contain the rising cost of health insurance and simplify the selection of a health plan for employees. Employees are able to decide on which plan to select on the basis of:

1. Cost of the plan to them
2. Quality of services provided
3. Access to specific physicians or other health care providers
4. Plan referral policies

Uniform Benefits does not mean that all plans will treat all illnesses in an identical manner. Treatment will vary depending on the needs of the patient, the physicians involved and the managed care policies and procedures of each insurance plan.

The following pages describe the benefits which will be offered by all alternate plans in 2008. Your plan is not required to provide a separate description of benefits. It is very important that you keep this brochure for your reference throughout 2008. If you have questions, please contact the plans directly.

The Uniform Benefits will cover some oral surgery, but alternate plans also have the option of offering other dental benefits. Plans offering dental benefits are listed on page G-3.

Uniform Benefits do not apply to the Standard Plan except that the prescription drug coverage is through the Pharmacy Benefit Manager (PBM).

NOTABLE CHANGE TO UNIFORM BENEFITS
EFFECTIVE JANUARY 1, 2008

<i>Topic</i>	<i>Page</i>	<i>Section</i>	<i>Year 2008 Benefit</i>	<i>Year 2007 Benefit</i>
Annual Prescription Drug Out-of-Pocket Maximum	D-7	Schedule of Benefits	For all participants, except those enrolled in the Standard Plan: \$350 per individual \$700 per family For participants enrolled in the Standard Plan: \$1,000 per individual \$2,000 per family	For all participants, except those enrolled in the Standard Plan: \$320 per individual \$640 per family For participants enrolled in the Standard Plan: \$1,000 per individual \$2,000 per family

The benefit change described above is a notable change to Uniform Benefits for 2008. Other minor modifications have been made to clarify the intent of specific contract language, however, these clarifications do not change your level of coverage.

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I. SCHEDULE OF BENEFITS

All benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of Your coverage and certain rules, if any, You must follow to obtain covered services. In some situations (for example, Emergency services received from a Non- Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Health Plan will result in all benefit maximums restarting at \$0 with the exception of the prescription annual out-of-pocket maximum. This does not include dental and orthodontia benefits that Health Plans may offer that are not a part of Uniform Benefits. This also does not include Your lifetime maximum benefit if You were previously covered by the Health Plan, as Your lifetime maximum benefit may include any benefits paid during all periods of coverage with the same Health Plan under this program.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug benefits formerly provided directly by the Health Plans and Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the terms and conditions of the Uniform Benefits. The prescription drug benefits are dependent on being insured under the State of Wisconsin group health insurance program.

NOTE: For Participants enrolled in a Preferred Provider Plan (WPS Patients Choice), this Schedule of Benefits applies to services received from Plan Providers. Your Health Plan will provide You with a supplemental Schedule of Benefits that will show the level of benefits for services provided by Non-Plan Providers.

The benefits that are administered by the Health Plan are subject to the following:

- Policy Deductible: **NONE**
- Policy Coinsurance: 100% of charges, except as described below
- Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: **\$2,000,000 per Participant**
- Ambulance: Covered as Medically Necessary for Emergency or urgent transfers.
- Diagnostic Services Limitations: **NONE**
- Outpatient Physical, Speech and Occupational Therapy Maximum: Covered up to 50 visits for all therapies combined per calendar year. This limit combines therapy in all settings (for example, home care, etc.). Additional Medically Necessary visits may be Prior Authorized by the Health Plan, up to a maximum of 50 additional visits per therapy per calendar year.
- Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Supplies Coinsurance: Payable at 80%. Out-of-pocket expense will not exceed \$500.00 annually per Participant.

One hearing aid per ear no more than once every three years payable at 80%, up to a maximum payment of \$1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.

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- Cochlear Implants: Device, surgery for implantation of the device, and follow-up sessions to train on use of the device when Medically Necessary and Prior Authorized by the Health Plan, payable at 80%. Hospital charges for the surgery are covered at 100%. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.
- Home Care Benefits Maximum: 50 visits per Participant per calendar year. Fifty additional Medically Necessary visits per calendar year may be authorized by the Health Plan.
- Hospice Care Benefits: Covered when the Participant's life expectancy is 6 months or less, as authorized by the Health Plan.
- Transplants: Limited to transplants listed in Benefits and Services Section, subject to a lifetime benefit of \$1,000,000 for transplants, including Preoperative and Postoperative Care.
- Licensed Skilled Nursing Home Maximum: 120 days per Benefit Period payable for Skilled Care.
- Mental Health/Alcohol/Drug Abuse Services:

Outpatient Services: \$1,800 maximum per Participant per calendar year
Transitional Services: \$2,700 maximum per Participant per calendar year
Inpatient Services: 30 days or \$6,300, whichever is less, per Participant per calendar year

Maximum Benefit: The maximum benefit for inpatient, outpatient and transitional services is \$7,000 per Participant per calendar year.

The maximum is determined using the average amount paid to the Providers by the Health Plan and excludes costs associated with diagnostic testing and prescription drugs. The benefit is not subject to Copayment.

Note: Annual dollar maximums for mental health only services are suspended. However, day limit maximums do apply, if applicable.

Annual dollar maximums remain in force for treatment of alcohol and drug abuse. Any benefits paid during the year for mental health services will be applied toward the annual benefit maximum for alcohol and drug abuse treatment when determining whether benefits for alcohol and drug abuse treatment remain available.

- Vision Services: One routine exam per calendar year. Non-routine eye exams are covered as Medically Necessary.
- Oral Surgery: Limited to procedures listed in Benefits and Services Section.
- Temporomandibular Disorders: The maximum benefit for diagnostic procedures and non-surgical treatment is \$1,250 per Participant per calendar year. Intraoral splints are subject to the Durable Medical Equipment Coinsurance (that is, payable at 80%) and apply to the non-surgical treatment maximum benefit.

- Dental Services: No Coverage provided under Uniform Benefits. However, each Health Plan may choose to provide a dental plan to all of its members.
- Hospital Emergency Room Copayment: \$60 per visit; waived if admitted as an inpatient directly from the emergency room. (An inpatient stay is generally 24 hours or longer.)

The benefits that are administered by the Pharmacy Benefit Manager (PBM) are subject to the following:

- Prescription Drugs and Insulin:

Level 1* Copayment for Formulary Prescription Drugs:	\$ 5.00
Level 2** Copayment for Formulary Prescription Drugs:	\$15.00
Level 3 Copayment for Covered Non-Formulary Prescription Drugs:	\$35.00

*Level 1 consists of Formulary Generic Drugs and certain low cost Brand Name Drugs.

**Level 2 consists of Formulary Brand Name Drugs and certain higher cost Generic Drugs.

Annual Out-of-Pocket Maximum (The amount You pay for Your Level 1 and Level 2 Prescription Drugs and Insulin):

\$350 per individual or \$700 per family for all Participants, except:

\$1,000 per individual or \$2,000 per family for Participants enrolled in the Standard Plan

NOTE: Level 3 Copayments do not apply to the out-of-pocket maximum and must continue to be paid after the annual out-of-pocket maximum has been met.

Disposable Diabetic Supplies and Glucometers Coinsurance: 20% per purchase, which will be applied to the Prescription Drug Annual Out-of-Pocket Maximum.

Smoking Cessation: One consecutive three-month course of pharmacotherapy covered per calendar year.

II. DEFINITIONS

The terms below have special meanings in this plan. Defined terms are capitalized when used in the text of this plan.

- **BED AND BOARD:** Means all Usual and Customary Hospital charges for: (a) Room and meals; and (b) all general care needed by registered bed patients.
- **BENEFIT PERIOD:** Means the total duration of Confinements that are separated from each other by less than 60 days.
- **BRAND NAME DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and Generic Drug classifications.
- **COMORBIDITY:** Means accompanying but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease processes.

CONFINEMENT/CONFINED: Means (a) the period of time between admission as an inpatient or outpatient to a Hospital, AODA residential center, Skilled Nursing Facility or licensed ambulatory surgical center on the advice of Your physician; and discharge therefrom, or (b) the time spent receiving Emergency Care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement. Charges for Hospital or other institutional Confinements are incurred on the date of admission. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.

- **CONGENITAL:** Means a condition which exists at birth.
- **COINSURANCE:** A specified percentage of the charges that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **COPAYMENT:** A specified dollar amount that the Participant or family must pay each time those covered services are provided, subject to any maximums specified in the Schedule of Benefits.
- **CUSTODIAL CARE:** Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a Plan Provider, has reached the maximum level of recovery. Custodial Care is provided to Participants who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. It shall not be considered Custodial Care if the Participant is under active medical, surgical or psychiatric treatment to reduce the disability to the extent necessary for the Participant to function outside of a protected, monitored and/or controlled environment or if it can reasonably be expected, in the opinion of the Plan Provider, that the medical or surgical treatment will enable that person to live outside an institution.

Custodial Care also includes rest cures, respite care, and home care provided by family members.

- **DEPENDENT:** Means the Subscriber's:
 - ▶ spouse
 - ▶ unmarried children
 - ▶ legal wards who become legal wards of the Subscriber prior to age 19, but not temporary wards
 - ▶ adopted children and children placed for adoption as provided for in Wis. Stat. § 632.896. Adoptive children become Dependents when placed in the custody of the parent
 - ▶ stepchildren
 - ▶ grandchildren if the parent is a Dependent child. The Dependent grandchild will be covered until the end of the month in which the Dependent child turns age 18.

Dependent children must be dependent on the Subscriber (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a Dependent for federal income tax purposes, whether or not the child is claimed.

Children born outside of marriage become Dependents of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health and Family Services or the equivalent if the birth was outside of 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 spouse and stepchildren cease to be Dependents at the end of the month in which a marriage is terminated by divorce or annulment. Other children cease to be Dependents at the end of the calendar year in which they turn 19 years of age or cease to be dependent for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

1. Children age 19 or over who are full-time students, if otherwise eligible (that is, continues to be a Dependent for support and maintenance and is not married), cease to be Dependents:
 - ▶ At the end of the calendar year in which they cease to be full-time students or in which they turn age 25, whichever occurs first.
 - ▶ At the end of the month in which they cease to be dependent for support or maintenance or marry, whichever occurs first.

Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an accredited institution, which 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. Per the Internal Revenue Service, this includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools and similar on-line programs, intersession courses (for example, courses during winter break), night schools and student commitments after the semester ends, such as student teaching.

2. If otherwise eligible, children who are, or become, incapable of self-support because of a physical or mental disability which can be expected to be of long-continued or indefinite duration of at least one year or longer, continue to be, or resume their status of, Dependents regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible Dependent under this program in order to continue or resume coverage. The Health Plan will monitor mental or physical disability at least annually, but will only terminate coverage prospectively upon determining the Dependent is no longer so

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disabled, and will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

3. A child who is considered a Dependent ceases to be a Dependent on the date the child becomes insured as an Eligible Employee.
4. Legal Wards cease to be Dependents at the end of the month in which they cease to be wards.

Any Dependent eligible for benefits will be provided benefits based on the date of eligibility, not on the date of notification to the Health Plan and/or PBM.

- **DURABLE MEDICAL EQUIPMENT:** Means an item which can withstand repeated use and is, as determined by the Health Plan, primarily used to serve a medical purpose with respect to an Illness or Injury, generally not useful to a person in the absence of an Illness or Injury, appropriate for use in the Participant's home, and prescribed by a Plan Provider.
- **EFFECTIVE DATE:** The date, as certified by the Department of Employee Trust Funds and shown on the records of the Health Plan and/or PBM, on which the Participant becomes enrolled and entitled to the benefits specified in the contract.
- **ELIGIBLE EMPLOYEE:** As defined under Wis. Stat. § 40.02 (25) or 40.02 (46) or Wis. Stat. § 40.19 (4) (a), of an employer as defined under Wis. Stat. § 40.02 (28). Employers, other than the State, must also have acted under Wis. Stat. § 40.51 (7), to make health care coverage available to its employees.
- **EMERGENCY:** Means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:
 1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
 2. Serious impairment to the Participant's bodily functions.
 3. Serious dysfunction of one or more of the Participant's body organs or parts.

Examples of Emergencies are listed in Section III., A., 1., e.

- **EXPENSE INCURRED:** Means an expense at or after the time the service or supply is actually provided - not before.
- **EXPERIMENTAL:** The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a Participant's Illness or Injury that, as determined by the Health Plan and/or PBM: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that Illness or Injury for a Participant's Illness or Injury. The criteria that the Health Plan and/or PBM uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be Experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment,

procedure, facility, equipment, drug, device or supply is generally accepted to treat that Illness or Injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the Illness or Injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

- **FORMULARY:** A list of prescription drugs, established by a committee of physicians and pharmacists, which are determined to be medically- and cost-effective. The PBM may require Prior Authorization for certain Formulary and non-Formulary drugs before coverage applies.
- **GENERIC DRUGS:** Are defined by MediSpan (or similar organization). MediSpan is a national organization that determines brand and generic classifications.
- **GENERIC EQUIVALENT:** Means a prescription drug that contains the same active ingredients, same dosage form, and strength as its Brand Name Drug counterpart.
- **GRIEVANCE:** Means a written complaint filed with the Health Plan and/or PBM concerning some aspect of the Health Plan and/or PBM. Some examples would be a rejection of a claim, denial of a formal Referral, etc.
- **HEALTH PLAN:** The Health Maintenance Organization (HMO) or Preferred Provider Plan (PPP) providing health insurance benefits under the Group Insurance Board's program and which is selected by the Subscriber to provide the uniform benefits during this calendar year.
- **HOSPICE CARE:** Means services provided to a Participant whose life expectancy is six months or less. The care is available on an intermittent basis with on-call services available on a 24-hour basis. It includes services provided in order to ease pain and make the Participant as comfortable as possible. Hospice Care must be provided through a licensed Hospice Care Provider approved by the Health Plan.
- **HOSPITAL:** Means an institution that:
 1. (a) Is licensed and run according to Wisconsin laws, or other applicable jurisdictions, that apply to Hospitals; (b) maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, Injury and Illness; (c) provides this care for fees; (d) provides such care on an inpatient basis; (e) provides continuous 24-hour nursing services by registered graduate nurses; or
 2. (a) Qualifies as a psychiatric or tuberculosis Hospital; (b) is a Medicare Provider; and (c) is accredited as a Hospital by the Joint Commission of Accreditation of Hospitals.

The term Hospital does not mean an institution that is chiefly: (a) a place for treatment of chemical dependency; (b) a nursing home; or (c) a federal Hospital.

- **HOSPITAL CONFINEMENT or CONFINED IN A HOSPITAL:** Means (a) being registered as a bed patient in a Hospital on the advice of a Plan Provider; or (b) receiving Emergency care for Illness or Injury in a Hospital. Hospital swing bed Confinement is considered the same as Confinement in a Skilled Nursing Facility.

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- **ILLNESS:** Means a bodily disorder, bodily Injury, disease, mental disorder, or pregnancy. It includes Illnesses which exist at the same time, or which occur one after the other but are due to the same or related causes.
- **IMMEDIATE FAMILY:** Means the Dependents, parents, brothers and sisters of the Participant and their spouses.
- **INJURY:** Means bodily damage that results directly and independently of all other causes from an accident.
- **MAINTENANCE THERAPY:** Means ongoing therapy delivered after an acute episode of an Illness or Injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Therapy" is made by the Health Plan after reviewing an individual's case history or treatment plan submitted by a therapist.
- **MEDICALLY NECESSARY:** A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care Provider that is required to identify or treat a Participant's Illness or Injury and which is, as determined by the Health Plan and/or PBM: (1) consistent with the symptom(s) or diagnosis and treatment of the Participant's Illness or Injury; (2) appropriate under the standards of acceptable medical practice to treat that Illness or Injury; (3) not solely for the convenience of the Participant, physician, Hospital or other health care Provider; (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.
- **MEDICARE:** Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
- **MEDICAID:** Means a program instituted pursuant to Title XIX (Grants to States for Medical Assistance Program) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or hereafter amended.
- **MISCELLANEOUS HOSPITAL EXPENSE:** Means Usual and Customary Hospital ancillary charges, other than Bed and Board, made on account of the care necessary for an Illness or other condition requiring inpatient or outpatient hospitalization for which Plan Benefits are available under this Health Plan.
- **NATURAL TOOTH:** Means a tooth that would not have required restoration in the absence of a Participant's trauma or Injury, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or root canal therapy.
- **NON-EXPERIMENTAL:** Means: (a) any discrete and identifiable technology, regimen or modality regularly and customarily used to diagnose or treat Illness; and (b) for which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe, efficient and effective.
- **NON-PARTICIPATING PHARMACY:** Means a pharmacy who does not have a signed agreement and is not listed on the most current listing of the PBM's provider directory of Participating Pharmacies.

- **NON-PLAN PROVIDER:** Means a Provider who does not have a signed participating Provider agreement and is not listed on the most current edition of the Health Plan's professional directory of Plan Providers. Care from a Non-Plan Provider requires prior-authorization from the Health Plan unless it is an Emergency or Urgent Care.
- **NUTRITIONAL COUNSELING:** This counseling consists of the following services:
 1. Consult evaluation and management or preventive medicine service codes for medical nutrition therapy assessment and/or intervention performed by physician
 2. Re-assessment and intervention (individual and group)
 3. Diabetes outpatient self-management training services (individual and group sessions)
 4. Dietitian visit
- **OUT-OF-AREA SERVICE:** Means any services provided to Participants outside the Plan Service Area.
- **PARTICIPANT:** The Subscriber or any of his/her Dependents who have been specified for enrollment and are entitled to benefits.
- **PARTICIPATING PHARMACY:** A pharmacy who has agreed in writing to provide the services that are administered by the PBM and covered under the policy to Participants. The pharmacy's written participation agreement must be in force at the time such services, or other items covered under the policy are provided to a Participant. The PBM agrees to give You lists of Participating Pharmacies.
- **PBM:** The Pharmacy Benefit Manager (PBM) is a third party administrator that is contracted with the Group Insurance Board to administer the prescription drug benefits under this health insurance program. It is primarily responsible for processing and paying prescription drug claims, developing and maintaining the Formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.
- **PLAN BENEFITS:** Comprehensive prepaid health care services and benefits provided by the Health Plan to Participants in accordance with its contract with the Group Insurance Board. In addition, prescription drugs covered by the PBM under the terms and conditions as outlined in Uniform Benefits are Plan Benefits.
- **PLAN DEPENDENT:** Means a Dependent who becomes a Participant of the Health Plan and/or PBM.
- **PLAN PROVIDER:** A Provider who has agreed in writing by executing a participation agreement to provide, prescribe or direct health care services, supplies or other items covered under the policy to Participants. The Provider's written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a Participant. The Health Plan agrees to give You lists of affiliated Providers. Some Providers require Prior Authorization by the Health Plan in advance of the services being provided.
- **PLAN SERVICE AREA:** Specific zip codes in those counties in which the affiliated physicians are approved by the Health Plan to provide professional services to Participants covered by the Health Plan.
- **POSTOPERATIVE CARE:** Means the medical observation and care of a Participant necessary for recovery from a covered surgical procedure.

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- **PREOPERATIVE CARE:** Means the medical evaluation of a Participant prior to a covered surgical procedure. It is the immediate preoperative visit in the Hospital or elsewhere necessary for the physical examination of the Participant, the review of the Participant's medical history and assessment of the laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.
- **PRIMARY CARE PROVIDER:** Means a Plan Provider who is a physician named as a Participant's primary health care contact. He/She provides entry into the Health Plan's health care system. He/She also (a) evaluates the Participant's total health needs; and (b) provides personal medical care in one or more medical fields. When medically needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other Provider health services and refers the Participant to other Providers.

You must name Your Primary Care Provider on Your enrollment application or in a later written notice of change. Each family member may have a different primary physician.

- **PRIOR AUTHORIZATION:** Means obtaining approval from Your Health Plan before obtaining the services. Unless otherwise indicated by Your Health Plan, Prior Authorization is required for care from any Non-Plan Providers unless it is an Emergency or Urgent Care. The Prior Authorization must be in writing. Prior Authorizations are at the discretion of the Health Plan and are described in Section G, Plan Descriptions, of the "It's Your Choice" book. Some prescriptions may also require Prior Authorization, which must be obtained from the PBM and are at its discretion.
- **PROVIDER:** Means a doctor, Hospital, and clinic; and (b) any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Plan Benefits.
- **REFERRAL:** When a Participant's Primary Care Provider sends him/her to another Provider for covered services. In many cases, the Referral must be in writing and on the Health Plan Prior Authorization form and approved by the Health Plan in advance of a Participant's treatment or service. Referral requirements are determined by each Health Plan and are described in Section G, Plan Descriptions, of the "It's Your Choice" book. The authorization from the Health Plan will state: a) the type or extent of treatment authorized; and b) the number of Prior Authorized visits and the period of time during which the authorization is valid. In most cases, it is the Participant's responsibility to ensure a Referral, when required, is approved by the Health Plan before services are rendered.
- **SCHEDULE OF BENEFITS:** The document that is issued to accompany this document which details specific benefits for covered services provided to Participants by the Health Plan You elected.
- **SELF-ADMINISTERED INJECTABLE:** Means an injectable that is administered subcutaneously and can be safely self-administered by the Participant and is obtained by prescription. This does not include those drugs delivered via IM (intramuscular), IV (intravenous) or IA (intra-arterial) injections or any drug administered through infusion.
- **SKILLED CARE:** Means medical services rendered by registered or licensed practical nurses; physical, occupational, and speech therapists. Patients receiving Skilled Care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip and patients requiring complicated wound care. In the majority of cases, "Skilled Care" is necessary for only a

limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children or other family or relatives. Examples of care provided by "nonskilled" persons include: range of motion exercises; strengthening exercises; wound care; ostomy care; tube and gastrostomy feedings; administration of medications; and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets or assisting patients with taking their medicines; or 24-hour supervision for potentially unsafe behavior, do not require "Skilled Care" and are considered Custodial.

- **SKILLED NURSING FACILITY:** Means an institution which is licensed by the State of Wisconsin, or other applicable jurisdiction, as a Skilled Nursing Facility.
- **SPECIALTY MEDICATIONS:** Means medications that require special storage and handling and as a result, are more costly and usually not available from all Participating Pharmacies.
- **STATE:** Means the State of Wisconsin as the policyholder.
- **SUBSCRIBER:** An Eligible Employee who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.
- **URGENT CARE:** Means care for an accident or illness which is needed sooner than a routine doctor's visit. If the accident or injury occurs when the Participant is out of the Plan Service Area, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her Primary Care Provider. It also does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.
- **USUAL AND CUSTOMARY CHARGE:** An amount for a treatment, service or supply provided by a Non-Plan Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related charges) prior to receiving services. Health Plan approved Referrals to Non-Plan Providers are not subject to Usual and Customary Charges. However, Emergency or urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges while holding the member harmless.
- **YOU/YOUR:** The Subscriber and his or her covered Dependents.

III. BENEFITS AND SERVICES

The benefits and services which the Health Plan and PBM agrees to provide to Participants, or make arrangements for, are those set forth below. These services and benefits are available only if, and to the extent that, they are provided, prescribed or directed by the Participant's Primary Care Provider (except in the case of plan chiropractic services, Emergency or Urgent Care), and are received after the Participant's Effective Date.

Hospital services must be provided by a plan Hospital. In the case of non-Emergency care, the Health Plan reserves the right to determine in a reasonable manner the Provider to be used. In cases of Emergency or Urgent Care services, Plan Providers and Hospitals must be used whenever possible and reasonable (see items A., 1. and 2. below).

The Health Plan reserves the right to modify the list of Plan Providers at any time, but will honor the selection of any Provider listed in the current provider directory for the duration of that calendar year unless that Provider left the Health Plan due to normal attrition (limited to, retirement, death or a move from the Plan Service Area or as a result of a formal disciplinary action for quality of care).

Except as specifically stated for Emergency and Urgent Care, You must receive the Health Plan's written Prior Authorization for covered services from a Non-Plan Provider or You will be financially responsible for the services. The Health Plan may also require Prior Authorization for other services or they will not be covered.

Subject to the terms and conditions outlined in this plan and the attached Schedule of Benefits, a Participant, in consideration of the employer's payment of the applicable Health Plan and PBM premium, shall be entitled to the benefits and services described below.

Benefits are subject to: (a) Any Copayment, Coinsurance and other limitations shown in the Schedule of Benefits; and (b) all other terms and conditions outlined in this plan. All services must be Medically Necessary, as determined by the Health Plan and/or PBM.

A. Medical/Surgical Services

1. Emergency Care

- a. Medical care for an Emergency, as defined in Section II. Refer to the Schedule of Benefits for information on the emergency room Copayment.
- b. Plan Hospital emergency rooms should be used whenever possible. Should You be unable to reach Your Plan Provider, go to the nearest appropriate medical facility. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You are receiving Emergency care. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered. In addition to the emergency room Copayment, this out-of-plan Emergency care may be subject to Usual and Customary Charges.
- c. It is the Member's (or another individual on behalf of the member) responsibility to notify the Health Plan of Emergency or Urgent Out-of-Area Hospital admissions or facility Confinements by the next business day after admission or as soon as reasonably possible. Out-of-Area Service means medical care received outside the defined Plan Service Area.

- d. Emergency services include reasonable accommodations for repair of Durable Medical Equipment as Medically Necessary.
- e. Some examples of Emergencies are:
 - ▶ Acute allergic reactions
 - ▶ Acute asthmatic attacks
 - ▶ Convulsions
 - ▶ Epileptic seizures
 - ▶ Acute hemorrhage
 - ▶ Acute appendicitis
 - ▶ Coma
 - ▶ Heart attack
 - ▶ Attempted suicide
 - ▶ Suffocation
 - ▶ Stroke
 - ▶ Drug overdoses
 - ▶ Loss of consciousness
 - ▶ Any condition for which You are admitted to the Hospital as an inpatient from the emergency room

2. Urgent Care

- a. Medical care received in an Urgent Care situation as defined in Section II. URGENT CARE IS NOT EMERGENCY CARE. It does not include care that can be safely postponed until the Participant returns to the Plan Service Area to receive such care from a Plan Provider.
- b. You must receive Urgent Care from a Plan Provider if You are in the Plan Service Area, unless it is not reasonably possible. If You are out of the Plan Service Area, go to the nearest appropriate medical facility unless You can safely return to the Plan Service Area to receive care from a Plan Provider. If You must go to a Non-Plan Provider for care, call the Health Plan by the next business day or as soon as possible and tell the Health Plan where You received Urgent Care. Urgent Care from Non-Plan Providers may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from a Plan Provider unless it is Prior Authorized by the Health Plan or it will not be covered.
- c. Some examples of Urgent Care cases are:
 - ▶ Most Broken Bones
 - ▶ Minor Cuts
 - ▶ Sprains
 - ▶ Most Drug Reactions
 - ▶ Non-Severe Bleeding
 - ▶ Minor Burns

3. Surgical Services

Surgical procedures, wherever performed, when needed to care for an Illness or Injury. These include: (a) Preoperative and Postoperative Care; and (b) needed services of assistants and consultants.

4. Reproductive Services

The following services do not require a Referral to a Plan Provider who specializes in obstetrics and gynecology, however, the Health Plan may require that the Participant obtain Prior Authorization for some services or they may not be covered.

- a. Maternity Services for prenatal and postnatal care, including services such as normal deliveries, ectopic pregnancies, Cesarean sections, therapeutic abortions, and miscarriages. Maternity benefits are also available for a daughter who is covered under this plan as a Participant. However, this does not extend coverage to the newborn who is not otherwise eligible (limited to if the Dependent daughter is age 18 or over at the time of birth). In accordance with the federal Newborns' and Mother' Health Protection Act, the inpatient stay will be covered for 48 hours following a normal delivery and 96 hours following a cesarean delivery, unless a longer inpatient stay is Medically Necessary. A shorter hospitalization related to maternity and newborn care may be provided if the shorter stay is deemed appropriate by the attending physician in consultation with the mother.
- b. Elective sterilization.
- c. Oral contraceptives, or cost-effective Formulary equivalents as determined by the PBM, and diaphragms, as described under the Prescription Drug benefit.
- d. IUDs , as described under the Durable Medical Equipment provision.
- e. Medroxyprogesterone acetate injections for contraceptive purposes (for example, Depo Provera).

If the Participant is in her second or third trimester of pregnancy when the Provider's participation in the Health Plan terminates, the Participant will continue to have access to the Provider until completion of postpartum care for the woman and infant. A Prior Authorization is not required for the delivery, but the Health Plan may request that it be notified of the inpatient stay prior to the delivery or shortly thereafter.

5. Medical Services

Medically Necessary professional services and office visits provided to inpatients, outpatients, and to those receiving home care services by an approved Provider.

- a. Routine physical examinations consistent with accepted preventive care guidelines and immunizations as medically appropriate.
- b. Well-baby care, including lead screening as required by Wis. Stat. § 632.895 (10), and childhood immunizations.
- c. Routine patient care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6),
- d. Medically Necessary travel-related preventive treatment. Preventive travel-related care such as typhoid, diphtheria, tetanus, yellow fever and Hepatitis A vaccinations if determined to be medically appropriate for the Participant by the Health Plan. It does not apply to travel required for work. (See Exclusion A., 2., e.)
- e. Injectable and infusible medications, except for Self-Administered Injectable medications.

- f. Nutritional Counseling provided by a participating registered dietician or Plan Provider.
- g. A second opinion from a Plan Provider or when Prior Authorized by the Health Plan.

6. Anesthesia Services

Covered when provided in connection with other medical and surgical services covered under this plan. It will also include anesthesia services for dental care as provided under item B., 1., c., of this section.

7. Radiation Therapy

Covered when accepted therapeutic methods, such as x-rays, radium and radioactive isotopes are administered and billed by an approved Provider.

8. Detoxification Services

Covers Medically Necessary detoxification services provided by an approved Provider.

9. Ambulance Service

Covers licensed professional ambulance service (or comparable Emergency transportation if authorized by the Health Plan) when necessary to transport to the nearest Hospital where appropriate medical care is available when the conveyance is an Emergency or Urgent in nature and medical attention is required en route, as described in the Schedule of Benefits. Ambulance services include Medically Necessary transportation and all associated supplies and services provided therein. If the Participant is not in the Plan's Service Area, the Health Plan or Plan Provider should be contacted, if possible, before Emergency or Urgent transportation is obtained. In most cases, medical attention should be received at the closest appropriate medical facility rather than returning to the Service Area for treatment.

10. Diagnostic Services

Medically Necessary testing and evaluations, including, but not limited to, x-rays and lab tests given with general physical examinations; vision and hearing tests to determine if correction is needed; annual routine mammography screening when ordered and performed by a Plan Provider, including nurse practitioners; and other covered services. Services of a nurse practitioner will be covered in connection with mammography screening, Papanicolaou tests and pelvic examinations.

11. Outpatient Physical, Speech and Occupation Therapy

Medically Necessary services as a result of Illness or Injury, provided by a Plan Provider. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit maximum described in the Schedule of Benefits, although up to 50 additional visits per therapy per calendar year may be Prior Authorized by the Health Plan if the therapy continues to be Medically Necessary and is not otherwise excluded.

12. Home Care Benefits

Care and treatment of a Participant under a plan of care. The Plan Provider must establish this plan; approve it in writing; and review it at least every two (2) months unless the physician determines that less frequent reviews are sufficient.

All home care must be Medically Necessary as part of the home care plan. Home care means one or more of the following:

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- a. Home nursing care that is given part-time or from time to time. It must be given or supervised by a registered nurse.
- b. Home health aide services that are given part-time or from time to time and are skilled in nature. They must consist solely of caring for the patient. A registered nurse or medical social worker must supervise them.
- c. Physical, respiratory, occupational and speech therapy. (These apply to the therapy maximum.)
- d. Medical supplies, drugs and medicines prescribed by a Health Plan physician; and lab services by or for a Hospital. They are covered to the same extent as if the Participant was Confined in a Hospital.
- e. Nutritional Counseling. A registered dietician must give or supervise these services.
- f. The assessment of the need for a home care plan, and its development. A registered nurse, physician extender or medical social worker must do this. The attending physician must ask for or approve this service.

Home care will not be covered unless the attending physician certifies that:

- 1) Hospital Confinement or Confinement in a Skilled Nursing Facility would be needed if home care were not provided.
- 2) The Participant's Immediate Family, or others living with the Participant, cannot provide the needed care and treatment without undue hardship.
- 3) A state licensed or Medicare certified home health agency or certified rehabilitation agency will provide or coordinate the home care.

A Participant may have been Confined in a Hospital just before home care started. If so, the home care plan must be approved, at its start, by the physician who was the primary Provider of care during the Hospital Confinement.

Home care benefits are limited to the maximum number of visits specified in the Schedule of Benefits, although up to 50 additional home care visits per calendar year may be Prior Authorized by the Health Plan if the visits continue to be Medically Necessary and are not otherwise excluded. Each visit by a person providing services under a home care plan, evaluating Your needs or developing a plan counts as one visit. Each period of four (4) straight hours in a twenty-four (24) hour period of home health aide services counts as one home care visit.

13. Hospice Care

Covers Hospice Care if the Primary Care Provider certifies that the Participant's life expectancy is 6 months or less, the care is palliative in nature, and is authorized by the Health Plan. Hospice Care is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. Hospice Care includes, but is not limited to, medical supplies and services, counseling, bereavement counseling for 1 year after the Participant's death, Durable Medical Equipment rental, home

visits, and Emergency transportation. Coverage may be continued beyond a 6-month period if authorized by the Health Plan.

14. Phase II Cardiac Rehabilitation

Services must be approved by the Health Plan and provided in an outpatient department of a Hospital, in a medical center or clinic program. This benefit may be appropriate only for Participants with a recent history of: (a) a heart attack (myocardial infarction); (b) coronary bypass surgery; (c) onset of angina pectoris; (d) heart valve surgery; (e) onset of decubital angina; (f) onset of unstable angina; (g) percutaneous transluminal angioplasty; or (h) heart transplant. Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under this contract.

15. Extraction of Natural Teeth and Replacement with Artificial Teeth Because of Accidental Injury

Total extraction or total replacement (limited to, bridge or denture) of Natural Teeth by an approved Plan Provider when necessitated by an Injury. The treatment must commence within eighteen months of the accident. Crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the Health Plan before the service is performed. Injuries caused by chewing or biting are not considered to be accidental Injuries for the purpose of this provision.

16. Oral Surgery

Participants should contact the Health Plan prior to any oral surgery to determine if Prior Authorization by the Health Plan is required. When performed by Plan Providers, approved surgical procedures are as follows:

- a. Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars.
- b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.
- c. Frenotomy. (Incision of the membrane connecting tongue to floor of mouth.)
- d. Surgical procedures required to correct accidental Injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such Injuries are incurred while the Participant is continuously covered under this contract or a preceding contract provided through the Board.
- e. Apicoectomy. (Excision of apex of tooth root.)
- f. Excision of exostoses of the jaws and hard palate.
- g. Intraoral and extraoral incision and drainage of cellulitis.
- h. Incision of accessory sinuses, salivary glands or ducts.
- i. Reduction of dislocations of, and excision of, the temporomandibular joints.

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- j. Gingivectomy for the excision of loose gum tissue to eliminate infection; or osseous surgery and related Medically Necessary guided tissue regeneration and bone-graft replacement, when performed in place of a covered gingivectomy.
- k. Alveolectomy or alveoplasty (if performed for reasons other than preparation for dentures, dental implants, or other procedures not covered under Uniform Benefits) and associated osseous (removal of bony tissue) surgery.

Retrograde fillings are covered when Medically Necessary following covered oral surgery procedures.

Oral surgery benefits shall not include benefits for procedures not listed above; for example, root canal procedures, filling, capping or recapping.

17. Treatment of Temporomandibular Disorders

As required by Wis. Stat. § 632.895 (11), coverage is provided for diagnostic procedures and Prior Authorized Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

- a. A Congenital, developmental or acquired deformity, disease or Injury caused the condition.
- b. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care Provider rendering the service.
- c. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Intraoral splints are covered under this provision but are subject to the Durable Medical Equipment Coinsurance as outlined in the Schedule of Benefits. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, will be payable up to \$1,250 per calendar year.

18. Transplants

The following transplantations are covered, however, all services, including transplant work-ups, must be Prior Authorized by the Health Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill. All transplant-related expenses, including Preoperative and Postoperative Care, are applied to the \$1,000,000 maximum lifetime benefit for transplants.

Limited to one transplant per organ per Participant per Health Plan during the lifetime of the policy, except as required for treatment of kidney disease. Organ retransplantation, which applies to items b., e., f., and g. as listed below, is not a covered benefit.

- a. Autologous (self to self) and allogeneic (donor to self) bone marrow transplantations, including peripheral stem cell rescue, used only in the treatment of:
 - ▶ Aplastic anemia
 - ▶ Acute leukemia
 - ▶ Severe combined immunodeficiency, for example, adenosine deaminase deficiency and idiopathic deficiencies

- ▶ Wiskott-Aldrich syndrome
 - ▶ Infantile malignant osteopetrosis (Albers-Schoenberg disease or marble bone disease)
 - ▶ Hodgkins and non-Hodgkins lymphoma
 - ▶ Combined immunodeficiency
 - ▶ Chronic myelogenous leukemia
 - ▶ Pediatric tumors based upon individual consideration
 - ▶ Neuroblastoma
 - ▶ Myelodysplastic syndrome
 - ▶ Homozygous Beta-Thalassemia
 - ▶ Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
 - ▶ Multiple Myeloma, Stage II or Stage III
 - ▶ Germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound
- b. Parathyroid transplantation
- c. Musculoskeletal transplantations intended to improve the function and appearance of any body area, which has been altered by disease, trauma, Congenital anomalies or previous therapeutic processes.
- d. Corneal transplantation (keratoplasty) limited to:
- ▶ Corneal opacity
 - ▶ Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a Participant who cannot wear a contact lens;
 - ▶ Corneal ulcer
 - ▶ Repair of severe lacerations
- e. Heart transplants will be limited to the treatment of:
- ▶ Congestive Cardiomyopathy
 - ▶ End-Stage Ischemic Heart Disease
 - ▶ Hypertrophic Cardiomyopathy
 - ▶ Terminal Valvular Disease
 - ▶ Congenital Heart Disease, based upon individual consideration
 - ▶ Cardiac Tumors, based upon individual consideration
 - ▶ Myocarditis
 - ▶ Coronary Embolization
 - ▶ Post-traumatic Aneurysm
- f. Liver transplants will be limited to the treatment of:
- ▶ Extrahepatic Biliary Atresia
 - ▶ Inborn Error of Metabolism
 - Alpha -1- Antitrypsin Deficiency
 - Wilson's Disease
 - Glycogen Storage Disease
 - Tyrosinemia
 - ▶ Hemochromatosis
 - ▶ Primary Biliary Cirrhosis
 - ▶ Hepatic Vein Thrombosis

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- ▶ Sclerosing Cholangitis
 - ▶ Post-necrotic Cirrhosis, Hbe Ag Negative
 - ▶ Chronic Active Hepatitis, Hbe Ag Negative
 - ▶ Alcoholic Cirrhosis, abstinence for 12 or more months
 - ▶ Epithelioid Hemangioepithelioma
 - ▶ Poisoning
 - ▶ Polycystic Disease
- g. Kidney/pancreas, heart/lung, and lung transplants as determined to be Medically Necessary by the Health Plan.
- h. In addition to the above-listed diagnoses for covered transplants, the Health Plan may Prior Authorize a transplant for a non-listed diagnosis if the Health Plan determines that the transplant is a Medically Necessary and a cost effective alternate treatment.
- i. Kidney Transplants. See item 19. below.

19. Kidney Disease Treatment

Coverage for inpatient and outpatient kidney disease treatment will be provided. This benefit is limited to all services and supplies directly related to kidney disease, including but not limited to, dialysis, transplantation (applies to transplant maximum-see Transplants section A., 18), donor-related services, and related physician charges.

20. Chiropractic Services

When performed by a Plan Provider. Benefits are not available for Maintenance Therapy.

21. Women's Health and Cancer Act of 1998

Under the Women's Health and Cancer Act of 1998, coverage for the treatment of breast cancer includes:

- ▶ Reconstruction of the breast on which a mastectomy was performed;
- ▶ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ▶ Prostheses (see DME in section C., 3.) and physical complications of all stages of mastectomy, including lymphedemas.

22. Smoking Cessation

Coverage includes pharmacological products that by law require a written prescription and are described under the Prescription Drug benefits in Section D., 1. Coverage also includes one office visit for counseling and to obtain the prescription. Additional counseling may be authorized by the Health Plan.

B. Institutional Services

Covers inpatient and outpatient Hospital services and Skilled Nursing Facility services that are necessary for the admission, diagnosis and treatment of a patient when provided by a Plan Provider. Each Participant in a health care facility agrees to conform to the rules and regulations of the institution. The Health Plan may require that the hospitalization be Prior Authorized.

1. Inpatient Care

- a. Hospitals and Specialty Hospitals: Covered for semi-private room, ward or intensive care unit and Medically Necessary Miscellaneous Hospital Expenses, including prescription

drugs administered during the Confinement. A private room is payable only if Medically Necessary for isolation purposes as determined by the Health Plan.

- b. Licensed Skilled Nursing Facility: Must be admitted within twenty-four (24) hours of discharge from a general Hospital for continued treatment of the same condition. Care must be Skilled. Custodial Care is excluded. Benefits limited to the number of days specified in the Schedule of Benefits. Benefits include prescription drugs administered during the Confinement. Confinement in a swing bed in a Hospital is considered the same as a Skilled Nursing Facility Confinement.
- c. Hospital and Ambulatory Surgery Center Charges and related Anesthetics for Dental Care: Covered if services are provided to a Participant who is under five years of age; has a medical condition that requires hospitalization or general anesthesia for dental care; or has a chronic disability that meets all of the conditions under Wis. Stat. § 230.04 (9r) (a) 2. a., b., and c.

2. Outpatient Care

Emergency Care: First aid, accident or sudden illness requiring immediate Hospital services. Subject to the Copayment described in the Schedule of Benefits. Follow-up care received in an emergency room to treat the same Injury is also subject to the Copayment.

Mental Health/Alcohol and Drug Abuse Services: See below for benefit details.

Diagnostic Testing: Includes chemotherapy, laboratory, x-ray, and other diagnostic tests.

Surgical Care: Covered.

C. Other Medical Services

1. Mental Health Services/Alcohol and Drug Abuse

Participants should contact the Health Plan prior to any services to determine if Prior Authorization or a Referral is required from the Health Plan.

a. Outpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. The outpatient services means non-residential services by Providers as defined and set forth under Wis. Stat. § 632.89 (1) (e).

This benefit also includes services for a full-time student attending school in Wisconsin but out of the Plan Service Area as required by Wis. Stat. § 609.655.

b. Transitional Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits. Transitional Care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89.

c. Inpatient Services

Covers Medically Necessary services provided by a Plan Provider as described in the Schedule of Benefits and as required by Wis. Stat. §632.89. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by a Non-Plan Provider, if provided pursuant to an Emergency detention or on an Emergency basis and the Provider notifies the Health Plan within 72 hours after the initial provision of service.

d. Other

- 1) Prescription drugs used for the treatment of mental health, alcohol and drug abuse will be subject to the prescription drug benefit as described in Section D., 1. The charges for such drugs will not be applied the maximum benefit available for any mental health, alcohol or drug abuse services.
- 2) The dollar amounts applied to the maximum benefits available for the treatment of mental health, alcohol, and drug abuse will be based upon the average amount paid to the Provider by the Health Plan.

2. Durable and Disposable Diabetic Supplies

When prescribed by a Plan Provider for treatment of diabetes and purchased from a Plan Provider, durable diabetic equipment and durable and disposable supplies that are required for use with the durable diabetic equipment, will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for Durable Medical Equipment. Durable diabetic equipment includes:

- Automated injection devices.
- Continuing glucose monitoring devices.
- Insulin infusion pumps, limited to one pump in a calendar year and You must use the pump for thirty (30) days before purchase.

All Durable Medical Equipment purchases or monthly rentals must be Prior Authorized as determined by the Health Plan.

(Glucometers are available through the PBM. Refer to section D. for benefit information.)

3. Medical Supplies and Durable Medical Equipment

When prescribed by a Plan Provider for treatment of a diagnosed Illness or Injury and purchased from a Plan Provider, medical supplies and Durable Medical Equipment will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. All purchases or monthly rentals must be Prior Authorized as determined by the Health Plan. The following supplies and equipment will be covered:

- Initial acquisition of artificial limbs or eyes or as needed for growth and development.
- Casts, splints, trusses, crutches, prostheses, orthopedic braces and appliances and custom-made orthotics.

- Rental or, at the option of the Health Plan, purchase of equipment such as, but not limited to: wheelchairs, hospital-type beds, and artificial respiration equipment.
- An initial lens per surgical eye following cataract surgery (contact lens or framed lens).
- IUDs.
- Elastic support hose, for example, JOBST, which are prescribed by a Plan Provider. Limited to two pairs per calendar year.
- Cochlear implants, which includes the device, surgery for implantation of the device, and follow-up sessions to train on use of the device, covered at 80% as determined Medically Necessary by the Health Plan. Hospital charges for the surgery are covered at 100%. The annual out-of-pocket maximum for Durable Medical Equipment does not apply to this benefit.
- One hearing aid, per ear, no more than once every three years, as determined by the Health Plan to be Medically Necessary, up to a maximum payment of \$1,000 per hearing aid. The Participant's out-of-pocket costs are not applied to the annual out-of-pocket maximum for Durable Medical Equipment.
- Ostomy and catheter supplies.
- Other medical equipment and supplies as approved by the Health Plan. Rental or purchase of equipment/supplies is at the option of the Health Plan.
- When Prior Authorized as determined by the Health Plan, repairs, maintenance and replacement of covered Durable Medical Equipment/supplies, including replacement of batteries. When determining whether to repair or replace the Durable Medical Equipment/supplies, the Health Plan will consider whether: i) the equipment/supply is still useful or has exceeded its lifetime under normal use; or ii) the Participant's condition has significantly changed so as to make the original equipment inappropriate (for example, due to growth or development).

4. Out-of-Plan Coverage For Full-Time Students

If a Dependent is a full-time student attending school outside of the HMO Service Area, the following services will be covered:

- a. Emergency or Urgent Care. Non-urgent follow-up care out of the Service Area must be Prior Authorized or it will not be covered; and
- b. Outpatient mental health services and treatment of alcohol or drug abuse if the Dependent is a full-time student attending school in Wisconsin, but outside of the Plan Service Area, pursuant to Wis. Stat. 609.655. In that case, the Dependent may have a clinical assessment by a Non-Plan Provider when Prior Authorized by the Health Plan. If outpatient services are recommended, coverage will be provided for five (5) visits outside of the Plan's Service Area when Prior Authorized by the Health Plan. Additional visits may be approved by the Health Plan. If the student is unable to maintain full-time student status, he/she must return to the Plan's Service Area for the treatment to be covered. This benefit is subject to

the limitations shown in the Schedule of Benefits for mental health/alcohol/drug abuse services and will not serve to provide additional benefits to the Participant.

5. Congenital Defects and Birth Abnormalities

Pursuant to Wis. Stat. §632.895 (5) and Wis. Adm. Code § INS 3.38 (2) (d), if a Dependent is continuously covered under any plan under this health insurance program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal functioning or in preparation for surgery to restore function for treatment of cleft palate.

D. Prescription Drugs and Other Benefits Administered by the Pharmacy Benefit Manager (PBM)

You must obtain benefits at a PBM Participating Pharmacy except when not reasonably possible because of Emergency or Urgent Care. In these circumstances, You may need to make a claim as described in the paragraph below.

If You do not show Your PBM identification card at the pharmacy at the time You are obtaining benefits, You may need to pay the full amount and submit to the PBM for reimbursement an itemized bill, statement, and receipt that includes the pharmacy name, pharmacy address, patient's name, patient's identification number, NDC (national drug classification) code, prescription name, and retail price (in U.S. currency). In these situations, You may be responsible for more than the Copayment amount. The PBM will determine the benefit amount based on the network price.

Except as specifically provided, all provisions of Uniform Benefits including, but not limited to, exclusions and limitations, coordination of benefits and services, and miscellaneous provisions, apply to the benefits administered by the PBM. The PBM may offer cost savings initiatives as approved by the Department. Contact the PBM if You have questions about these benefits.

Any benefits that are not listed in this section and are covered under this program are administered by the Health Plan.

1. Prescription Drugs

Coverage includes legend drugs and biologicals that are FDA approved which by law require a written prescription; are prescribed for treatment of a diagnosed Illness or Injury; and are purchased from a PBM Network Pharmacy after a Copayment or Coinsurance amount, as described in the Schedule of Benefits. A Copayment will be applied to each prescription dispensed. The PBM may lower the Copayment amount in certain situations. The PBM may classify a prescription drug as not covered if it determines that prescription drug does not add clinical or economic value over currently available therapies.

An annual out-of-pocket maximum applies to Participants' Copayments for Level 1 and Level 2 Formulary prescription drugs as described on the Schedule of Benefits. When any Participant meets the annual out-of-pocket maximum, when applicable, as described on the Schedule of Benefits, that Participant's Level 1 and Level 2 Formulary prescription drugs will be paid in full for the rest of the calendar year. Further, if participating family members combined have paid in a year the family annual out-of-pocket maximum as described in the Schedule of Benefits, even if no one Participant has met his or her individual annual out-of-pocket maximum, all family members will have satisfied the annual out-of-pocket maximum for that calendar year. The

Participant's cost for Level 3 drugs will not be applied to the annual out-of-pocket maximum. If the cost of a prescription drug is less than the applicable Copayment, the Participant will pay only the actual cost and that amount will be applied to the annual out-of-pocket maximum for Level 1 and Level 2 Formulary prescription drugs.

The Health Plan, not the PBM, will be responsible for covering prescription drugs administered during home care, office setting, Confinement, emergency room visit or Urgent Care setting, if otherwise covered under Uniform Benefits. However, prescriptions for covered drugs written during home care, office setting, Confinement, emergency room visit or Urgent Care setting will be the responsibility of the PBM and payable as provided under the terms and conditions of Uniform Benefits, unless otherwise specified in Uniform Benefits (for example, Self-Administered Injectable).

Where a Medicare prescription drug plan is the primary payor, the Participant is responsible for the Copayment plus any charges in excess of the PBM allowed amount. The allowed amount is based on the pricing methodology used by the preferred prescription drug plan administered by the PBM.

Notwithstanding the exclusion in Section IV., 12., (b) for Participants in the Wisconsin Public Employers' group, the PBM will pay prescription drug benefits for Medicare eligible members as secondary, regardless of whether or not the Participant is actually enrolled in a Medicare Part D prescription drug plan.

Prescription drugs will be dispensed as follows:

- a. In maximum quantities not to exceed a 30 consecutive day supply per Copayment.
- b. The PBM may apply quantity limits to medications in certain situations (for example, due to safety concerns).
- c. Single packaged items are limited to 2 items per Copayment or up to a 30-day supply, whichever is more appropriate, as determined by the PBM.
- d. Oral Contraceptives are not subject to the 30-day supply and will be dispensed at one Copayment per package or a 28-day supply, whichever is less.
- e. Smoking cessation coverage includes pharmacological products that by law require a written prescription and are prescribed for the purpose of achieving smoking cessation and are on the Formulary. These require a prescription from a physician and must be filled at a Participating Pharmacy. Only one 30-day supply of medication may be obtained at a time and is subject to the prescription drug Copayment and annual out-of-pocket maximum. Coverage is limited to a maximum of one consecutive three-month course of pharmacotherapy per calendar year.
- f. Prior Authorization from the PBM may be required for certain prescription drugs. A list of prescription drugs requiring Prior Authorization is available from the PBM.
- g. Cost-effective Generic Equivalents will be dispensed unless the Plan Provider specifies the Brand Name Drug and indicates that no substitutions may be made, in which case the Brand Name Drug will be covered at the Copayment specified in the Formulary.

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- h. Mail order is available for many prescription drugs. For certain Level 1 and Level 2 Formulary prescription drugs determined by the PBM that are obtained from a designated mail order vendor, two Copayments will be applied to a 90-day supply of drugs if at least a 90-day supply is prescribed. Self-Administered Injectables and narcotics are among those for which a 90-day supply is not available.
- i. Tablet Splitting is a voluntary program in which the PBM may designate certain Level 1 and Level 2 Formulary drugs that the member can split the tablet of a higher strength dosage at home. Under this program, the member gets half the usual quantity for a 30-day supply (15 tablets – 30-day supply). Participants who use tablet splitting will pay half the normal Copayment amount.
- j. Generic sampling is available to encourage the use of Level 1 Formulary medications, whereby the PBM may waive the Copayment of a Level 1 Formulary prescription drug on the initial prescription fill for certain medications for up to three months, if that medication has not been tried previously.
- k. The PBM reserves the right to designate certain over the counter drugs on the Formulary.
- l. Specialty Medications and Self-Administered Injectables when obtained by prescription and which can safely be administered by the Participant, must be obtained from a PBM Participating Pharmacy or in some cases, the PBM may need to limit availability to specific pharmacies.

This coverage includes investigational drugs for the treatment of HIV, as required by Wis. Stat. § 632.895 (9).

2. *Insulin, Disposable Diabetic Supplies, Glucometers*

The PBM will list on the Formulary approved products. Prior Authorization is required for anything not listed on the Formulary.

- a. Insulin is covered as a prescription drug. Insulin will be dispensed in a maximum quantity of a 30 consecutive day supply for one prescription drug Copayment, as described on the Schedule of Benefits.
- b. Disposable Diabetic Supplies and Glucometers will be covered after a 20% Coinsurance as outlined in the Schedule of Benefits when prescribed for treatment of diabetes and purchased from a PBM Network Pharmacy. Disposable diabetic supplies including needles, syringes, alcohol swabs, lancets, lancing devices, blood or urine test strips. The Participant's Coinsurance will be applied to the annual out-of-pocket maximum for prescription drugs.

3. *Other Devices and Supplies*

Other devices and supplies administered by the PBM that are subject to a 20% Coinsurance and applied to the annual out-of-pocket maximum for prescription drugs are as follows:

- ▶ Diaphragms
- ▶ Syringes/Needles
- ▶ Spacers/Peak Flow Meters

IV. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following is a list of services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the Plan Benefits); or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by Health Plans and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. **The exclusions do not apply solely to the category in which they are listed except that subsection 11 applies only to the pharmacy benefit administered by the PBM.** Some of the listed exclusions may be Medically Necessary, but still are not covered under this plan, while others may be examples of services which are not Medically Necessary or not medical in nature, as determined by the Health Plan and/or PBM.

1. *Surgical Services*

- a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.
- b. Treatment, services and supplies for cosmetic or beautifying purposes, except when associated with a covered service to correct Congenital bodily disorders or conditions or when associated with covered reconstructive surgery due to an Illness or accidental Injury (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.
- c. Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.
- d. Keratorefractive eye surgery, including but not limited to, tangential or radial keratotomy, or laser surgeries for the correction of vision.

2. *Medical Services*

- a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation in athletics, or examinations or treatment ordered by a court, unless otherwise covered as stated in the Benefits section.
- b. Expenses for medical reports, including preparation and presentation.
- c. Services rendered (a) in the examination, treatment or removal of all or part of corns, calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting, trimming or other nonoperative partial removal of toenails; (c) treatment of flexible flat feet; or (d) in connection with any of these except when prescribed by a Plan Provider who is treating the Participant for a metabolic or peripheral disease or if the skin or tissue is infected.
- d. Weight loss programs including dietary and nutritional treatment in connection with obesity. This does not include Nutritional Counseling as provided in the Benefits section.

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- e. Work related preventive treatment (for example, Hepatitis vaccinations, Rabies vaccinations, small pox vaccinations, etc.).
- f. Services of a blood donor. Medically Necessary autologous blood donations are not considered to be services of a blood donor.
- g. Genetic testing and/or genetic counseling services, unless Medically Necessary to diagnose or treat an existing illness.

3. Ambulance Services

- a. Ambulance service, except as outlined in the Benefits and Services section, unless authorized by the Health Plan.
- b. Charges for, or in connection with, travel, except for ambulance transportation as outlined in the Benefits Section.

4. Therapies

- a. Vocational rehabilitation including work hardening programs.
- b. Maintenance Therapy. Examples include: physical, speech and occupational therapy and other special therapy except as specifically listed in the Benefits section.
- c. Therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein.

These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction.

- d. Physical fitness or exercise programs.
- e. Biofeedback, except that provided by a physical therapist for treatment of headaches and spastic torticollis.
- f. Massage therapy.

5. Oral Surgery/Dental Services/Extraction and Replacement Because of Accidental Injury

- a. All services performed by dentists and other dental services, including all orthodontic services, except those specifically listed in the Benefits and Services Section or which would be covered if it was performed by a physician and is within the scope of the dentist's license. This includes, but is not limited to, dental implants; shortening or lengthening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits Section. (Note: Mandated TMJ benefits under Wis. Stat. § 632.895 (11) may limit this exclusion.)

- b. All periodontic procedures, except gingivectomy surgery as listed in the Benefits Section.
- c. All oral surgical procedures not specifically listed in the Benefits Section.

6. Transplants

- a. Transplants and all related services, except those listed as covered procedures.
- b. Services in connection with covered transplants unless Prior Authorized by the Health Plan.
- c. Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.
- d. Purchase price of bone marrow, organ or tissue that is sold rather than donated.
- e. All separately billed donor-related services, except for kidney transplants.
- f. Non-human organ transplants or artificial organs.

7. Reproductive Services

- a. Infertility services which are not for treatment of Illness or Injury (i.e., which are for the purpose of achieving pregnancy). The diagnosis of infertility alone does not constitute an Illness.
- b. Reversal of voluntary sterilization procedures and related procedures when performed for the purpose of restoring fertility.
- c. Services for storage or processing of semen (sperm); donor sperm.
- d. Harvesting of eggs and their cryopreservation.
- e. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures, and related Hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
- f. Implantable birth control devices (for example, Norplant).
- g. Surrogate mother services.
- h. Maternity services received out of the Plan Service Area in the ninth month of pregnancy, unless Prior Authorized (Prior Authorization will be granted only if the situation is out of the Participant's control (for example, family emergency)).
- i. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.

8. Hospital Inpatient Services

- a. Take home drugs and supplies dispensed at the time of Hospital discharge, which can reasonably be purchased on an outpatient basis.

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- b. Hospital stays, which are extended for reasons other than Medical Necessity, limited to lack of transportation, lack of caregiver, inclement weather and other, like reasons.
- c. A continued Hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting, for example, Skilled Nursing Facility.

9. Mental Health Services/Alcohol and Drug Abuse

- a. Hypnotherapy.
- b. Marriage counseling.
- c. Residential care except transitional care as required by Wis. Stat. § 632.89.
- d. Biofeedback.

10. Durable Medical or Diabetic Equipment and Supplies

- a. All Durable Medical Equipment purchases or rentals unless authorized by the Health Plan.
- b. Repairs and replacement of Durable Medical Equipment/supplies unless authorized by the Health Plan.
- c. Medical supplies and Durable Medical Equipment for comfort, personal hygiene and convenience items such as, but not limited to, wigs, hair prostheses, air conditioners, air cleaners, humidifiers; or physical fitness equipment, physician's equipment; disposable supplies; alternative communication devices; and self-help devices not Medically Necessary, as determined by the Health Plan, including, but not limited to, shower chairs and reaches.
- d. Home testing and monitoring supplies and related equipment except those used in connection with the treatment of diabetes or infant apnea or as Prior Authorized by the Health Plan.
- e. Equipment, models or devices that have features over and above that which are Medically Necessary for the Participant will be limited to the standard model as determined by the Health Plan.
- f. Oxygen therapy and other inhalation therapy and related items for home use except as authorized by the Health Plan.
- g. Motor vehicles (for example, cars, vans) or customization of vehicles, lifts for wheel chairs and scooters, and stair lifts.
- h. Customization of buildings for accommodation (for example, wheelchair ramps).

11. Outpatient Prescription Drugs – Administered by the PBM

- a. Charges for supplies and medicines with or without a doctor's prescription, unless otherwise specifically covered.
- b. Charges for prescription drugs which require Prior Authorization unless approved by the PBM.
- c. Charges for cosmetic drug treatments such as Retin-A, Rogaine, or their medical equivalent.

- d. Any FDA medications approved for weight loss (for example, appetite suppressants, Xenical).
- e. Anorexic agents.
- f. Non-FDA approved prescriptions, including compounded estrogen, progesterone or testosterone products, except as authorized by the PBM.
- g. All over the counter drug items, except those designated as covered by the PBM.
- h. Unit dose medication, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging.
- i. Charges for injectable medications, except for Self-Administered Injectable medications.
- j. Charges for supplies and medicines purchased from a Non-Participating Pharmacy, except when Emergency or Urgent Care is required.
- k. Drugs recently approved by the FDA may be excluded until reviewed and approved by the PBM's Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.
- l. Infertility and fertility medications.
- m. Charges for medications obtained through a discount program or over the Internet, unless Prior Authorized by the PBM.
- n. Charges for spilled, stolen or lost prescription drugs.

12. General

- a. Any additional exclusion as described in the Schedule of Benefits.
- b. Except for benefits payable under Medicare Part D, services to the extent the Participant is eligible for all other Medicare benefits, regardless of whether or not the Participant is actually enrolled in Medicare. This exclusion only applies if Medicare is the primary payor.
- c. Treatment, services and supplies for which the Participant: (a) has no obligation to pay or which would be furnished to a Participant without charge; (b) would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or (c) would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if this contract was not in effect.
- d. Injury or Illness caused by: (a) Atomic or thermonuclear explosion or resulting radiation; or (b) any type of military action, friendly or hostile. Acts of domestic terrorism do not constitute military action.
- e. Treatment, services and supplies for any Injury or Illness as the result of war, declared or undeclared, enemy action or action of Armed Forces of the United States, or any State of the United States, or its Allies, or while serving in the Armed Forces of any country.

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- f. Treatment, services and supplies furnished by the U.S. Veterans Administration, except for such treatment, services and supplies for which under the policy the Health Plan and/or PBM is the primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.
- g. Services for holistic medicine, including homeopathic medicine, or other programs with an objective to provide complete personal fulfillment.
- h. Treatment, services or supplies used in educational or vocational training.
- i. Treatment or service in connection with any Illness or Injury caused by a Participant (a) engaging in an illegal occupation or (b) commission of, or attempt to commit, a felony.
- j. Care provided to assist with activities of daily living (ADL).
- k. Personal comfort or convenience items such as in-Hospital television, telephone, private room, housekeeping, shopping, and homemaker services, and meal preparation services as part of home health care.
- l. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.
- m. Custodial, nursing facility (except skilled), or domiciliary care. This includes community re-entry programs.
- n. Expenses incurred prior to the coverage Effective Date in the Health Plan and/or PBM, or services received after the Health Plan and/or PBM coverage or eligibility terminates. Except when a Participant's coverage terminates because of Subscriber cancellation or non-payment of premium, benefits shall continue to the Participant if he or she is Confined as an inpatient on the coverage termination date but only until the attending physician determines that Confinement is no longer Medically Necessary; the contract maximum is reached; the end of 12 months after the date of termination; or Confinement ceases, whichever occurs first. If the termination is a result of a Subscriber changing Health Plans during a prescribed enrollment period as determined by the Board, benefits after the effective date with the succeeding Health Plan will be the responsibility of the succeeding Health Plan unless the facility in which the Participant is Confined is not part of the succeeding Health Plan's network. In this instance, the liability will remain with the previous insurer.
- o. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye following cataract surgery.
- p. Any service, treatment, procedure, equipment, drug, device or supply which is not reasonably and Medically Necessary or not required in accordance with accepted standards of medical, surgical or psychiatric practice.
- q. Charges for any missed appointment.
- r. Experimental services, treatments, procedures, equipment, drugs, devices or supplies, including, but not limited to: Treatment or procedures not generally proven to be effective as determined by the Health Plan and/or PBM following review of research protocol and

individual treatment plans; orthomolecular medicine, acupuncture, cytotoxin testing in conjunction with allergy testing, hair analysis except in conjunction with lead and arsenic poisoning. Phase I, II and III protocols for cancer treatments and certain organ transplants. In general, any service considered to be Experimental, except drugs for treatment of an HIV infection, as required by Wis. Stat. § 632.895 (9) and routine care administered in a cancer clinical trial as required by Wis. Stat. § 632.87 (6).

- s. Services provided by members of the Subscriber's Immediate Family or any person residing with the Subscriber.
- t. Services, including non-physician services, provided by Non-Plan Providers. Exceptions to this exclusion:
 - 1) On written Referral by Plan Provider with the prior written authorization of the Health Plan.
 - 2) Emergencies in the Service Area when the Primary Care Provider or another Plan Provider cannot be reached.
 - 3) Emergency or Urgent Care services outside the Service Area. Non-urgent follow-up care requires Prior Authorization from the Health Plan.
- u. Services of a specialist without a Plan Provider's written Referral, except in an Emergency or by written Prior Authorization of the Health Plan. Any Hospital or medical care or service not provided for in this document unless authorized by the Health Plan.
- v. Coma Stimulation programs.
- w. Orthoptics (Eye exercise training) except for two sessions as Medically Necessary per lifetime. The first session for training, the second for follow-up.
- x. Any diet control program, treatment, or supply for weight reduction.
- y. Food or food supplements except when provided during a covered outpatient or inpatient Confinement.
- z. Services to the extent a Participant receives or is entitled to receive, any benefits, settlement, award or damages for any reason of, or following any claim under, any Worker's Compensation act, employer's liability insurance plan or similar law or act. Entitled means You are actually insured under Worker's Compensation.
- aa. Services related to an Injury that was self-inflicted for the purpose of receiving Health Plan and/or PBM Benefits.
- ab. Charges directly related to a non-covered service, such as hospitalization charges, except when a complication results from the non-covered service that could not be reasonably expected and the complication requires Medically Necessary treatment that is performed by a Plan Provider or Prior Authorized by the Health Plan. The treatment of the complication must be a covered benefit of the Health Plan and PBM. Non-covered services do not include any treatment or service that was covered and paid for under any plan in our program.

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- ac. Any smoking cessation program, treatment, or supply that is not specifically covered in the Benefits section.
- ad. Any charges for, or in connection with, travel. This includes but is not limited to meals, lodging and transportation. An exception is Emergency ambulance transportation.
- ae. Sexual counseling services related to infertility and sexual transformation.
- af. Services that a child's school is legally obligated to provide, whether or not the school actually provides them and whether or not You choose to use those services.

B. Limitations

1. Copayments or Coinsurance are required for, and/or limitations apply to, the following services: Outpatient Services/Mental Health Services/Alcohol and Drug Abuse, Durable Medical Equipment, Prescription Drugs, Smoking Cessation, Cochlear Implants, treatment of Temporomandibular Disorders and care received in an emergency room.
2. Benefits are limited for the following services: Replacement of Natural Teeth because of accidental Injury, Oral Surgery, Hospital Inpatient, licensed Skilled Nursing Facility, Physical, Speech and Occupational Therapy, Home Care Benefits, Transplants, Hearing Aids, and Orthoptics.
3. Use of Non-Plan Providers and Hospitals requires prior written approval by the Participant's Primary Care Provider and the Health Plan to determine medical appropriateness and whether services can be provided by Plan Providers.
4. Major Disaster or Epidemic: If a major disaster or epidemic occurs, Plan Providers and Hospitals render medical services (and arrange extended care services and home health service) insofar as practical according to their best medical judgment, within the limitation of available facilities and personnel. This extends to the PBM and its Participating Pharmacies. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.
5. Circumstances Beyond the Health Plan's and/or PBM's Control: If, due to circumstances not reasonably within the control of the Health Plan and/or PBM, such as a complete or partial insurrection, labor disputes not within the control of the Health Plan and/or PBM, disability of a significant part of Hospital or medical group personnel or similar causes, the rendition or provision of services and other benefits covered hereunder is delayed or rendered impractical, the Health Plan, Plan Providers and/or PBM will use their best efforts to provide services and other Benefits covered hereunder. In this case, Participants may receive covered services from Non-Plan Providers and/or Non-Participating Pharmacies.
6. Speech and Hearing Screening Examinations: Limited to the routine screening tests performed by a Plan Provider for determining the need for correction.
7. Outpatient Physical, Occupational, Speech and Rehabilitation Therapy: These therapies are benefits only for treatment of those conditions which, in the judgment of the attending physicians, are expected to yield significant patient improvement within two months after the beginning of treatment.

8. Lifetime policy maximum for transplant benefits: \$1,000,000.

Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease.

9. Lifetime maximum benefits under this policy for charges paid by the Health Plan and PBM: \$2,000,000 (includes transplant benefits) per Health Plan.

V. COORDINATION OF BENEFITS AND SERVICES

A. Applicability

1. This Coordination of Benefits ("COB") provision applies to This Plan when a Participant has health care coverage under more than one Plan at the same time. "Plan" and "This Plan" are defined below.
2. If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - a. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
 - b. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Section D below, Effect on the Benefits of This Plan.

B. Definitions

In this section, the following words are defined as follows:

1. "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined by the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

However, notwithstanding the above, when there is a maximum benefit limitation for a specific service or treatment, the secondary plan will also be responsible for paying up to the maximum benefit allowed for its plan. This will not duplicate benefits paid by the primary plan.

2. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.
3. "Plan" means any of the following which provides benefits or services for, or because of, medical, pharmacological or dental care or treatment:
 - a. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - b. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other

arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

4. "Primary Plan"/"Secondary Plan": The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

5. "This Plan" means the part of your group contract that provides benefits for health care and pharmaceutical expenses.

C. Order Of Benefit Determination Rules

1. General

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:

- a. the other Plan has rules coordinating its benefits with those of This Plan; and
- b. both those rules and This Plan's rules described in subparagraph 2 require that This Plan's benefits be determined before those of the other Plan.

2. Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- a. Non-Dependent/Dependent

The benefits of the Plan which covers the person as an employee or Participant are determined before those of the Plan which covers the person as a Dependent of an employee or Participant.

- b. Dependent Child/Parents Not Separated or Divorced

Except as stated in subparagraph 2., c. below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

- 1) the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but
- 2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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However, if the other Plan does not have the rule described in 1. above but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- 1) first, the Plan of the parent with custody of the child;
- 2) then, the Plan of the spouse of the parent with the custody of the child; and
- 3) finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to C., 2., b.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Active/Inactive Employee

The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule d. is ignored.

e. Continuation Coverage

- 1) If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:
 - i) First, the benefits of a plan covering the person as an employee, member, or subscriber or as a dependent of an employee, member, or subscriber.
 - ii) Second, the benefits under the continuation coverage.
- 2) If the other plan does not have the rule described in subparagraph 1), and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

D. Effect On The Benefits Of The Plan

1. When This Section Applies

This Section D. applies when, in accordance with Section C., Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in subparagraph 2. below.

2. Reduction in This Plan's Benefits

The benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

- a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
- b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

E. Right To Receive And Release Needed Information

The Health Plan has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state and federal law. Each person claiming benefits under This Plan must give the Health Plan any facts it needs to pay the claim.

F. Facility Of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, the Health Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under This Plan. The Health Plan will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right Of Recovery

If the amount of the payments made by the Health Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or

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3. other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

VI. MISCELLANEOUS PROVISIONS

A. Right To Obtain and Provide Information

Each Participant agrees that the Health Plan and/or PBM may obtain from the Participant's health care Providers the information (including medical records) that is reasonably necessary, relevant and appropriate for the Health Plan and/or PBM to evaluate in connection with its treatment, payment, or health care operations.

Each Participant agrees that information (including medical records) will, as reasonably necessary, relevant and appropriate, be disclosed as part of treatment, payment, or health care operations, including not only disclosures for such matters within the Health Plan and/or PBM but also disclosures to:

1. Health care Providers as necessary and appropriate for treatment;
2. Appropriate Department of Employee Trust Funds employees as part of conducting quality assessment and improvement activities, or reviewing the Health Plan's/PBM's claims determinations for compliance with contract requirements, or other necessary health care operations;
3. The tribunal, including an independent review organization, and parties to any appeal concerning a claim denial.

B. Physical Examination

The Health Plan, at its own expense, shall have the right and opportunity to examine the person of any Participant when and so often as may be reasonably necessary to determine his/her eligibility for claimed services or benefits under this plan (including, without limitation, issues relating to subrogation and coordination of benefits). By execution of an application for coverage under the Health Plan, each Participant shall be deemed to have waived any legal rights he/she may have to refuse to consent to such examination when performed or conducted for the purposes set forth above.

C. Case Management/Alternate Treatment

The Health Plan may employ a professional staff to provide case management services. As part of this case management, the Health Plan reserves the right to recommend that a Participant consider receiving treatment for an Illness or Injury which differs from the current treatment if it appears that:

- a. the recommended treatment offers at least equal medical therapeutic value; and
- b. the current treatment program may be changed without jeopardizing the Participant's health; and
- c. the charges incurred for services provided under the recommended treatment will probably be less.

If the Participant or his/her authorized representative and the attending physician agree, the recommended treatment will be provided as soon as it is available. If the recommended treatment includes services for which benefits are not otherwise payable (for example, biofeedback,

2008 Miscellaneous Provisions

acupuncture), payment of benefits will be as determined by the Health Plan. The PBM may establish similar case management services.

D. Disenrollment

No person other than a Participant is eligible for health insurance benefits. The Subscriber's rights to group health insurance coverage is forfeited if a Participant assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.

Change to an alternate Health Plan via dual-choice enrollment is available during a regular dual-choice enrollment period, which begins a minimum of 12 months after the disenrollment date.

The Department may at any time request such documentation as it deems necessary to substantiate Subscriber or Dependent eligibility. Failure to provide such documentation upon request shall result in the suspension of benefits.

In situations where a Participant has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate Primary Care Provider, disenrollment efforts may be initiated by the Health Plan or the Board. The Subscriber's disenrollment is effective the first of the month following completion of the Grievance process and approval of the Board. Coverage may be transferred to the Standard Plan only, with options to enroll in alternate Health Plans during subsequent dual-choice enrollment periods. Re-enrollment in the Health Plan is available during a regular dual-choice enrollment period that begins a minimum of 12 months after the disenrollment date.

E. Recovery Of Excess Payments

The Health Plan and/or PBM might pay more than the Health Plan and/or PBM owes under the policy. If so, the Health Plan and/or PBM can recover the excess from You. The Health Plan and/or PBM can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from the Health Plan and/or PBM.

Each Participant agrees to reimburse the Health Plan and/or PBM for all payments made for benefits to which the Participant was not entitled. Reimbursement must be made immediately upon notification to the Subscriber by the Health Plan and/or PBM. At the option of the Health Plan and/or PBM, benefits for future charges may be reduced by the Health Plan and/or PBM as a set-off toward reimbursement.

F. Limit On Assignability Of Benefits

This is Your personal policy. You cannot assign any benefit to other than a physician, Hospital or other Provider entitled to receive a specific benefit for You.

G. Severability

If any part of the policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

H. Subrogation

Each Participant agrees that the insurer under these Uniform Benefits, whether that is a Health Plan or the Public Employee Trust Fund, shall be subrogated to a Participant's rights to damages, to the

extent of the benefits the insurer provides under the policy, for Illness or Injury a third party caused or is liable for. It is only necessary that the Illness or Injury occur through the act of a third party. The insurer's rights of full recovery may be from any source, including but not limited to:

- The third party or any liability or other insurance covering the third party
- The Participant's own uninsured motorist insurance coverage
- Under-insured motorist insurance coverage
- Any medical payments, no-fault or school insurance coverages which are paid or payable.

Participant's rights to damages shall be, and they are hereby, assigned to the insurer to such extent.

The insurer subrogation rights shall not be prejudiced by any Participant. Entering into a settlement or compromise arrangement with a third party without the insurer's prior written consent shall be deemed to prejudice the insurer's rights. Each Participant shall promptly advise the insurer in writing whenever a claim against another party is made on behalf of a Participant and shall further provide to the insurer such additional information as is reasonably requested by the insurer. The Participant agrees to fully cooperate in protecting the insurer's rights against a third party. The insurer has no right to recover from a Participant or insured who has not been "made whole" (as this term has been used in reported Wisconsin court decisions), after taking into consideration the Participant's or insured's comparative negligence. If a dispute arises between the insurer and the Participant over the question of whether or not the Participant has been "made whole", the insurer reserves the right to a judicial determination whether the insured has been "made whole".

In the event the Participant can recover any amounts, for an Injury or Illness for which the insurer provides benefits, by initiating and processing a claim pursuant to a workmen's or worker's compensation act, disability benefit act, or other employee benefit act, the Participant shall either assert and process such claim and immediately turn over to the insurer the net recovery after actual and reasonable attorney fees and expenses, if any, incurred in effecting the recovery, or, authorize the insurer in writing to prosecute such claim on behalf of the and in the name of the Participant, in which case the insurer shall be responsible for all actual attorney's fees and expenses incurred in making or attempting to make recovery. If a Participant fails to comply with the subrogation provisions of this contract, particularly, but without limitation, by releasing the Participant's right to secure reimbursement for or coverage of any amounts under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act, as part of settlement or otherwise, the Participant shall reimburse the insurer for all amounts theretofore or thereafter paid by the insurer which would have otherwise been recoverable under such acts and the insurer shall not be required to provide any future benefits for which recovery could have been made under such acts but for the Participant's failure to meet the obligations of the subrogation provisions of this contract. The Participant shall advise the insurer immediately, in writing, if and when the Participant files or otherwise asserts a claim for benefits under any workmen's or worker's compensation act, disability benefit act, or other employee benefit act.

I. Proof Of Claim

As a Participant, it is Your responsibility to notify Your Provider of Your participation in the Health Plan and PBM.

Failure to notify a Plan Provider of Your membership in the Health Plan may result in claims not being filed on a timely basis. This could result in a delay in the claim being paid.

2008 Miscellaneous Provisions

If You receive services from a Non-Plan Provider outside the Plan Service Area, obtain and submit an itemized bill and submit to the Health Plan, clearly indicating the Health Plan's name and address. If the services were received outside the United States, indicate the appropriate exchange rate at the time the services were received and provide an English language itemized billing to facilitate processing of Your claim.

Claims for services must be submitted as soon as reasonably possible after the services are received. If the Health Plan and/or PBM does not receive the claim within 12 (twelve) months, or if later, as soon as reasonably possible, after the date the service was received, the Health Plan and/or PBM may deny coverage of the claim.

J. Grievance Process

All participating Health Plans and the PBM are required to make a reasonable effort to resolve members' problems and complaints. If You have a complaint regarding the Health Plan's and/or PBM's administration of these benefits (for example, denial of claim or Referral), You should contact the Health Plan and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, You may file a written Grievance with the Health Plan and/or PBM. Contact the Health Plan and/or PBM for specific information on its Grievance procedures.

If You exhaust the Health Plan's and/or PBM's Grievance process and remain dissatisfied with the outcome, You may appeal to the Department by completing an ETF complaint form. You should also submit copies of all pertinent documentation including the written determinations issued by the Health Plan and/or PBM. The Health Plan and/or PBM will advise You of Your right to appeal to the Department.

You may also request an independent review per Wis. Adm. Code § INS 18.11. In this event, You must notify the Health Plan and/or PBM of Your request. In accordance with Wis. Adm. Code § INS 18.11 any determination by an Independent Review Organization is final and binding. You have no further right to administrative review once the Independent Review Organization decision is rendered.

K. Appeals To The Group Insurance Board

After exhausting the Health Plan's or PBM's Grievance process and review by the Department, the Participant may appeal the Department's determination to the Group Insurance Board, unless an Independent Review Organization decision has been rendered. The Group Insurance Board does not have the authority to hear appeals relating to issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of medical necessity or whether a treatment or service is Experimental. These appeals are reviewed only to determine whether the Health Plan breached its contract with the Group Insurance Board.

Health Plan Report Cards

Section E - Health Plan Report Cards



CAHPS[®]

Health Care Quality Information
From the Consumer Perspective

HEDIS[®]

Health Care Quality Information
Based on Health Plan Performance

Health Plan Report Card

2007

- ◆ The health plan you choose can make a difference in the quality of care you get.
- ◆ This health plan report provides useful information on health care quality from a consumer perspective and from actual clinical performance.

Health Plan Report Card Summary..... page E-3

Health Plans included in the Report Cards page E-4

2008 Health Plan Quality Comparison page E-6

Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) page E-8

CAHPS[®] Background and Demographic Profile of Survey Participants..... page E-9

Survey Methodology (CAHPS[®]) page E-11

Interpreting the Results (CAHPS[®])..... page E-11

Historical Trending Summary (CAHPS[®])..... page E-13

Overall Ratings Summary (CAHPS[®])..... page E-14

Health Plan Rating Summary (CAHPS[®])..... page E-15

Details for Selected Health Plan Results (CAHPS[®])..... page E-17

Health Care Rating Summary (CAHPS[®])..... page E-24

Details for Selected Health Care Results (CAHPS[®]) page E-26

Grievance and Complaint Tables page E-31

HEDIS[®] Health Plan Report Card Summary page E-33

HEDIS[®] Results..... page E-35

The Department of Employee Trust Funds (ETF) would like to thank all of the respondents for participating in this year’s successful survey. We look forward to your continued enthusiastic support and cooperation in future member satisfaction surveys.

CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality.
HEDIS[®] is a registered trademark of the National Committee for Quality Assurance.

Health Plan Report Card Summary

CHOOSING A HEALTH PLAN. The health plan report card section provides employees and their families with the results of the annual member satisfaction survey and clinical evidence of health plan performance. Each year in the *It's Your Choice* booklet, selected survey questions and results as well as measures of actual care given to prevent and manage illness are included for members to review.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) section of the report card is a representation of survey respondents' perceptions and opinions of health care services provided by their health plan and primary care provider during the previous year. This information is included to provide a consumer perspective for employees who are considering selecting or changing their health plan. The Healthcare Effectiveness Data and Information Set (HEDIS[®]) section of the report card demonstrates health plan performance from a clinical perspective. Health plan success is measured by determining whether or not members who should be receiving screenings or procedures to prevent or manage illness are receiving the recommended care.

The **2008 Health Plan Quality Comparison** (found on page E-6) provides summary quality scores that evaluate health plans based on the following three areas of care: Wellness and Prevention, Disease Management, and Consumer Satisfaction and Experiences. An overall rating score is presented for health plan performance on a broader spectrum of HEDIS[®] and CAHPS[®] measures, including the three areas of specialization mentioned above.

ETF COMPLAINTS. The charts starting on page E-31 represent the number of complaints, by health plan, received by ETF in 2006. Members are asked to complete their health plan's grievance process before filing a complaint with ETF. **More information on filing a complaint can be found in Section C of the Question & Answer Section (see Question & Answer #5, "What if I have a complaint about my health plan or PBM?").**

QUALITY AND SAFETY INFORMATION

Leapfrog is a nationwide effort to address patient safety in hospitals and focuses on four hospital quality and safety practices:

- Computer Physician Order Entry (CPOE)—medication orders are entered electronically to prevent prescribing errors. *Applies to urban hospitals only.*
- ICU Physician Staffing (IPS)—looks at staffing with doctors who have special training in critical care medicine called "intensivists." *Applies to urban hospitals only.*
- Evidence-Based Hospital Referral (EHR)—information is provided to consumers on which hospitals have the best success rate with certain high-risk surgeries and conditions. *Applies to urban hospitals only.*
- Leapfrog Quality Index-The National Quality Forum's 27 Safe Practices—these cover a range of practices that are designed to reduce the harm in certain processes, systems or environments of care. *Applies to rural and urban hospitals.*

For more information on Leapfrog, visit their website at www.leapfroggroup.org.

Checkpoint is a program sponsored by the Wisconsin Hospital Association that currently provides reliable data on 14 interventions that medical experts agree should be taken to treat heart attacks (6), congestive heart failure (4), and pneumonia (4); 12 surgical infection prevention measures; and 5 error prevention goals. More measures will be added to this program in the future. The 128 hospitals that currently participate in Checkpoint provide care to 99 percent of Wisconsin's patient population. Information is also available on how patients can create a better hospital experience for themselves. For more information, visit the Checkpoint website at www.wicheckpoint.org.

Please see the notable changes on page (ii) for information on how ETF is involved with these quality efforts. Information on Leapfrog and Checkpoint participation and data reporting is displayed in hospital listings of the plan description pages in section G of this booklet.

The Wisconsin Collaborative for Healthcare Quality (WCHQ)

The WCHQ site provides links to a variety of performance measures, comparing information from participating physician groups, hospitals, and health plans. Consumers can view reports comparing the performance of providers on measures such as diabetes management, hypertension management, postpartum care, cancer screenings, access to care, critical care, surgery, health information technology, patient safety, patient satisfaction, appointment wait times and more. Website: www.wchq.org

Other Information on Choosing a Health Plan

Choosing a health plan is a complex and individual decision based on many considerations, such as cost, choice of primary care provider, location of services, hospital and provider network, ease of accessing services, ease of using the managed care system, and consumer satisfaction. In addition to information on quality, the *It's Your Choice* booklet includes supplemental health plan information that may be beneficial in choosing health plan coverage. For example **Section C (Common Questions & Answers)**, includes information on what to consider when choosing a provider, **Section G (Plan Descriptions)** includes a comparison grid in which health plans are compared on features such as mental health referrals, availability of a smoking cessation program and whether or not members have online access to their medical information. The individual health plan description pages found in **Section G** provide information on the health plan's operations, providers available, and referral and prior authorization requirements.

HEALTH PLANS INCLUDED IN THE REPORT CARDS

For the 2008 Health Plan Quality Comparison, all HMO health plans that were available in 2007 were included in the calculation of the composite scores. The results are only published for health plans that are available in 2008.

The CAHPS[®] report card includes health plans that have been available in the ETF program since at least January 2007 and that will be available in 2008. CAHPS[®] data is collected from State employees, including the university and graduate assistants and State retirees. As of January 1, 2007, the CompCareBlue Aurora service area was combined with the CompCareBlue Southeast region and was offered as a single health plan, therefore the survey data collected

among members of the combined health plans is reported for the combined service area, now called Anthem BCBS Southeast.

Note that health plan, health care, and provider ratings could be influenced by the model of care provided. The Standard Plan and WPS Patients Choice are PPO plans and are different from the HMO plans in that they do not require a gatekeeper or referral in order to access health care. As a result, PPO patients could have different experiences than HMO patients, which could influence how they respond to the survey.

The ETF Grievance and Complaints tables on pages E-31 and E-32 report grievance and complaints for all health plans received in 2006. Results are only displayed for health plans available to members in 2008.

The HEDIS[®] report card includes all HMOs that are available to ETF members in 2008, for which there is available data. No HEDIS[®] data is available for the WPS Patient Choice plans, the Standard Plan, and SMP. HEDIS[®] data is collected for an HMO's entire block of business in Wisconsin and is not separated by health plan or employer. For example, data is not collected separately for Humana-Eastern and Humana-Western, but rather is collected for Humana's entire block of business in Wisconsin (including non-ETF members).

For HMO's such as Humana, Anthem BCBS, and UnitedHealthcare, the overall HEDIS[®] results may not be reflective of the care given in each region of the state that the HMO operates. For example, scores tend to be lower in the Southeastern region than they are in the Northeastern region of the state. Thus the scores presented in the HEDIS[®] report card for UnitedHealthcare, may be higher than the true scores achieved in the Southeast region and lower than the true scores achieved in the Northeast region.

2008 Health Plan Quality Comparison

HEALTH PLAN	Overall Quality Score	Wellness and Prevention Score	Disease Management Score	Consumer Satisfaction and Experiences Score
Anthem BCBS Northwest*	★	★	★	★
Anthem BCBS Southeast**	★	★	★	★
Arise Health Plan***	★★	★★	★★	★★
Dean Health Plan	★★	★★	★★	★★
GHC Eau Claire	★★★★	★★	★★★★	★★★★
GHC-SCW	★★★★	★★★★	★★	★★★★
Gundersen Lutheran	★★★★	★★	★★	★★★★
Health Tradition	★★	★	★★	★★
Humana Eastern	★	★★	★	★
Humana Western	★	★★	★	★
Medical Associates	★★★	★★	★★	★★★
MercyCare Health Plan	★★★	★★	★★	★★
Network Health Plan	★★★★	★★★★	★★★★	★★★
Physicians Plus	★★★	★★	★★	★★★
Security Health Plan	★★★	★★	★★	NA
UnitedHealthcare NE	★★	★★	★★	★
UnitedHealthcare SE	★★	★★	★★	★★
Unity Community	★★★	★★	★★	★★★
Unity UW Health	★★★	★★	★★	★★★

*Anthem BCBS NW was formerly known as CompareBlue Northwest.

**Anthem BCBS SE was formerly known as CompareBlue Southeast.

***Arise Health Plan was formerly known as WPS Prevea Health Plan.

★★★★

★★★

★★

★

Score is one standard deviation or more above the mean

Score is above the mean by less than one standard deviation

Score is below the mean by less than one standard deviation

Score is one standard deviation or more below the mean

2008 Quality Comparison Descriptions

Overall Quality Score

The overall score is based on a comprehensive set of HEDIS[®] and CAHPS[®] measures that address many domains of care. All the measures that are included in the three areas of focus described below are included in the overall quality score. In addition, mental health measures for the treatment of depression and follow up after a hospitalization for mental illness were also included in the overall quality score. The performance of each health plan is compared to the average performance of all health plans available in 2006, except for the WPS Patient Choice plans, the Standard Plan, and the State Maintenance Plan (SMP).

If the composite score for a health plan is one standard deviation or more above the mean composite score, then the health plan's performance is noted with four stars. Composite scores that are above the mean by less than one standard deviation are noted with three stars and composite scores that are below the mean by less than one standard deviation are noted with two stars. If the composite score for a health plan is one standard deviation or more below the mean composite score, then the health plan's performance is noted with one star. One standard deviation is on average, how much each score varies from a set of scores. Note that there may be meaningful differences in the performance on individual measures that were not noted as statistically above or below the average score. Detailed results of health plans available to members in 2008 are published in CAHPS[®] (page E-8 through page E-30) and HEDIS[®] (page E33 through page E-44) report cards.

Wellness and Prevention Score

This composite includes HEDIS[®] measures such as Childhood and Adolescent Immunizations, Well Child Visits, Prenatal and Postpartum Care, screenings for breast, cervical and colorectal cancers and Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis. This composite also includes survey questions that ask members about wellness information provided by their doctor and whether or not their doctor asked them about tobacco usage.

Disease Management Score

This composite includes HEDIS[®] measures that address how an HMO treats members with Acute Cardiovascular Conditions, Hypertension, Diabetes, and Asthma.

Consumer Satisfaction and Experiences Score

This composite includes CAHPS[®] scores that measure member satisfaction with their health plan and the health care they receive as well as their experiences with getting needed care, getting care quickly, getting wellness information, health plan customer service and how their claims were processed.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS

(CAHPS®). The CAHPS® survey was developed collaboratively by several leading health care research organizations such as the Agency for Healthcare Policy and Research, Harvard Medical School, RAND, Research Triangle Institute, and Westat. The CAHPS® survey instrument was thoroughly tested for reliability and validity by the CAHPS® development team. CAHPS® is designed to:

- Focus on information that consumers want when choosing a plan and present this information in easy to understand reports;
- Cover specific plan features such as access to specialists, quality of patient-physician interaction, and coordination of care;
- Provide standardized questionnaires for assessing experiences across different populations, health care delivery systems, and geographic areas;
- Improve the utility and value of survey questions and enhance the reliability and the comparability of survey results across different plans and population groups.

THINKING ABOUT QUALITY. One way to measure quality of care is to look at the technical side. For example, if people have surgery, do they get well? Do they recover quickly? The technical side of quality also includes looking at whether the care people receive helps them stay as healthy as possible. For example, do young children get the shots needed to prevent disease? Do people get checkups and other preventative care that catches health problems at an early stage? The technical side of health care quality is very important and is presented in the HEDIS® report card, but it doesn't give you the whole picture.

That is what the survey information in this health plan report card is about. The annual member satisfaction survey covers areas where people enrolled in the health plans are really the experts about how well their plan is working. The survey does not ask about technical issues that can be hard for patients to judge, such as the skill level of a surgeon. Instead, patients are asked about their experiences. Below are the types of questions they are asked:

- Could they get appointments quickly when they needed them?
- Did their doctors explain issues in a way they could understand?
- Did their doctor include them in decision-making when there was more than one choice for treatment or healthcare?
- Could they get the information they needed from the health plan?

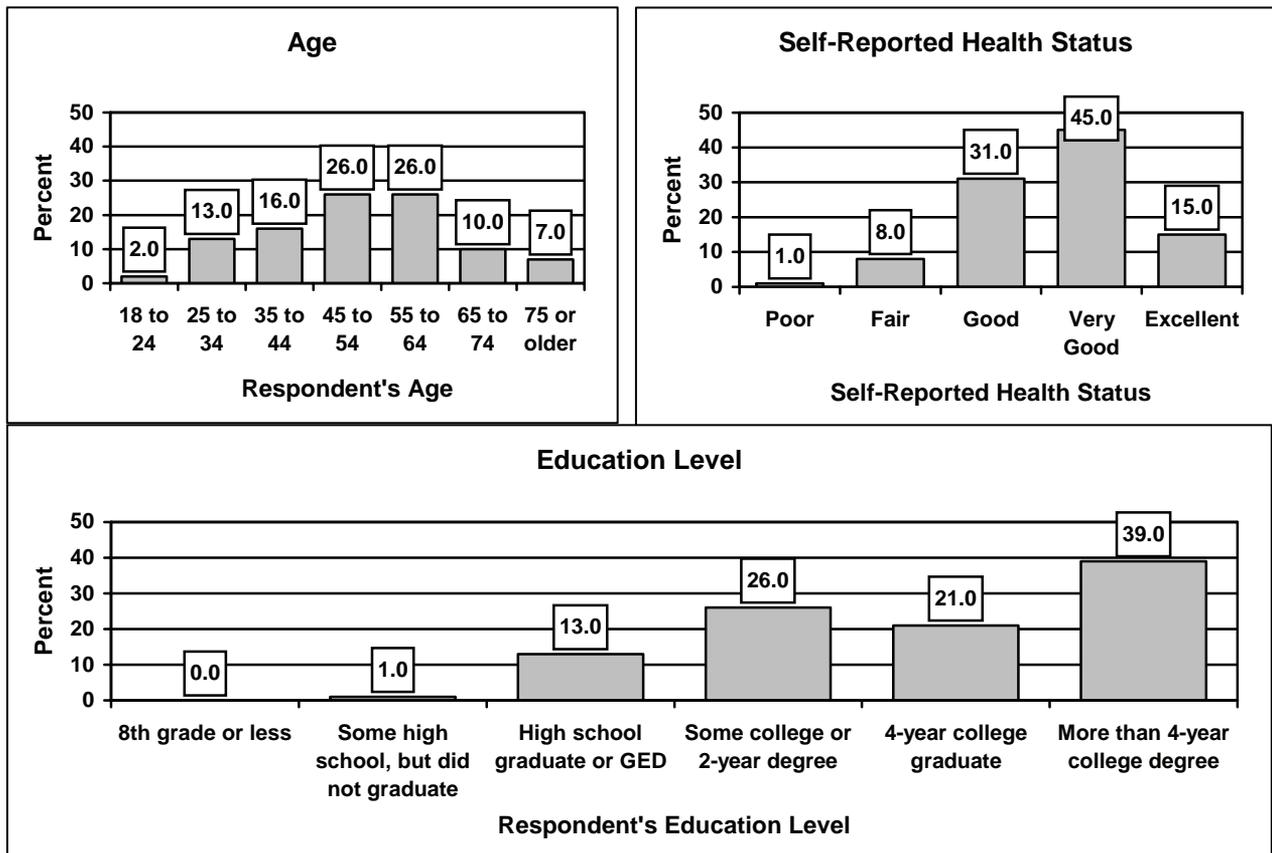
Answers to these and other questions are in this section to help you evaluate your health plan choices. The survey results are the opinions and judgments of the people who were surveyed. Your experience with a health plan could be different from those of the people surveyed. However, it can be helpful to know what other people's experiences have been. The survey results are only meant to help consumers make more informed choices and are not the evaluation or recommendations of ETF.

Background on the Survey and Demographic Profile of Study Participants

2007 ETF PARTICIPANT SURVEY. The health plan report card section includes results of a random sample of active health plan members from 21 health plans.¹ The survey was conducted from February to June of 2007, and a total of 6,201 members responded to the survey either via the Internet or mail. Health plan members were asked to answer the survey questions based on their experiences with their health plan during the previous 12 months.

WHO ADMINISTERED THE SURVEY. The survey was administered by Morpace Market Research & Consulting, an outside, independent firm located in Michigan. The Department of Employee Trust Funds (ETF) coordinated the study.

DEMOGRAPHIC PROFILE. When taking the combined response over all of the health plans, approximately 45 percent who completed the survey are male. Additional demographic information is shown in the following bar charts for all survey participants. Length of time with health plan is also available for each health plan on page E-10.



For more detailed demographic information by health plan, please visit the ETF website at: http://etf.wi.gov/members/health_ins.htm and view the supplemental report card.

¹ Respondents were randomly sampled with the intention to provide a precision level of $\pm 5\%$ at a 95% confidence interval for each participating health plan. This level of precision was largely achieved.

Length of Time in Health Plan

This chart shows:

- The percentage of people who responded “less than 1 year”, “at least 1 year but less than 2 years”, “at least 2 years but less than 5 years”, or “5 or more years” to the question, “How many years in a row have you been in this health plan?”

Due to rounding, total percentages may not add up to exactly 100 percent.

Health Plan Name	Less than 1 year	At least 1 year but less than 2 years	At least 2 years but less than 5 years	5 or more years
Average—All Health Plans	7%	15%	29%	49%
Anthem BCBS Northwest	11%	33%	39%	16%
Anthem BCBS Southeast	6%	15%	47%	33%
Arise Health Plan	3%	8%	30%	59%
Dean Health Plan	3%	6%	14%	78%
GHC Eau Claire	7%	44%	32%	17%
GHC-SCW	10%	8%	25%	57%
Gundersen Lutheran	5%	3%	12%	80%
Health Tradition	9%	10%	38%	43%
Humana Eastern	7%	19%	40%	34%
Humana Western	2%	12%	46%	40%
Medical Associates	3%	4%	15%	77%
MercyCare Health Plan	5%	6%	27%	62%
Network Health Plan	5%	7%	22%	66%
Physicians Plus	3%	6%	15%	76%
Standard Plan	4%	11%	20%	65%
State Maintenance Plan	11%	51%	33%	5%
UnitedHealthcare NE	4%	13%	52%	31%
UnitedHealthcare SE	25%	46%	27%	2%
Unity Community	12%	21%	28%	39%
Unity UW Health	6%	11%	32%	51%
WPS Patient Choice	28%	55%	17%	0%

HOW THE SURVEY WAS DONE. From February to June of 2007, state employees and retirees that had been with their current health plan for a year or more were randomly selected to participate in the study. Selected sample members for whom email addresses were available, were emailed an invitation to participate in the survey. The email invitation included information about the survey along with a link that, when clicked on, took survey participant directly to the questionnaire. Members who did not have an email address were sent an invitation in the U.S. Postal mail. The invitation encouraged their participation via the Internet and included the website, User I.D., and Password. State employees and retirees, who did not respond to the initial invitation to participate via the Internet, were sent a mail questionnaire. State employees and retirees who were selected to participate in the study were given the option of having another adult family member on their policy complete the questionnaire if that person was the more appropriate person to answer questions about experiences with the health plan.

Percentage of completed questionnaires by methodology:

	Number of Completed Questionnaires by Internet		Number of Completed Questionnaires by Mail		Total Number of Completed Questionnaires Across Both Modes	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
All Health Plans	4253	69%	1948	31%	6201	100%
Anthem BCBS Northwest	102	50%	104	50%	206	100%
Anthem BCBS Southeast	264	77%	78	23%	342	100%
Arise Health Plan	171	60%	116	40%	287	100%
Dean Health Plan	289	75%	99	25%	388	100%
GHC Eau Claire	245	67%	123	33%	368	100%
GHC-SCW	312	85%	54	15%	366	100%
Gundersen Lutheran	212	66%	111	34%	323	100%
Health Tradition	237	78%	69	22%	306	100%
Humana Eastern	299	85%	54	15%	353	100%
Humana Western	196	60%	132	40%	328	100%
Medical Associates	119	59%	84	41%	203	100%
MercyCare Health Plan	193	77%	57	23%	250	100%
Network Health Plan	249	70%	108	30%	357	100%
Physicians Plus	257	68%	121	32%	378	100%
Standard Plan	131	32%	281	68%	412	100%
State Maintenance Plan	93	72%	37	28%	130	100%
UnitedHealthcare NE	250	70%	109	30%	359	100%
UnitedHealthcare SE	89	70%	39	30%	128	100%
Unity Community	158	73%	58	27%	216	100%
Unity UW Health	293	77%	87	23%	380	100%
WPS Patient Choice	94	78%	27	22%	121	100%

INTERPRETING SURVEY RESULTS

STATISTICAL TESTS. The results presented in this survey are obtained from a sample of state employees and retirees. Since we only have the opinions of a portion of the target population represented in the survey, the estimates obtained from this study have a sampling margin of error that needs to be considered.

Due to this sampling margin of error, statistical tests are used to distinguish if the differences observed between scores are “real”, or only happen by chance.

Throughout this report you will notice references to “statistically significant differences” or “statistical testing.” “Statistically significant difference” means that given the sample characteristics, there is enough statistical evidence to support the conclusion that the two scores or percentages being compared are different.

All health plan and historical rating comparisons in this report use the $p \leq 0.05$ significance level for testing of a difference. This means that—given the assumptions and conditions of the statistical test—there is one chance in 20 that a noted difference came about just by chance. In other words, the noted difference is a “real” difference not caused by a chance occurrence.

HOW THE STARS (★) SHOW HEALTH PLAN COMPARISONS. The stars on pages E-14 through E-16, E-24, and E-25 show the results of statistical tests between each plan's score and the overall score for all health plans. These tests tell which plans are rated **significantly** higher or lower than average.

- For the "0 to 10" scale (0 meaning "worst possible" and 10 meaning "best possible"), scores are averages.
- For the questions that asked "how often", scores are averages on a scale from 1 to 4 (1 meaning "never" and 4 meaning "always").
- For the questions that asked, “did a doctor or other health provider”, scores are averages on a scale from 1 to 4 (1 meaning “definitely no”, 2 meaning “somewhat no”, 3 meaning “somewhat yes”, and 4 meaning “definitely yes”).
- All plan comparisons in this report use the $p < 0.05$ significance level for testing of a difference.

There were some differences from one health plan to another in the health, age, and educational level of survey respondents, and overall satisfaction levels with health plan, health care, doctors and specialists tend to be influenced in ways such as:

- Older members tend to give higher ratings.
- More educated members tend to give lower ratings.
- Members who have been with a health plan longer tend to give a higher rating.
- Members who report better health status tend to give higher ratings.

Since people's health, age, and educational background may influence the way they answer survey questions, minor statistical adjustments were made to average scores so that health plan comparisons could be made.

HOW THE BARS WORK. When you compare health plan results shown in the bar graphs, you should ignore small differences in percentages because survey results have a "margin of error." Differences between health plans may result from chance alone rather than any real difference among health plans. It is important to note that these results were not adjusted for demographic factors (e.g., health status, age, and education level), as were the health plan comparisons depicted by the stars.

Historical Rating Summary

The questions for overall ratings used a scale from 0 to 10, where 0 means “worst possible” and 10 means “best possible.” The average scores are presented in the chart below.

The historical rating summary compares the average scores from 2007 to the average scores from 2006. A two-tailed t-test was used to determine statistical differences between the two years at 95% confidence level.

↑/↓ indicates 2007 scores are significantly higher/lower than 2006 scores.

Health Plan	How people rated their HEALTH PLAN		How people rated their HEALTH CARE		How people rated their PRIMARY DOCTORS		How people rated their SPECIALISTS	
	2006	2007	2006	2007	2006	2007	2006	2007
Average—All Health Plans	8.06	8.03	8.47	8.30↓	8.36	8.64↑	8.34	8.42↑
Anthem BCBS Northwest*	NA	7.35	NA	8.26	NA	8.70	NA	8.44
Anthem BCBS Southeast**	7.58	7.49	8.33	7.83↓	8.20	8.30	8.27	8.09
Arise Health Plan***	8.27	8.07	8.65	8.43↓	8.42	8.61	8.40	8.56
Dean Health Plan	8.34	8.21	8.50	8.21↓	8.39	8.69↑	8.37	8.35
GHC Eau Claire	8.51	8.43	8.60	8.52	8.55	8.85↑	8.27	8.57
GHC-SCW	8.22	8.28	8.30	8.29	8.16	8.33	8.18	8.12
Gundersen Lutheran	8.48	8.51	8.77	8.55↓	8.69	8.93↑	8.62	8.45
Health Tradition	8.35	8.26	8.51	8.41	8.52	8.71	8.22	8.13
Humana Eastern	7.64	7.60	8.32	8.08↓	8.25	8.49	8.18	8.51↑
Humana Western	7.76	7.59	8.61	8.51	8.58	8.80↑	8.52	8.78
Medical Associates	8.60	8.45	8.77	8.58	8.72	9.05↑	8.59	8.48
MercyCare Health Plan	7.85	7.89	8.24	8.09	8.26	8.47	8.01	8.26
Network Health Plan	8.32	8.30	8.39	8.20	8.13	8.42↑	8.37	8.45
Physicians Plus	8.44	8.32	8.54	8.33	8.34	8.57	8.55	8.43
Standard Plan	8.45	8.39	8.76	8.56↓	8.59	8.90↑	8.63	8.85
State Maintenance Plan	6.98	6.98	8.07	7.94	8.14	8.63↑	8.00	8.23
UnitedHealthcare NE	7.46	7.69	8.39	8.23	8.25	8.62↑	8.33	8.20
UnitedHealthcare SE	NA	7.78	NA	8.31	NA	8.79	NA	8.30
Unity Community	7.97	8.24	8.31	8.34	8.22	8.68↑	7.82	8.45↑
Unity UW Health	8.37	8.19	8.58	8.31↓	8.34	8.47	8.45	8.40
WPS Patient Choice	NA	7.23	NA	8.07	NA	8.69	NA	8.08

NA denotes historical trending not available due to addition of health plan beginning January 1, 2007.

*Anthem BCBS NW was formerly known as CompCareBlue Northwest.

**Anthem BCBS SE was formerly known as CompCareBlue Southeast.

***Arise Health Plan was formerly known as WPS Prevea Health Plan.

Overall Ratings by People Who Were Surveyed

★★★ Score for health plan on the scale from 0-10 is **better than the average** score for all health plans.
 ★★ Score for health plan on the scale from 0-10 is **average** (neither higher nor lower than the average score for all health plans.)
 ★ Score for health plan on the scale from 0-10 is **below the average** score for all health plans.

- This chart shows results for individual survey questions that asked people to give their overall ratings of their health plan, health care, primary doctors and specialists.
- The questions for overall ratings used a scale from 0 to 10, where 0 means “worst possible” and 10 means “best possible.” The average scores are presented in the chart below.
- See page E-12 for more about the survey and how to interpret the survey results and for details about stars.

Overall Ratings And Ratings By People Who Have Had 3 Or More Medical Visits In The Last 12 Months

Health Plan	How people rated their HEALTH PLAN		How people rated their HEALTH CARE		How people rated their PRIMARY DOCTORS		How people rated their SPECIALISTS	
	Overall	3 or more visits	Overall	3 or more visits	Overall	3 or more visits	Overall	3 or more visits
Average—All Health Plans	8.03	8.10	8.30	8.31	8.64	8.68	8.42	8.45
Anthem BCBS Northwest	★	★	★★	★★	★★	★★	★★	★★
Anthem BCBS Southeast	★	★	★	★★	★	★	★★	★★
Arise Health Plan	★★	★★	★★	★★	★★	★★	★★	★★
Dean Health Plan	★★	★★	★★	★★	★★	★★	★★	★★
GHC Eau Claire	★★★	★★★	★★★	★★★	★★★	★★★	★★★	★★★
GHC-SCW	★★★	★★★	★★	★★	★★	★★	★★	★★
Gundersen Lutheran Health Tradition	★★★	★★★	★★★	★★★	★★★	★★★	★★★	★★★
Humana Eastern	★	★	★★	★★	★★	★★	★★★	★★★
Humana Western	★	★★	★★★	★★★	★★	★★	★★★	★★★
Medical Associates	★★★	★★	★★★	★★	★★★	★★★	★★	★★
MercyCare Health Plan	★★	★★	★★	★★	★★	★★	★★	★★
Network Health Plan	★★★	★★★	★★	★★	★	★	★★	★★
Physicians Plus	★★★	★★★	★★	★★	★★	★★	★★	★★
Standard Plan	★★	★★	★★	★★	★★	★★	★★	★★
State Maintenance Plan	★	★	★★	★★	★★	★★	★★	★★
UnitedHealthcare NE	★	★	★★	★★	★★	★★	★★	★★
UnitedHealthcare SE	★★	★★	★★	★★	★★	★★	★★	★★
Unity Community	★★★	★★★	★★	★★	★★	★★	★★	★★
Unity UW Health	★★★	★★★	★★	★★	★★	★★	★★	★★
WPS Patient Choice	★	★	★★	★★	★★	★★	★★	★★

Health Plan Summary

★★★ Score for health plan on the scale from 0-10 is **better than the average** score for all health plans.

★★ Score for health plan on the scale from 0-10 is **average** (neither higher nor lower than the average score for all health plans.)

★ Score for health plan on the scale from 0-10 is **below the average** score for all health plans.

- Rating of Health Plan
- Recommend Health Plan to Family and Friends

Health Plan	Overall Health Plan Rating			% Definitely/Probably would recommend health plan to family and friends
	Total Sample ¹	Among those with 3 or more medical visits in last 12 months ¹	% Who rated health plan 7 or above	
Average—All Health Plans	8.03	8.10	85	92
Anthem BCBS Northwest*	★	★	76	78
Anthem BCBS Southeast**	★	★	77	88
Arise Health Plan***	★★	★★	84	92
Dean Health Plan	★★	★★	86	93
GHC Eau Claire	★★★	★★★	93	98
GHC-SCW	★★★	★★★	88	95
Gundersen Lutheran	★★★	★★★	91	97
Health Tradition	★★★	★★★	89	96
Humana Eastern	★	★	79	90
Humana Western	★	★★	77	88
Medical Associates	★★★	★★	91	95
MercyCare Health Plan	★★	★★	82	87
Network Health Plan	★★★	★★★	89	95
Physicians Plus	★★★	★★★	90	96
Standard Plan	★★	★★	89	91
State Maintenance Plan	★	★	66	74
UnitedHealthcare NE	★	★	81	90
UnitedHealthcare SE	★★	★★	83	93
Unity Community	★★★	★★	88	94
Unity UW Health	★★★	★★★	89	96
WPS Patient Choice	★	★	69	82

¹Rating repeated from page E-14 for convenience of side-by-side comparison.

*Anthem BCBS NW was formerly known as CompCareBlue Northwest.

**Anthem BCBS SE was formerly known as CompCareBlue Southeast.

***Arise Health Plan was formerly known as WPS Prevea Health Plan.

Customer Service and Claims Processing Summary

★★★ Score for health plan on the scale from 0-10 is **better than the average** score for all health plans.

★★ Score for health plan on the scale from 0-10 is **average** (neither higher nor lower than the average score for all health plans.)

★ Score for health plan on the scale from 0-10 is **below the average** score for all health plans.

- **Customer Service Composite:**
 - Finding or understanding information in written materials or Internet
 - Getting information or help from customer service
 - Courteous and respectful customer service staff
 - Ease of filling out forms for health plan
- **Claims Processing Composite:**
 - Handling claims in a timely manner
 - Handling claims correctly

Customer Service and Claims Processing Summary		
Health Plan	Customer Service	Claims Processing
Anthem BCBS Northwest*	★	★
Anthem BCBS Southeast**	★★	★
Arise Health Plan***	★★	★★
Dean Health Plan	★★	★★
GHC Eau Claire	★★★	★★★
GHC-SCW	★★★	★★★
Gundersen Lutheran	★★	★★★
Health Tradition	★★	★★★
Humana Eastern	★	★
Humana Western	★	★
Medical Associates	★★	★★
MercyCare Health Plan	★	★★
Network Health Plan	★★★	★★★
Physicians Plus	★★	★★
Standard Plan	★★	★★
State Maintenance Plan	★	★
UnitedHealthcare NE	★	★
UnitedHealthcare SE	★★	★
Unity Community	★★★	★★★
Unity UW Health	★★★	★★★
WPS Patient Choice	★★	★

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**Anthem BCBS SE was formerly known as CompcareBlue Southeast.

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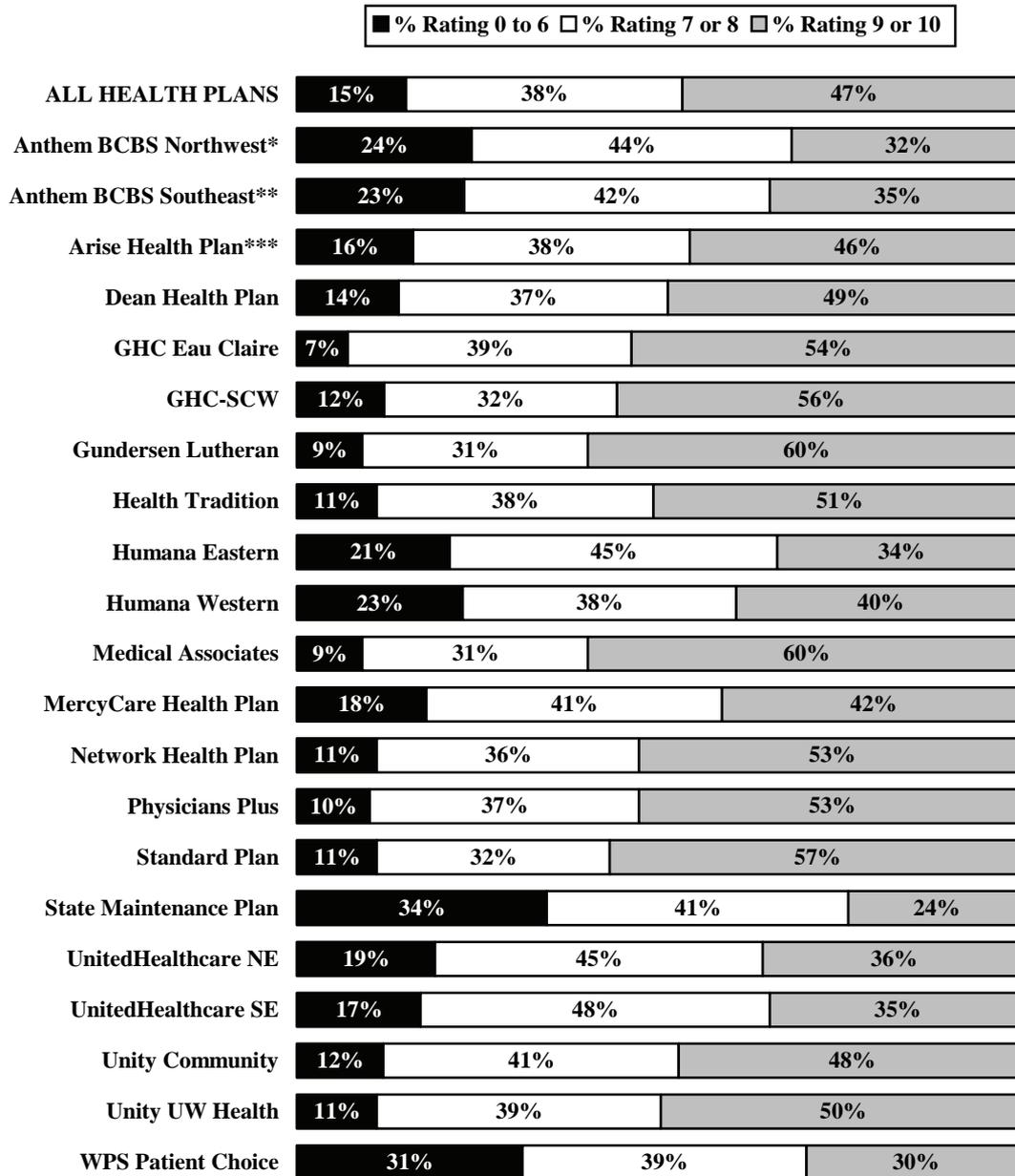
Overall Health Plan Ratings Detail

How people rated their HEALTH PLAN

This graph shows:

- The percentage of people who rated their health plan from "0 to 6," "7 to 8," or "9 to 10."
- Everyone who was surveyed was asked to rate their health plan on a scale from 0 to 10 with 0 meaning "worst possible" and 10 meaning "best possible."

Due to rounding, the bars may not add up to exactly 100 percent.



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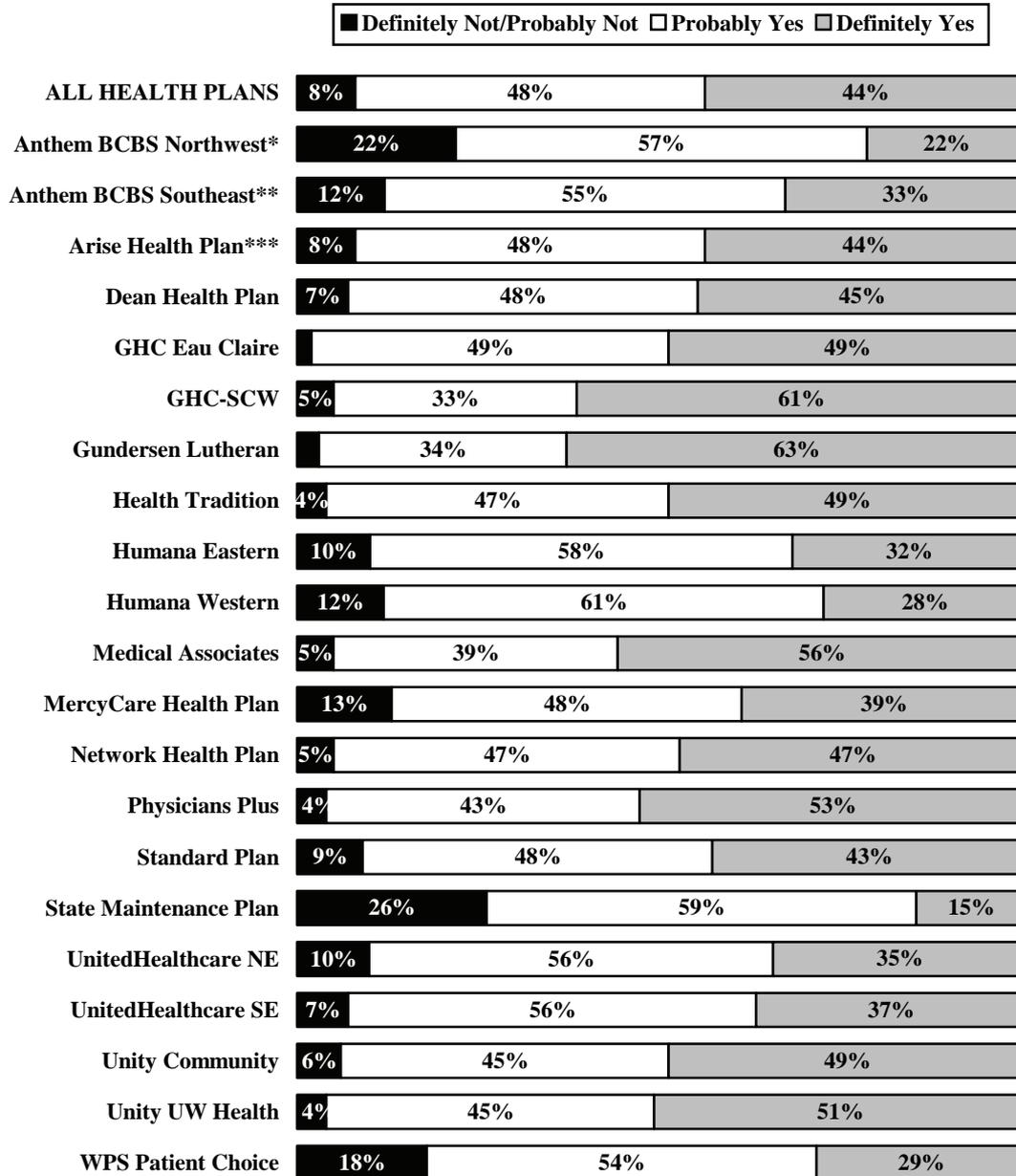
Health Plan Recommendation Detail

Would you recommend your
HEALTH PLAN to your
family and friends?

This graph shows:

- The percentage of people who said "**definitely not**" / "**probably not**," "**probably yes**," or "**definitely yes**" to the question, "Would you recommend your health plan to your family or friends?"

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



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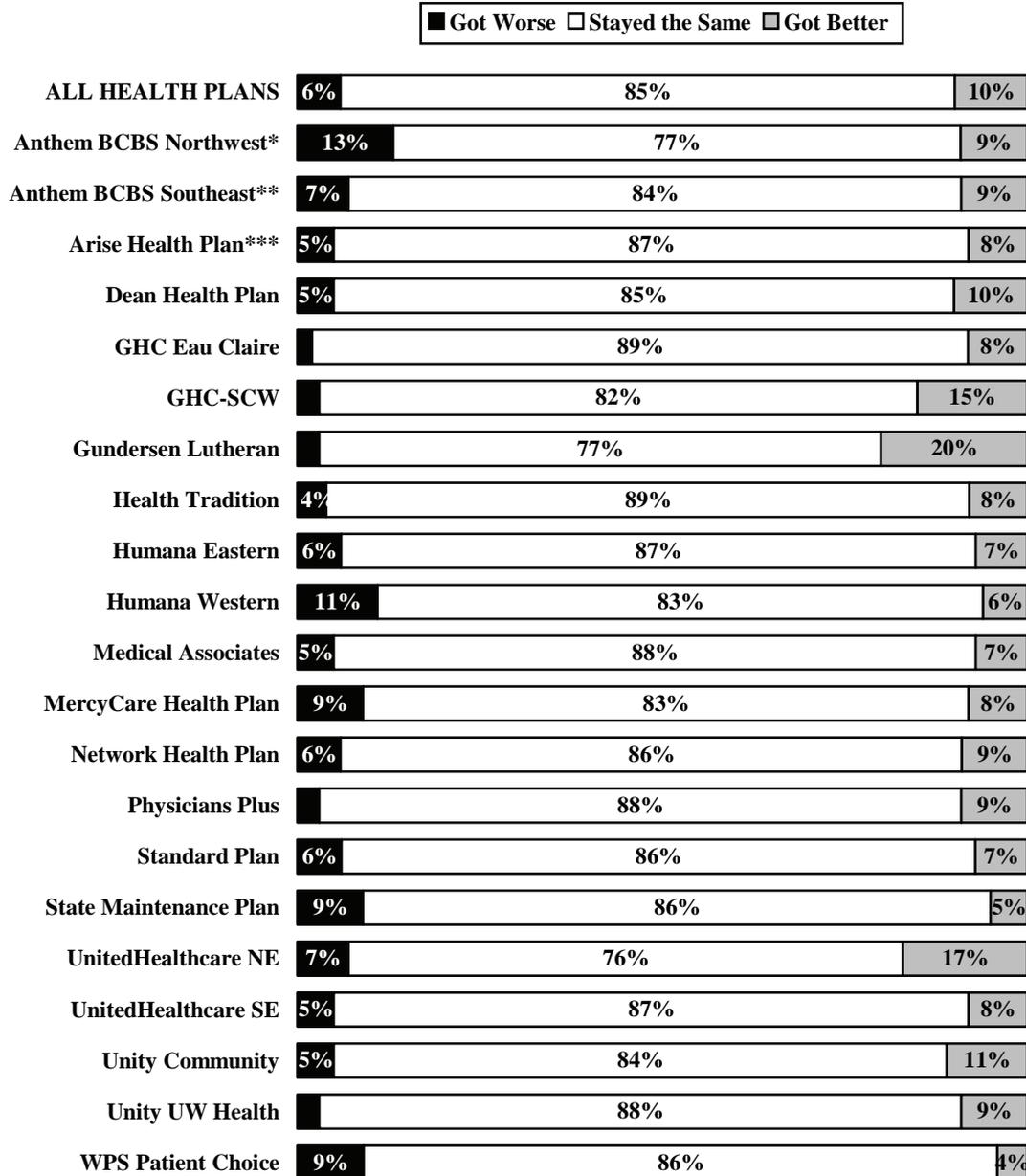
Health Plan Performance Detail

Over the past 12 months, did your plan's overall performance get better, stay the same, or get worse?

This graph shows:

- The percentage of people who said it is "got worse," "stayed the same," or "got better" to the question, "Over the past 12 months, did your health plan's overall performance get better, stay the same, or get worse?"

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



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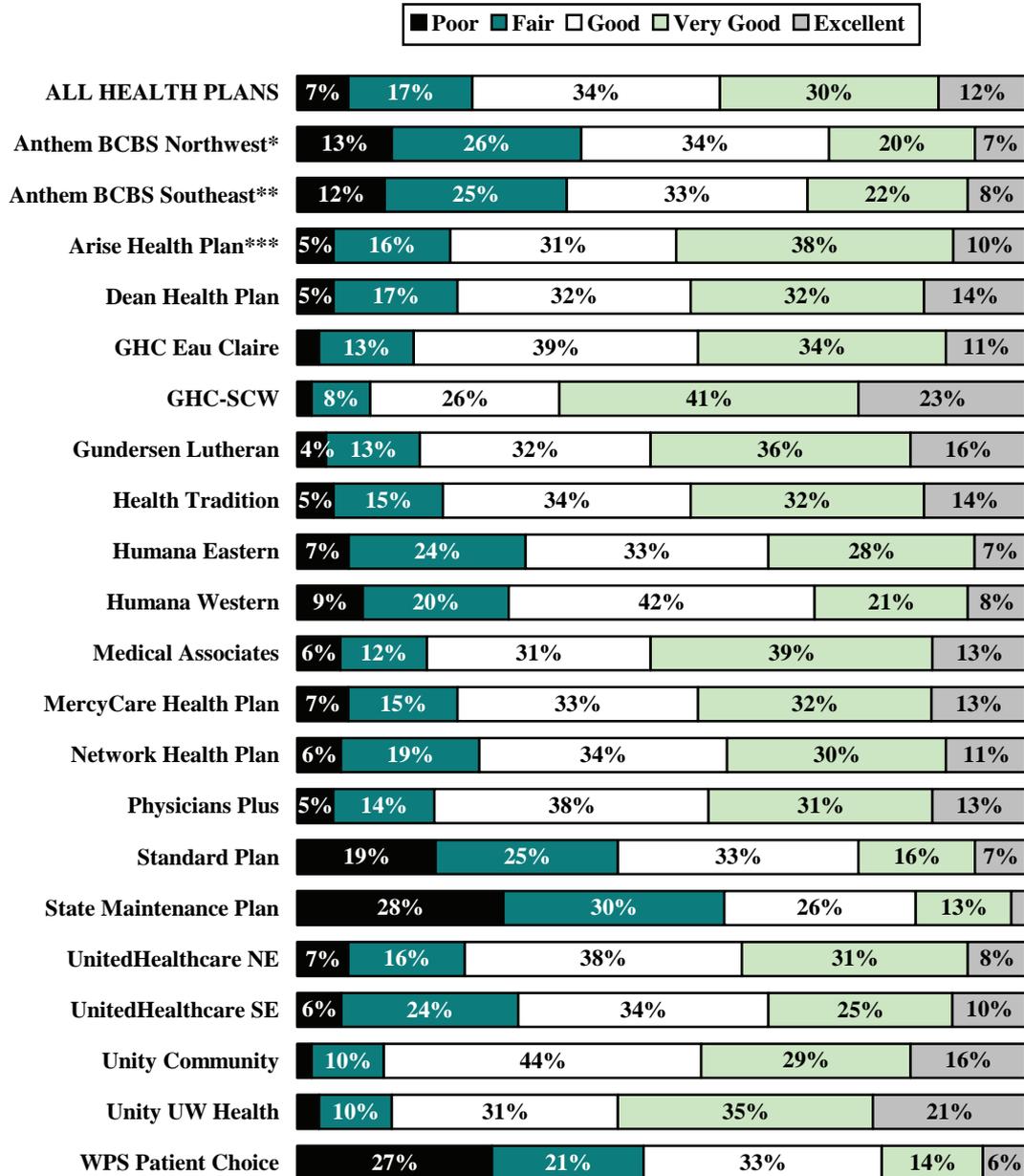
Health and Wellness Education Detail

Health Plan efforts to provide educational materials on health and wellness issues

This graph shows:

- The percentage of people who responded "excellent," "very good," "good," "fair," or "poor" to the question, "How would you rate your health plan's effort to provide you or your family with educational information on health and wellness issues such as smoking cessation, weight loss, and mammograms, etc.?"

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



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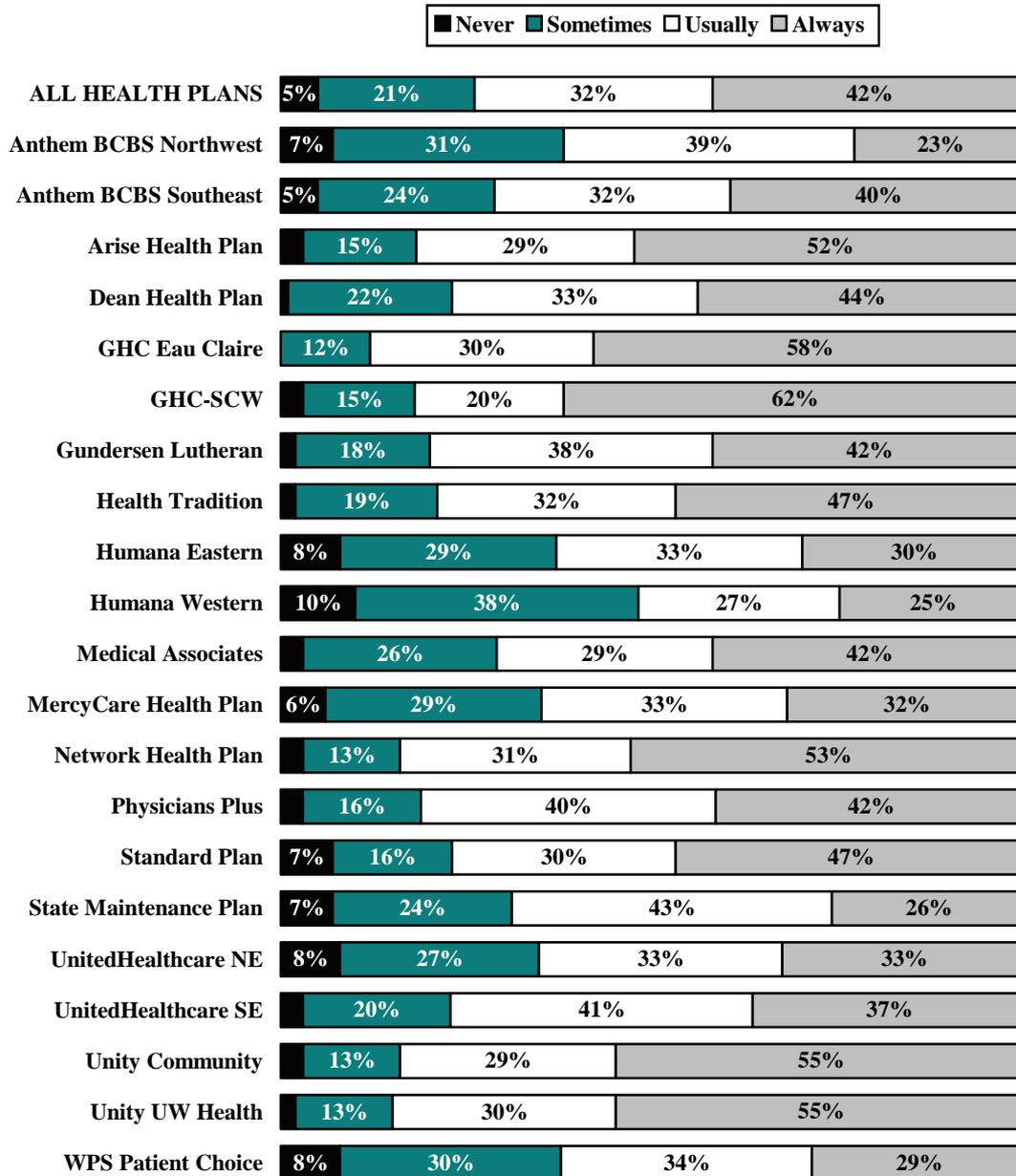
Customer Service Detail

How often did your health plan's customer service give you information or help you needed?

This graph shows:

- The percentage of people who said "always," "usually," "sometimes," or "never" to the question, "In the last 12 months, how often did your health plan's customer service give you information or help you needed?"
- This question was answered by those who responded "yes" to the question asking if the person tried to get information or help from the health plan's customer service. The percent of those who answered "yes" to this preliminary question ranges from 31 to 66 percent by health plan.

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



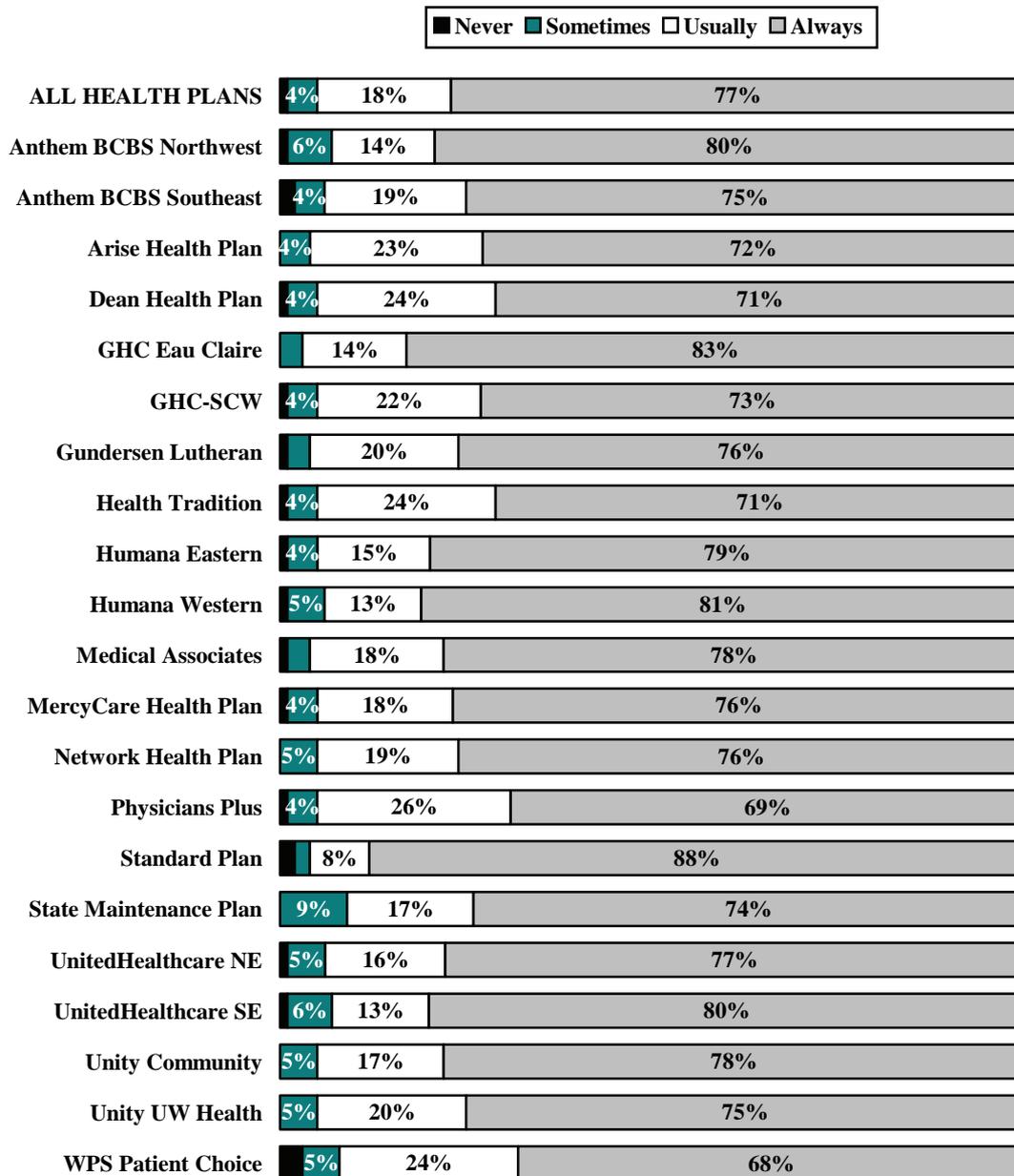
Customer Service Detail

How often were the FORMS from your health plan easy to fill out?

This graph shows:

- The percentage of people who said "always," "usually," "sometimes," or "never" to the question, "In the last 12 months, how often were the forms from your health plan easy to fill out?"
- This question was answered by those who responded "yes" to the question asking if the person had filled out any forms for the health plan. The percent that answered "yes" to this preliminary question ranges from 18 to 54 percent by health plan.

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



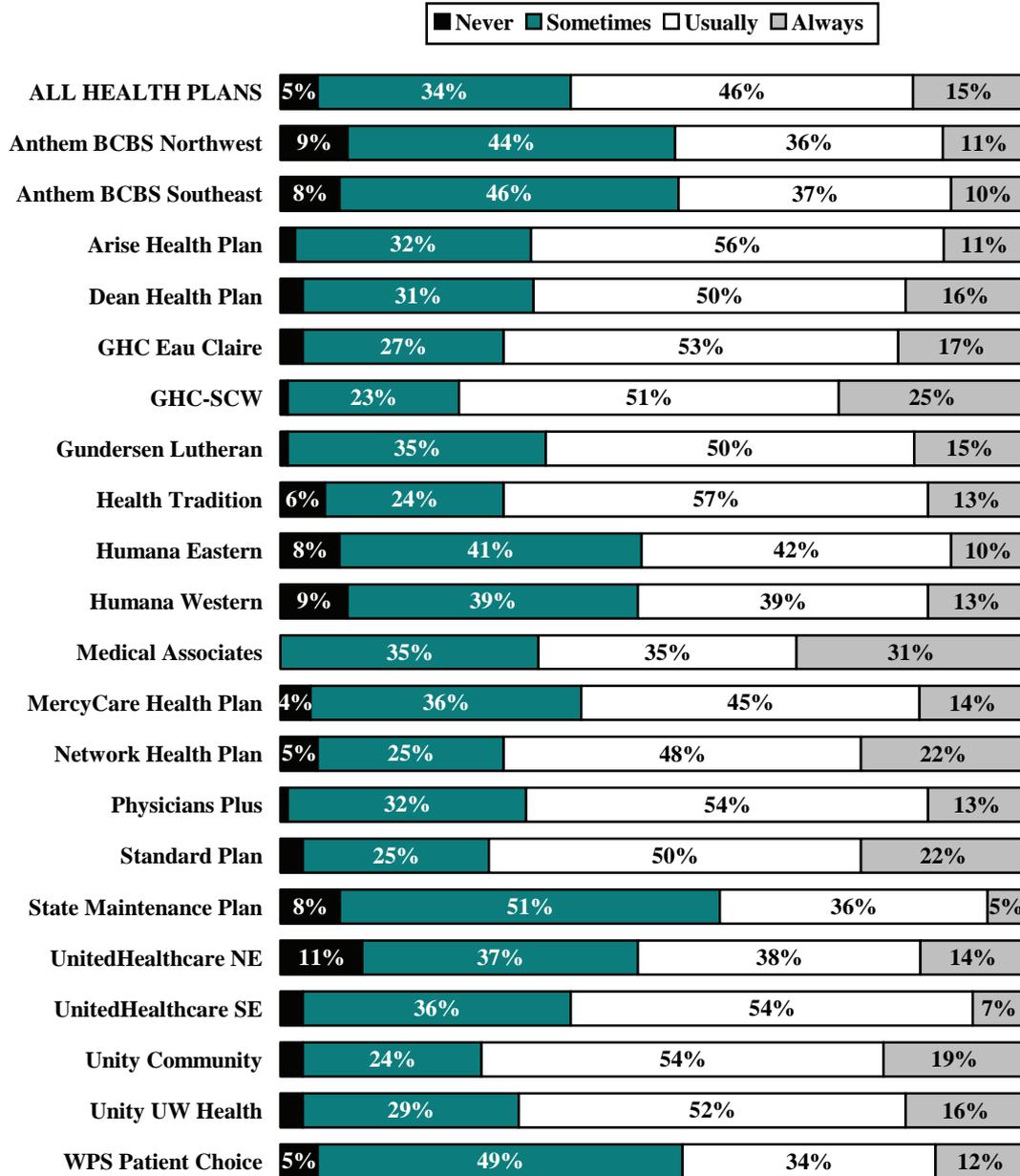
Customer Service Detail

How often did the written materials or the Internet provide the information you needed about how your health plan works?

This graph shows:

- The percentage of people who said **"always," "usually," "sometimes,"** or **"never"** to the question, "In the last 12 months, how often did the written material or the Internet provide the information you needed about how your health plan works?"
- This question was answered by those who responded "yes" to the question asking if the person looked for any information about how the health plan works. The percent of those who answered "Yes" to this preliminary question ranges from 27 to 69 percent by health plan.

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



Health Care Summary

- ★★★ Score for health plan is **better than the average** score for all health plans.
- ★★ Score for health plan is **average** (neither higher nor lower than the average score for health all plans.)
- ★ Score for health plan is **below the average** score for all health plans.

- Rating of Health Care
- Rating of Physician (star ratings are shown on page E-14)
- Rating of Specialist (star ratings are shown on page E-14)

Health Plan	Overall Health Care Rating				
	Total Sample ¹	Among those with 3 or more medical visits in last 12 months ¹	% of Total Sample Rating Health Care 7 or above	% of Total Sample Rating Primary Doctor 7 or above	% of Total Sample Rating Specialists 7 or above
Average—All Health Plans	8.30	8.31	90	91	89
Anthem BCBS Northwest*	★★	★★	90	94	90
Anthem BCBS Southeast**	★	★★	81	86	85
Arise Health Plan***	★★	★★	92	91	92
Dean Health Plan	★★	★★	91	92	87
GHC Eau Claire	★★★	★★★	93	93	90
GHC-SCW	★★	★★	90	87	85
Gundersen Lutheran	★★★	★★	93	94	91
Health Tradition	★★	★★	93	93	82
Humana Eastern	★★	★★	86	89	92
Humana Western	★★★	★★★	95	94	93
Medical Associates	★★★	★★	94	98	88
MercyCare Health Plan	★★	★★	86	89	86
Network Health Plan	★★	★★	87	90	88
Physicians Plus	★★	★★	91	89	88
Standard Plan	★★	★★	94	95	93
State Maintenance Plan	★★	★★	87	93	89
UnitedHealthcare NE	★★	★★	89	91	88
UnitedHealthcare SE	★★	★★	90	91	86
Unity Community	★★	★★	89	91	91
Unity UW Health	★★	★★	90	88	89
WPS Patient Choice	★★	★★	86	93	86

¹Rating repeated from page E-14 for convenience of side-by-side comparison.

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***Arise Health Plan was formerly known as WPS Prevea Health Plan.

Health Care Service Summary

★★★ Score for health plan is **better than the average** score for all health plans.

★★ Score for health plan is **average** (neither higher nor lower than the average score for health all plans.)

★ Score for health plan is **below the average** score for all health plans.

- **Getting Needed Care Composite:**
 - Getting the care, test, or treatment you needed through your health plan
 - Ease of getting appointments with specialists
- **Getting Care Quickly Composite:**
 - Getting care as soon as you needed
 - Getting an appointment as soon as you needed
- **How Well Doctors Communicate Composite:**
 - Listening carefully to you
 - Explaining things in a way you could understand
- **Shared Decision Making Composite:**
 - Showing respect for what you have to say
 - Spending enough time with you
 - Doctor discussing the pros and cons for each choice of treatment or health care with you
 - Doctor asking you which choice was best for you

Health Plan	Getting the care you need, when you need it		Doctors	
	Getting needed care	Getting care quickly	How well doctors communicate	Shared Decision Making
Anthem BCBS Northwest*	★★	★	★★	★★
Anthem BCBS Southeast**	★★	★★	★★	★★
Arise Health Plan***	★★	★★	★★	★★
Dean Health Plan	★	★★	★★	★★
GHC Eau Claire	★★	★★	★★★	★★
GHC-SCW	★★	★★	★★	★★
Gundersen Lutheran	★★	★★	★★	★★
Health Tradition	★★	★★★	★★	★★
Humana Eastern	★★	★★	★★	★★
Humana Western	★★	★★★	★★	★★
Medical Associates	★★★	★★	★★★	★
MercyCare Health Plan	★★	★★	★★	★★
Network Health Plan	★★	★★	★★	★★
Physicians Plus	★★	★	★★	★★
Standard Plan	★★	★★	★	★★
State Maintenance Plan	★	★★	★★	★★
UnitedHealthcare NE	★★	★★	★★	★★
UnitedHealthcare SE	★★	★★	★★	★★
Unity Community	★★	★★	★★	★★
Unity UW Health	★	★	★★	★★
WPS Patient Choice	★★	★★	★★	★★

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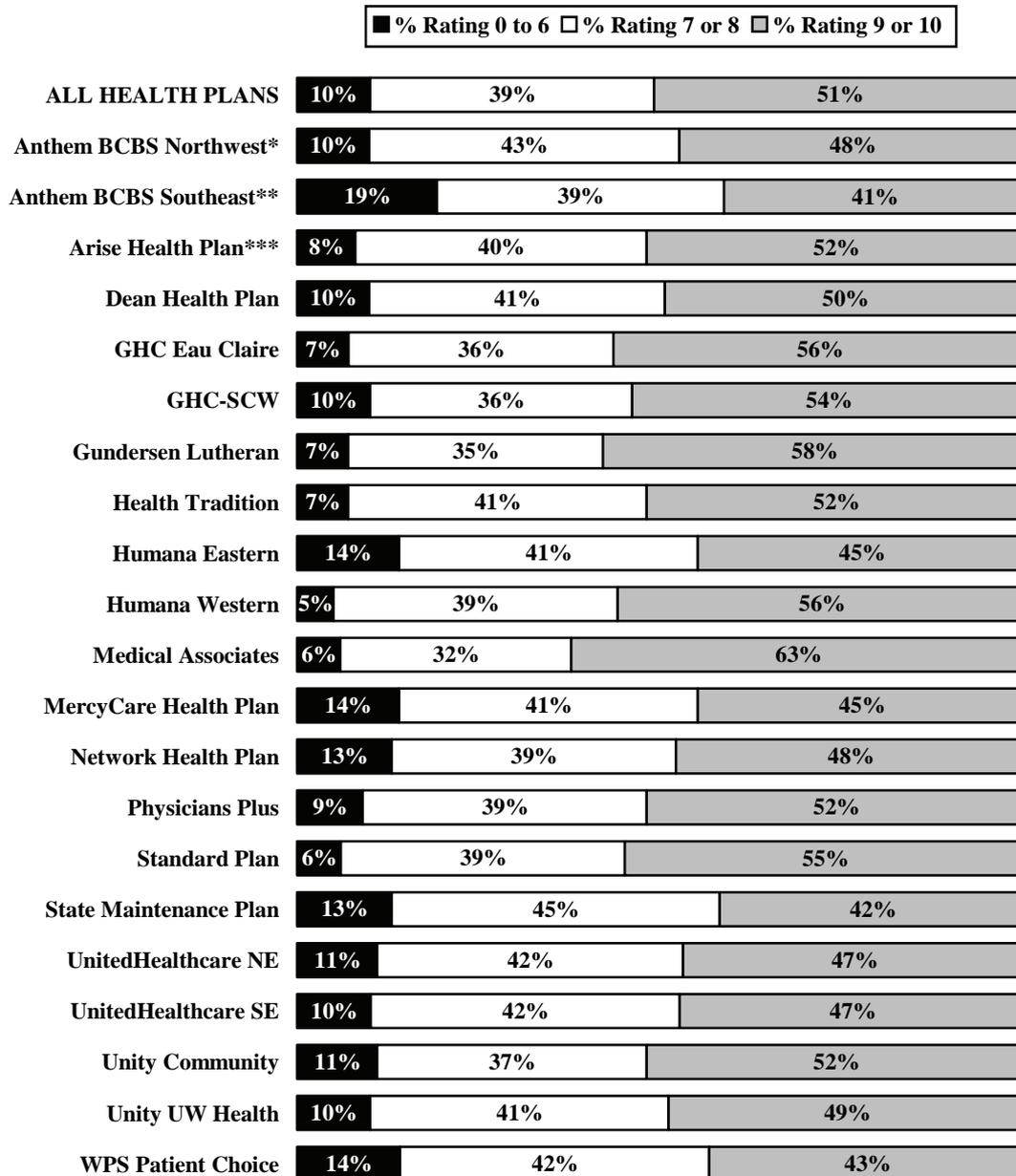
Overall Ratings Detail

Health Care

This graph shows:

- The percentage of people who rated their health care from "0 to 6," "7 to 8," or "9 to 10."
- Everyone who was surveyed was asked to rate their health care on a scale from 0 to 10 with 0 meaning "worst possible" and 10 meaning "best possible."

Due to rounding, the bars may not add up to exactly 100 percent.



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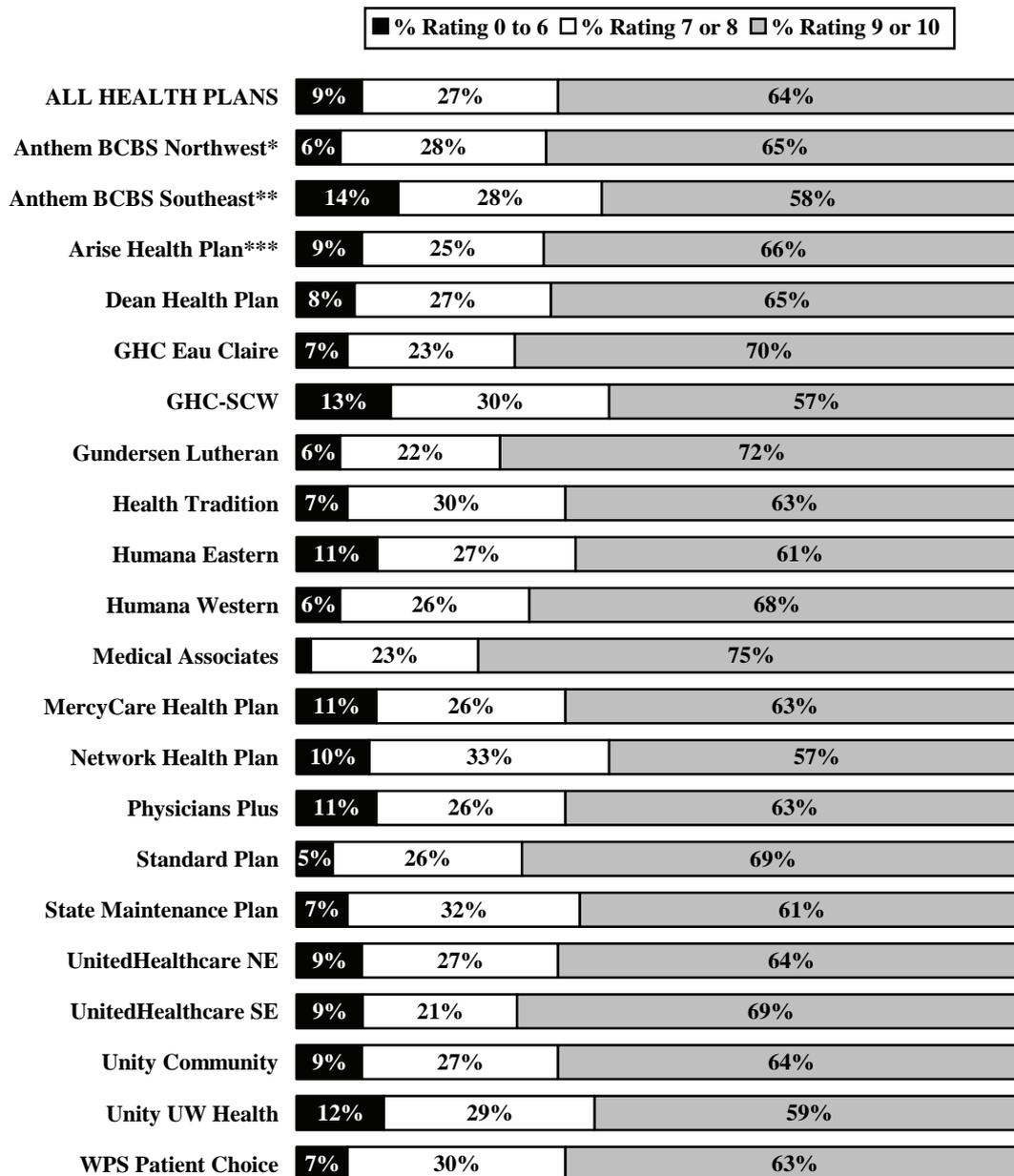
Overall Ratings Detail

Primary Doctor

This graph shows:

- The percentage of people who rated their primary doctor from "0 to 6," "7 to 8," or "9 to 10."
- Everyone who was surveyed was asked to rate their primary doctor on a scale from 0 to 10 with 0 meaning "worst possible" and 10 meaning "best possible."

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



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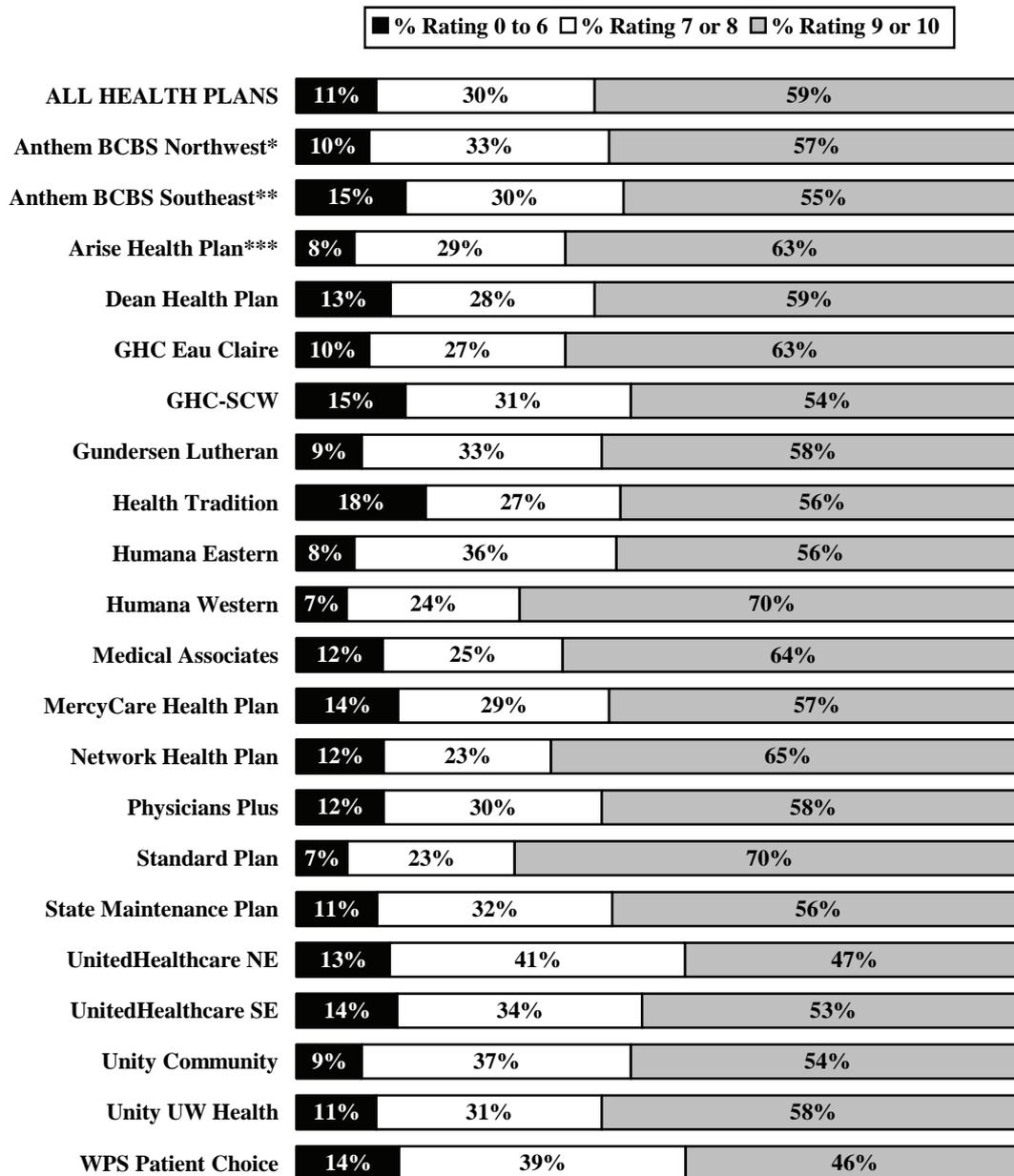
Overall Ratings Detail

Specialists

This graph shows:

- The percentage of people who rated their specialist from "0 to 6," "7 to 8," or "9 to 10."
- Everyone who was surveyed was asked to rate their specialist on a scale from 0 to 10 with 0 meaning "worst possible" and 10 meaning "best possible."

Due to rounding, the bars may not add up to exactly 100 percent.



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***Arise Health Plan was formerly known as WPS Prevea Health Plan.

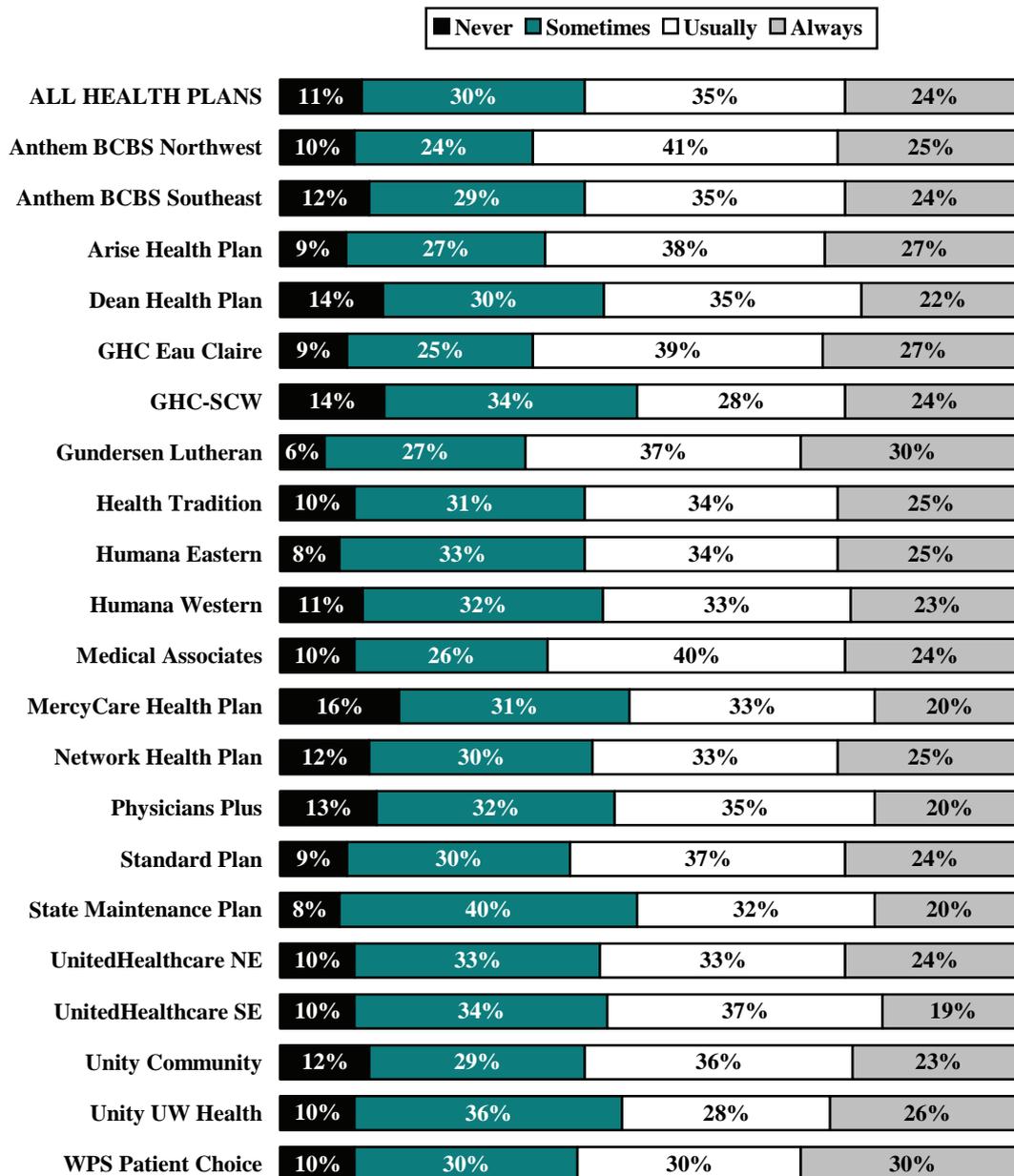
Health Care Detail

How often did you and a Doctor/Health Provider talk about specific things you could do to prevent illness?

This graph shows:

- The percentage of people who said "**always**," "**usually**," "**sometimes**," or "**never**" to the question, "How often did you and a doctor/health provider talk about specific things you could do to prevent illness?"
- This question was answered by those who answered "1 or more times" to the question asking how many times did you go to a doctor's office or clinic to get health care for yourself?"

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



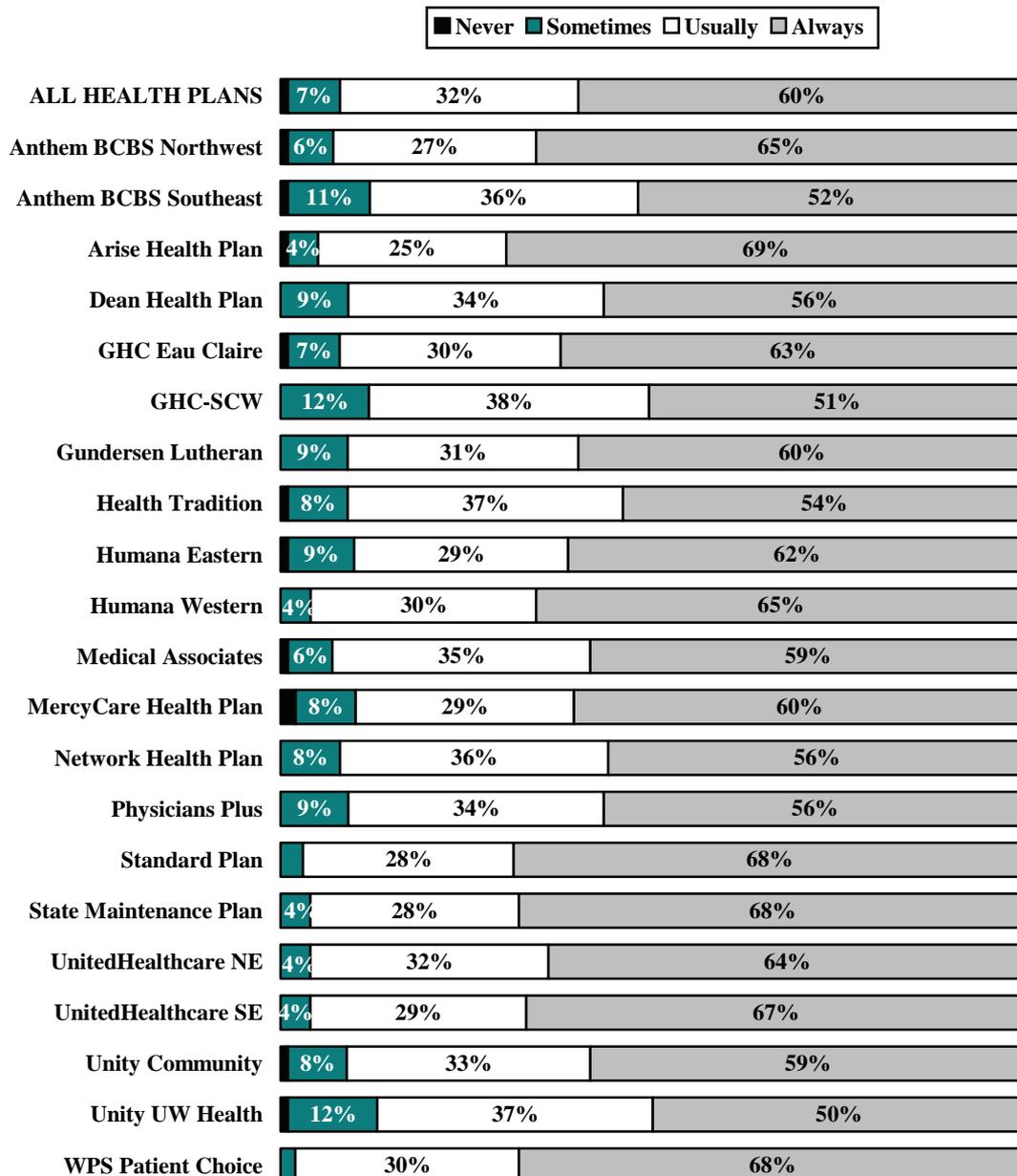
Health Care Detail

Received Care In Timely Manner

This graph shows:

- The percentage of people who said **"always," "usually," "sometimes,"** or **"never"** to the question, "In the last 12 months, when you last visited your doctor's office or clinic, were you able to see your provider and receive care and/or medical tests in a timely manner?"
- This question was answered by those who answered "1 or more times" to the question asking how many times did you visit your personal doctor to get care for yourself?"

Due to rounding, the bars may not add up to exactly 100 percent. Bar chart labels of less than 4% may not be visible due to limited space caused by small percentage results.



Grievance and Complaint Tables for Plans Available in 2008

2006 HEALTH PLAN GRIEVANCE REPORT¹ (SELF-REPORTED BY EACH PLAN)

Plan Name	Total grievances	Overtured Mbr's Favor	Health Plan Compromise	Percentage Partly/Fully Overtured	Percentage of Total Contracts	Percentage of Total Grievances
Anthem BCBS Northwest*	19	12	0	63%	0.68%	1.99%
Anthem BCBS Southeast**	16	6	0	38%	0.68%	1.67%
Arise Health Plan***	22	7	0	32%	0.79%	2.30%
CompcareBlue Aurora Family****	17	10	0	59%	1.75%	1.78%
Dean Health Plan	143	45	5	35%	22.42%	14.96%
GHC Eau Claire	6	3	2	83%	3.83%	0.63%
GHC-SCW	34	14	0	41%	8.48%	3.56%
Gundersen Lutheran	14	7	2	64%	2.12%	1.46%
Health Tradition	34	11	3	41%	2.09%	3.56%
Humana Eastern	252	183	2	73%	7.41%	26.36%
Humana Western	73	55	1	77%	2.64%	7.64%
Medical Associates	7	4	0	57%	0.49%	0.73%
MercyCare	7	4	0	57%	0.59%	0.73%
Network Health Plan	37	23	0	62%	4.21%	3.87%
Physicians Plus	24	4	1	21%	9.56%	2.51%
Standard Plans (all) ²	57	11	4	26%	12.86%	5.96%
UnitedHealthcare NE	104	68	0	65%	4.26%	10.88%
UnitedHealthcare SE	23	13	1	61%	0.95%	2.41%
Unity Community	7	1	0	14%	2.13%	0.73%
Unity UW Health	50	11	2	26%	11.79%	5.23%
WPS Patient Choice 1	7	4	0	57%	0.20%	0.73%
WPS Patient Choice 2	3	2	0	67%	0.03%	0.31%

¹ This information is collected by ETF and is not part of the CAHPS[®] survey.

² Includes State and Local Standard Plans, State Maintenance Plan, Local Annuitant Health Plan and Medicare Plus \$1,000,000; administered by WPS starting in 2006.

*Anthem BCBS NW was formerly known as CompcareBlue Northwest.

**Anthem BCBS SE was formerly known as CompcareBlue Southeast.

***Arise Health Plan was formerly known as WPS Prevea Health Plan.

****The Compcare Blue Aurora network was available through the Compcare Blue Southeast (now called Anthem BCBS Southeast) starting in January 2006.

Most Common Health Plan Grievance Types Reported:

- Excluded or Non-covered Benefit (26 percent of all grievances reported)
- Unauthorized Services (20 percent of all grievances reported)

**HEALTH PLAN COMPLAINTS
RECEIVED BY EMPLOYEE TRUST FUNDS IN 2006¹**

<i>Plan Name</i>	Number of Complaints	Percentage of Total Contracts	Percentage of Total ETF Health Insurance Complaints
Anthem BCBS Northwest*	2	0.68%	2.41%
Anthem BCBS Southeast**	3	0.68%	3.61%
Arise Health Plan***	2	0.79%	2.41%
CompcareBlue Aurora Family****	0	1.76%	0.00%
Dean Health Plan	15	22.42%	18.07%
GHC Eau Claire	1	3.83%	1.20%
GHC-SCW	1	8.48%	1.20%
Gundersen Lutheran	0	2.12%	0.00%
Health Tradition	5	2.09%	6.02%
Humana Eastern	7	7.41%	8.43%
Humana Western	1	2.64%	1.20%
Medical Associates	0	0.49%	0.00%
MercyCare	0	0.59%	0.00%
Network Health Plan	2	4.21%	2.41%
Physicians Plus	4	9.56%	4.82%
Standard Plans (all) ²	24	12.87%	28.92%
UnitedHealthcare NE	2	4.26%	2.41%
UnitedHealthcare SE	2	0.95%	2.41%
Unity Community	0	2.13%	0.00%
Unity UW Health	9	11.79%	10.84%
WPS Patient Choice 1	2	0.20%	2.41%
WPS Patient Choice 2	1	0.03%	1.20%

¹ This information is collected by ETF and is not part of the CAHPS[®] survey.

² Includes State and Local Standard Plans, State Maintenance Plan, Local Annuitant Health Plan and Medicare Plus \$1,000,000; administered by WPS starting in 2006.

*Anthem BCBS NW was formerly known as CompcareBlue Northwest.

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Most Common Health Plan Complaint Types Reported:

- Excluded or Non-covered Benefit (20 percent of all complaints reported)
- Unauthorized Services (14 percent of all complaints reported)

HEDIS[®] SUMMARY

What is HEDIS[®]? Healthcare Effectiveness Data and Information Set (HEDIS[®]) is the most widely used set of performance measures in the managed care industry. HEDIS[®] is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit health care quality organization. One purpose of HEDIS[®] is to improve the quality of health care by providing measures designed to increase accountability of managed care.

HEDIS[®] measures were originally designed as performance measures for private employers that purchase health insurance, but it has been adapted for use by public purchasers, regulators, and consumers. HEDIS[®] measures are designed to address health care issues that are meaningful to consumers and purchasers. Measures must have important health implications and health care systems should have the ability to take actions to improve their performance. Each measure includes the percentage of eligible members that received a treatment or screening. For example, if 180 of 200 women aged 42 to 69 received a mammogram in the last two years, the HMO would receive a score of 90 percent.

How can consumers use HEDIS[®]? Consumers can use HEDIS[®] measures to compare the performance of their health care options during the open enrollment period. In order to evaluate an HMO's performance, consumers should consider a number of measures relating to health care. It can be misleading to make simple comparisons based on a single measure. Furthermore, HEDIS[®] measures should only be considered as one tool of many in selecting a health plan. Other health plan selection considerations include the Consumer Assessment of Health Plans (CAHPS[®]) member satisfaction data, providers available in a plan, and employee share of insurance costs. Consumers may also use HEDIS[®] data to educate themselves about recommended preventative health screenings, procedures and provider contacts recommended for members who have been diagnosed with conditions such as diabetes, heart disease, hypertension, asthma, and depression. Consumers should keep in mind that rates can differ based on factors other than true and meaningful differences. For example, rates could differ because of random chance, different member populations and data collection issues.

Accuracy of results. HEDIS[®] measures have been developed and refined for over 10 years. In that time, Managed Care Organizations (or HMOs) have become increasingly better at data collection and reporting. Audited data may be more reliable than un-audited data because the auditing process ensures that only accurate measures are reported.

Different member populations. HEDIS[®] scores may differ across HMOs for a number of reasons, such as true differences in performance or lack of reliable data. Scores can also differ due to the various member populations each HMO serves. Every practitioner and Managed Care Organization provides care for a distinct subset of health care consumers. Some consumers are old, some are young, some are healthy, others have been chronically ill since birth. Some patients adhere closely to recommendations given by their health care professionals while others may be labeled "noncompliant." These are some of the many reasons that Managed Care Organizations may have different results even if they are *delivering care identically*. It may well be non-random events that cause Managed Care Organizations to serve different populations. For example, geography, marketing strategies to enroll employees in a specific industry, benefit

HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

design or the provider network may heavily influence the gender, ethnicity or educational status of the member population.

How should HEDIS[®] scores be interpreted? Generally, NCQA recommends that a difference in score not be interpreted as meaningful unless there is a 10-percentage point difference between the scores being compared. In cases in which there is a small sample size (N<100), a 20-percentage point difference is considered clinically significant and meaningful. A clinically meaningful difference is different than a statistically significant difference between two scores. A difference can be statistically significant and not have a material affect on the treatment that members receive.

Small sample sizes may also impact scores. This may be the result of a smaller HMO not having enough eligible members for the measure to make up an adequate sample. A minimum sample size of N=30 is needed for a measure to be included in any type of comparison. Scores for plans with low sample sizes are labeled as “NA” in the HEDIS[®] results section of this report card.

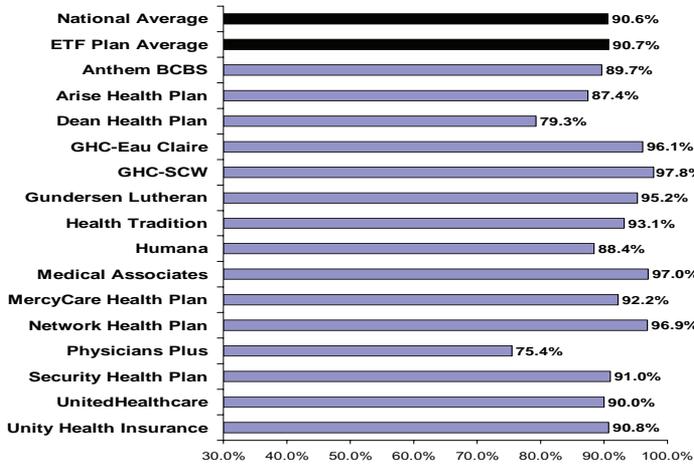
Items to consider when comparing the HMOs included in this report card:

- HEDIS[®] data is not available for the Standard Plan, the State Maintenance Plan, or the Patient Choice plans because Preferred Provider Plans do not emphasize the quality improvement and reporting functions of Managed Care Organizations.
- The Wisconsin averages included in this report card include only HMOs that participate in the State program.
- As explained above, the interpretation of meaningful differences must take into account the sample size. If the sample size is 100 or greater, then a difference of 10 percentage points is considered to be a meaningful difference. However, if the sample size is less than 100, then a difference of at least 20 percentage points is needed before a difference would be considered meaningful. Scores based on a sample size of less than 100 are identified by a double asterisk (**) after the score in the HEDIS[®] results section of this report card.
- Members can create their own interactive report card to evaluate the HMOs that are accredited by NCQA, by visiting the NCQA website: <http://www.ncqa.org> and clicking on the Report Cards link.

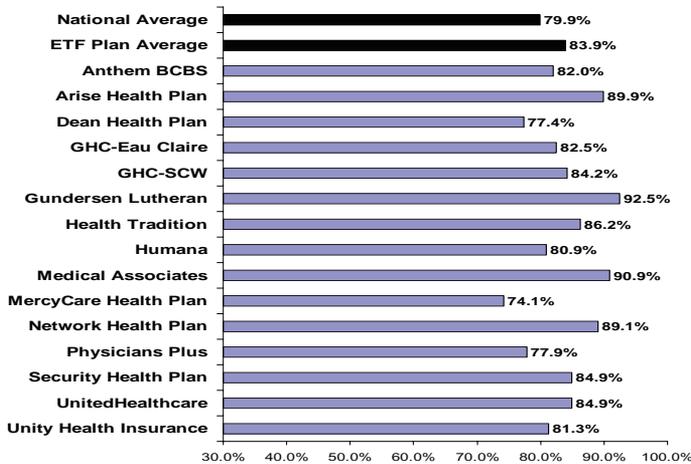
HEDIS® Results

Women and Children's Health

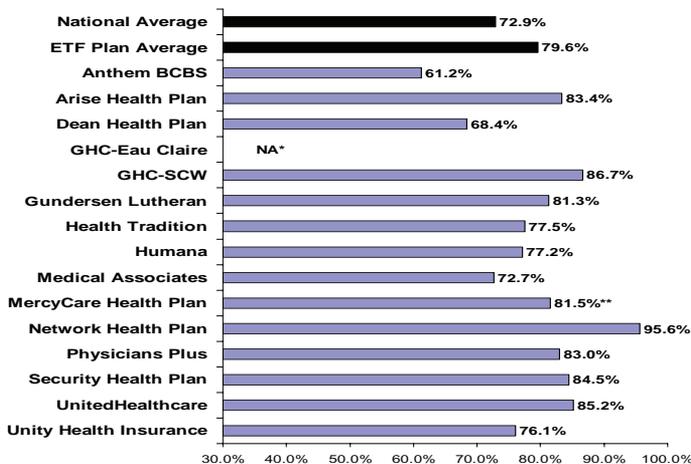
Timeliness of Prenatal Care



Postpartum Care



Well-Child Visits in the First 15 Months of Life



What percentage of pregnant women began prenatal care during the first 13 weeks of pregnancy or within 42 days of enrollment if more than 13 weeks pregnant when enrolled?

Prenatal care can be delivered by a variety of appropriate obstetrical, primary care or nurse-midwife practitioners. Healthy diet, counseling, vitamin supplementation, identification of maternal risk factors and health promotion all need to occur early in a pregnancy to have a maximum impact on outcomes. Poor outcomes include spontaneous abortions, low birth-weight babies, large-for-gestational-age babies, and neonatal infections.

What percentage of women who had live births had a postpartum visit between 21 and 56 days after delivery?

The 8 weeks after giving birth are a period of physical, emotional and social changes for the mother during a time when she is also adjusting to caring for her new baby. To give practitioners a chance to offer advice and assistance, the American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once between 4 and 6 weeks after giving birth. The first postpartum visit should include a physical exam and an opportunity for the health care practitioner to answer questions and give family planning guidance and counseling on nutrition.

What percentage of children had six or more well-child visits by the time they turned 15 months of age?

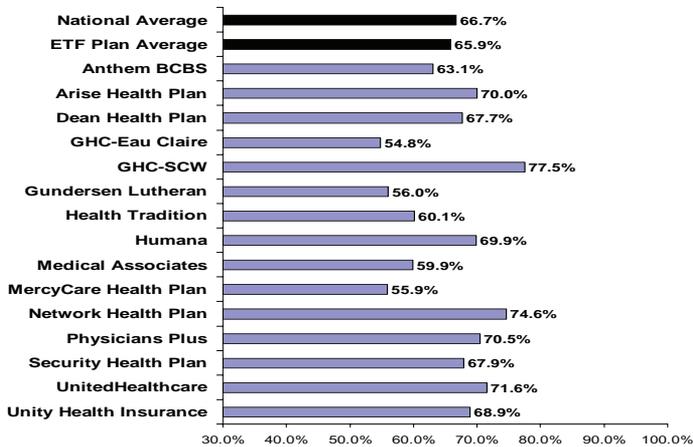
Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor-skills, hand-eye coordination and social and emotional growth. The American Academy of Pediatrics recommends 6 well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9 and 12 months of age.

* HEDIS® scores are not available because the sample size is too small to be meaningful. N<30.

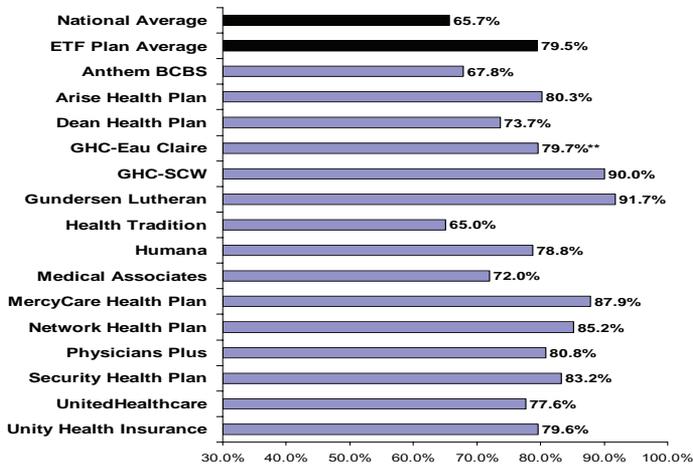
**HEDIS® scores are derived from a denominator <100. Only differences of 20 percentage points or more from this score should be interpreted as meaningful.

Women and Children's Health

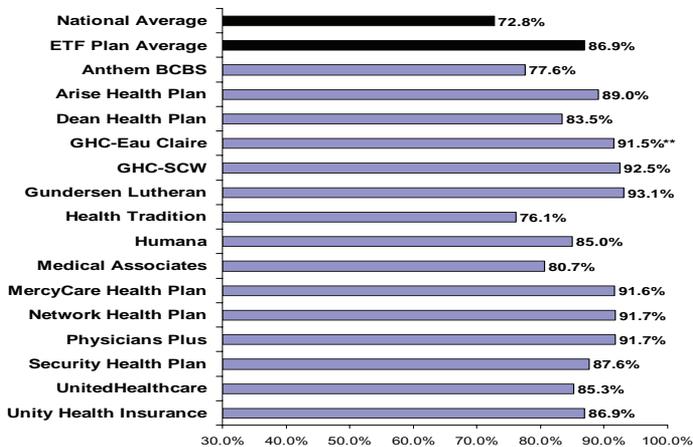
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



Childhood Immunization Status: Combination #3



Childhood Immunization Status: Pneumococcal Conjugate



What percentage of children who are 3, 4, 5, and 6 years old received at least one well-child visit with a primary care practitioner?

Well-child visits during the pre- and early school years are particularly important. A child can be helped through early detection of vision, speech, and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems. The American Academy of Pediatrics recommends annual well-child visits for 2 to 6 years olds.

Did children receive important immunizations before their second birthday, including:

- Four doses of DTaP/DT (diphtheria-tetanus-cellular pertussis/diphtheria-tetanus)
- At least three doses of IPV (polio)
- One dose of MMR (measles, mumps, rubella)
- At least three doses of HiB (haemphilus influenza type b), with at least one falling between the child's first and second birthday
- Three doses of hepatitis B
- One chicken pox (VZV) or documented illness
- Four doses of pneumococcal conjugate

Childhood immunizations help prevent serious illnesses, such as polio, tetanus, whooping cough, hepatitis, influenza and chicken pox. According to the National Foundation for Infectious Diseases, the pneumococcal conjugate vaccine (displayed separately from the five immunizations and also included in Combination #3), administered to infants and toddlers before their second birthday, protects against the 86 percent of the bacteria types that cause blood infections in children and 83 percent of those that cause meningitis in children.

For information on childhood immunizations in Wisconsin, please go to:

<http://www.dhfs.state.wi.us/immunization/vfc.htm>

**HEDIS® scores are derived from a denominator <100. Only differences of 20 percentage points or more from this score should be interpreted as meaningful.

Did adolescents receive important immunizations by age thirteen?

- MMR-2 (second dose of measles-mumps-rubella)
- Three doses of hepatitis B
- One dose of chicken pox (VZV) or documented illness

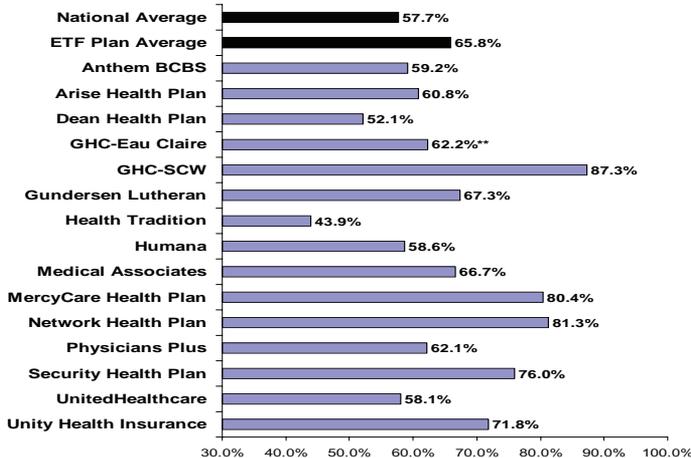
The Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians and Advisory Committee on Immunizations Practices recommend that by the time children are 13, they should have received their second dose of measles-mumps and rubella and three hepatitis B immunizations. They also recommend that children who have not had chicken pox receive that vaccination as well **(displayed separately and also included in combination #2)**.

Children are usually immunized against MMR during early childhood, but an immunization booster shot during adolescence is required to ensure continued protection against illness. Immunization rates may be low because many parents may not be aware of the importance of vaccinations and the recommended schedule for receiving them. Innovative health plans have worked with local schools to educate parents and students about immunizations.

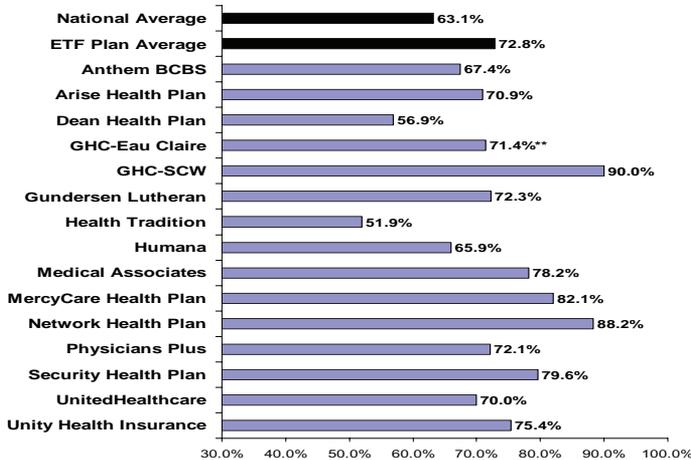
What percentage of adolescents 12–21 years of age had 1 or more well-care visits with a primary care provider or OB/GYN within the last year?

Adolescence is a time of transition between childhood and adult life and is accompanied by dramatic changes. Accidents, homicide and suicide are the leading causes of adolescent deaths. Sexually transmitted diseases, substance abuse, pregnancy and antisocial behavior are important causes of—or result from—physical, emotional and social adolescent problems. The American Medical Association’s Guidelines for Adolescent Preventive Services, the federal government’s Bright Futures program and the AAP guidelines all recommend comprehensive annual check-ups for adolescents.

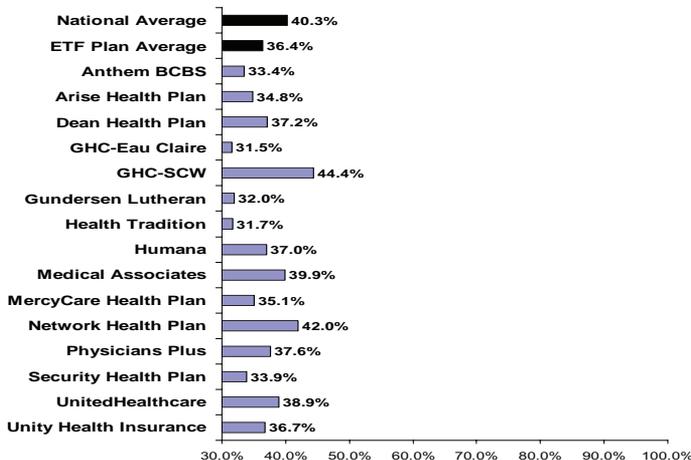
Adolescent Immunization Status: Combination #2



Adolescent Immunization Status: Chicken Pox

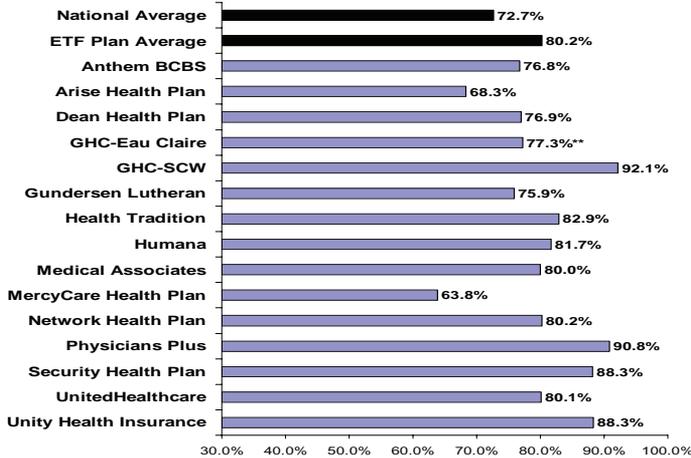


Adolescent Well-Care Visits

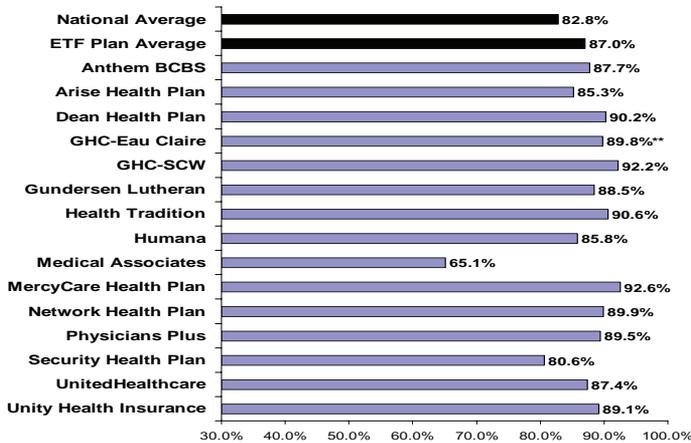


**HEDIS® scores are derived from a denominator <100. Only differences of 20 percentage points or more from this score should be interpreted as meaningful.

Appropriate Testing for Children with Pharyngitis

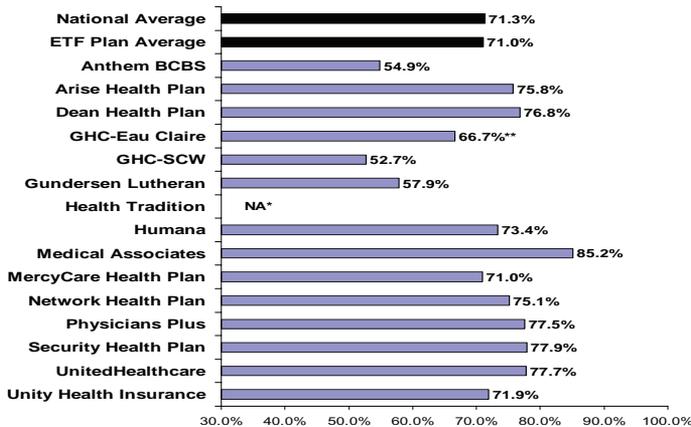


Appropriate Treatment for Children With Upper Respiratory Infection



Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis

A lower rate is an indication of better performance



Did children between ages 2 and 18 who were diagnosed with pharyngitis get prescribed an antibiotic at an outpatient visit and receive a group A streptococcus (group A strep) test?

Pharyngitis is the only condition among Upper Respiratory Infections whose diagnosis can easily be objectively validated through administrative and laboratory data, and it can serve as an important indicator of appropriate antibiotic use among all respiratory tract infections. Excessive use of antibiotics is highly prevalent for pharyngitis. About 35 percent of the total 9 million antibiotics prescribed for pharyngitis in 1998 were estimated to be inappropriate. The overuse of antibiotics has been proven to be directly linked to the prevalence of antibiotic resistance in the community. Promoting judicious use of antibiotics is important to reduce levels of antibiotic resistance.

Did children between 3 months and 18 years of age who were given a single diagnosis of URI at an outpatient visit not receive an antibiotic prescription for that episode of care within three days of the visit?

The common cold (upper respiratory infection [URI]) is a frequent reason for children visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. Pediatric clinical practice guidelines do not recommend antibiotics for a majority of upper respiratory tract infections, including the common cold.

Did adults between 18 and 64 years of age who were diagnosed with acute bronchitis receive an antibiotic prescription for that episode of care within three days?

Antibiotics are most often inappropriately prescribed for adults with acute bronchitis. Inappropriate antibiotic treatment of adults with acute bronchitis is of clinical concern, especially since misuse and overuse of antibiotics lead to antibiotic drug resistance. Acute bronchitis consistently ranks among the 10 conditions that account for most ambulatory office visits to U.S. physicians; furthermore, despite the fact that the majority of acute bronchitis cases have a nonbacterial cause (>90%), antibiotics are prescribed 65 percent to 80 percent of the time.

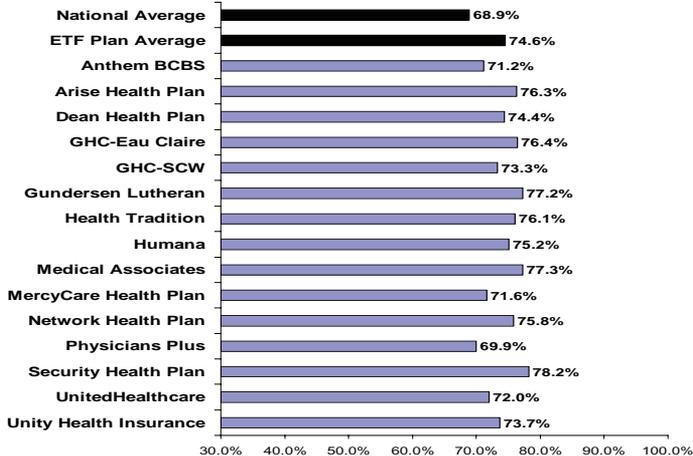
A lower score for this measure indicates better performance.

Cancer Screenings

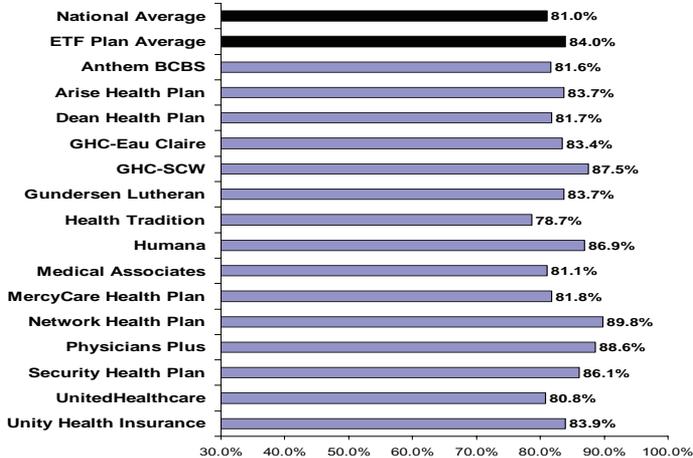
Did women 42 to 69 years old have a mammogram within the last two years?

Breast cancer is the second most common type of cancer among American women, with approximately 192,200 new cases reported each year. Early detection gives women more treatment choices and a better chance of survival. Mammography screening has been shown to reduce mortality by 20 to 30 percent among women age 50 and older. Note that the American Cancer Society recommends that women age 40 and older receive an annual mammogram. Younger women should receive mammograms if they have had cancer before or have a family history or genetic predisposition to cancer.

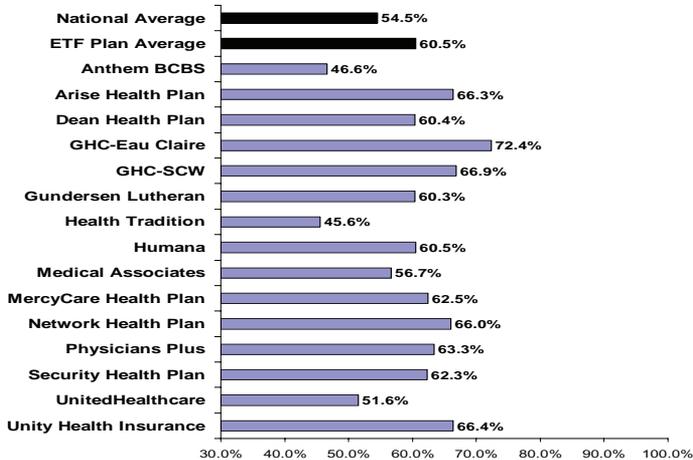
Breast Cancer Screening



Cervical Cancer Screening



Colorectal Cancer Screening



What percentage of women ages 24 to 64 had at least one Pap test during the past three years?

A number of organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association, and the American Cancer Society, recommend Pap testing every one to three years for all women who have been sexually active or who are over 21 years old. Cervical cancer can be detected in its early stages by regular screening using a Pap test.

Did adults age 50 to 80 have had appropriate screening for colorectal cancer? "Appropriate screening" is defined by meeting any one of the four criteria below:

- fecal occult blood test (FOBT) during the measurement year
- flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year
- colonoscopy during the measurement year or the nine years prior to the measurement year.

Colorectal cancer (CRC) is the second leading cause of cancer-related death in the United States. It places significant economic burden on society, with treatment costing over \$6.5 billion per year. Unlike other screening tests that only detect disease, some methods of CRC screening can detect pre-malignant polyps and guide their removal, which in theory can prevent development of cancer.

For more information on cancer in Wisconsin, please go to: <http://www.cancer.org/downloads/COM/WisconsinFF2007.pdf>

Living with Illness

What percentage of adults age 18 to 85 years old that were diagnosed with hypertension had their blood pressure controlled?

Control is demonstrated by a blood pressure reading that is less than both 140 mm Hg systolic and 90 mm Hg diastolic at the last office visit during the measurement year. Approximately 50 million Americans, including 30 percent of the adult population, have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduced mortality from heart disease, stroke and kidney failure. A pool of past clinical trials demonstrated that a 5 to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease.

What percentage of members age 18 to 75 with cardiovascular conditions within the prior year:

- had their LDL-C (cholesterol) screened between 60 and 365 days after the event?
- have a documented LDL-C level <100 mg/dL?

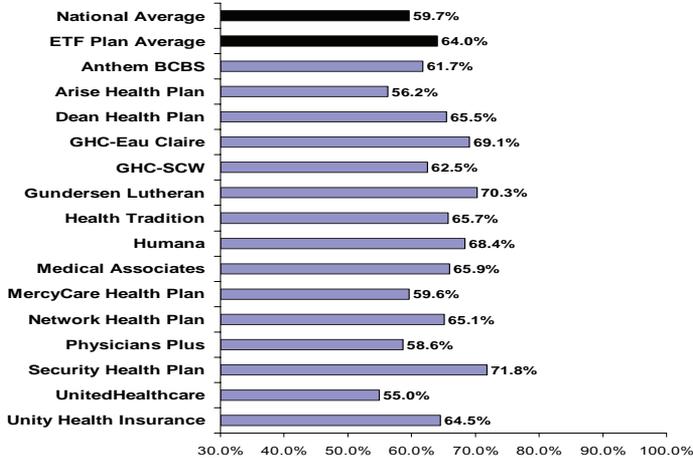
Total blood cholesterol is directly related to the development of coronary artery disease and coronary heart disease, with most of the risk associated with LDL cholesterol. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attacks and strokes) and mortality by as much as 40 percent.

The National Cholesterol Education Program (NCEP) guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for low-density lipoprotein cholesterol (LDL-C) of ≤ 100 mg/dL for such patients.

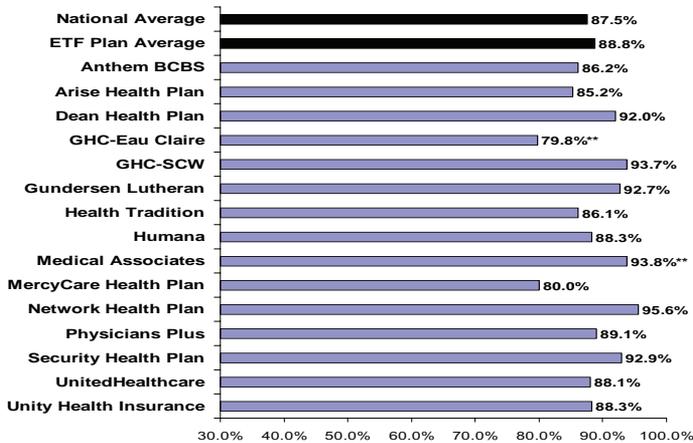
For information on heart disease in Wisconsin, visit the Wisconsin Cardiovascular Health Program at:

<http://dhfs.wisconsin.gov/Health/cardiovascular/index.htm>

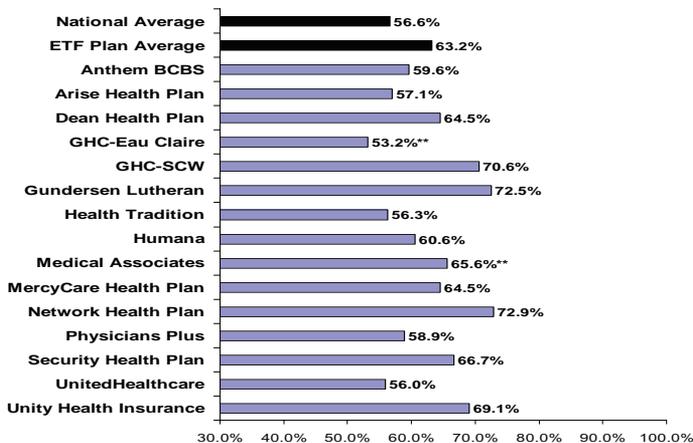
Controlling High Blood Pressure



Cholesterol Management after Acute Cardiovascular Conditions: Screening

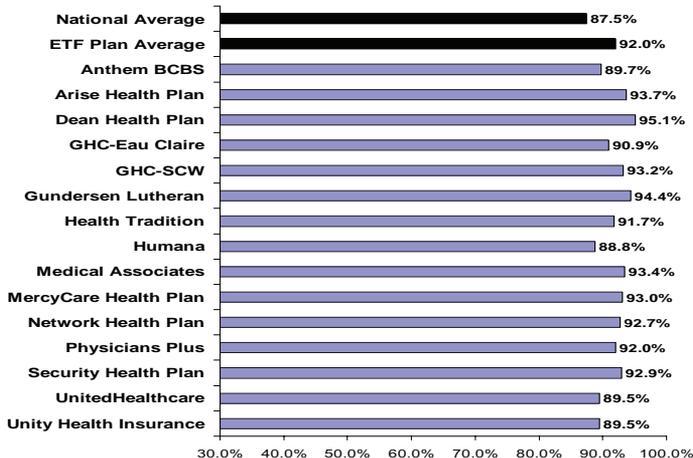


Cholesterol Management after Acute Cardiovascular Conditions: LDL-C <100

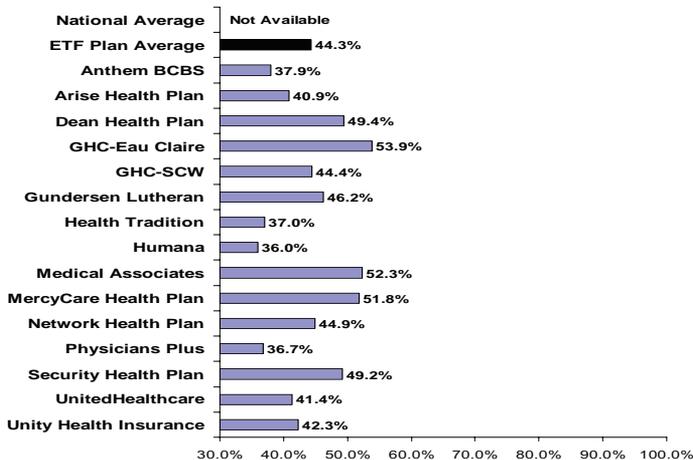


**HEDIS® scores are derived from a denominator <100. Only differences of 20 percentage points or more from this score should be interpreted as meaningful.

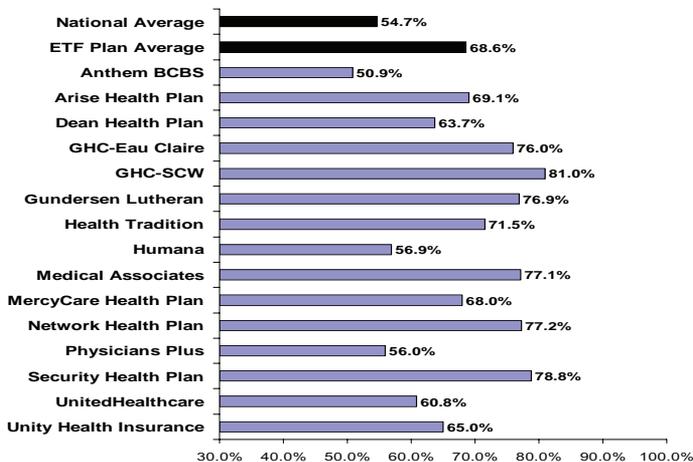
Diabetes Care: HbA1c Testing



Diabetes Care: Good HbA1c Control <7.0%



Diabetes Care: Eye Exam



What percent of members with diabetes age 18 to 75 years old:

- received a hemoglobin (HbA1c) screening (long term glucose blood test)
- have a HbA1c percentage with controlled diabetes (7% or less)
- received a retinal eye examination
- received a LDL-C (cholesterol) screening
- had a controlled LDL-C level (LDL-C<100 mg/dl)
- received medical attention for kidney disease

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 17 million Americans have diabetes; half of these cases are undiagnosed.

Complications from the disease cost the country nearly \$100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in persons over age 25. Many complications, such as amputations, blindness and kidney failure, can be prevented if diabetes is detected and addressed in the early stages.

Diabetes is a multi-faceted disease, affecting multiple organs and requiring the involvement of a multidisciplinary health care team. It is difficult to assess comprehensive diabetic care without examining several factors. This measure contains a variety of indicators that provide a comprehensive view of how providers and Managed Care Organizations are addressing this disease.

Many Managed Care Organizations have developed comprehensive diabetes management programs that help members with diabetes maintain control over their blood sugar and minimize the risk of complications. These programs can be very beneficial to quality of life and are cost-effective in the long run.

Diabetes continued on next page

Diabetes Continued

The challenge faced by Managed Care Organizations is to bring more members with diabetes into these programs and help them incorporate healthy behaviors and monitoring practices into their lifestyle.

According the Wisconsin Diabetes Prevention and Control Program:

- An estimated 329,460 adults (8%) have diabetes (94,130 are undiagnosed). An estimated 4,000 (0.3%) children and adolescents have diabetes. About 19% of Wisconsin residents 65 and older have diabetes.
- In 2002, estimated direct costs (health care) of diabetes totaled \$3.12 billion dollars and indirect costs (loss of productivity) were estimated at \$1.35 billion, for a total cost of \$4.47 billion in Wisconsin.

For information on efforts to control diabetes in Wisconsin, visit the Wisconsin Diabetes Prevention and Control Program website at:

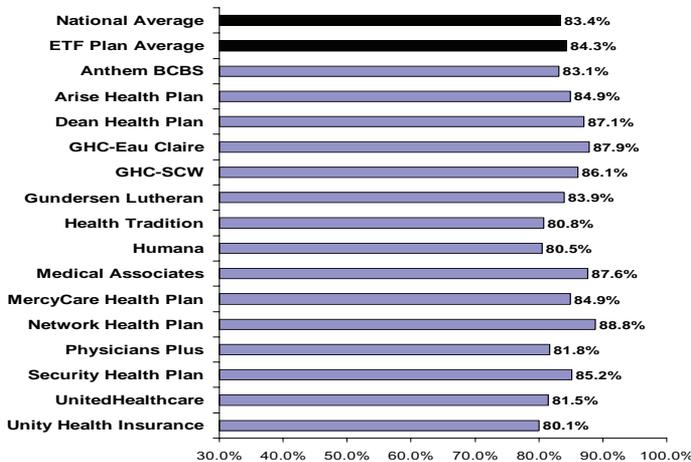
<http://dhfs.wisconsin.gov/health/diabetes/overview.htm>

Many resources are available for employers and people with diabetes or at risk of developing diabetes at the Alliance website at:

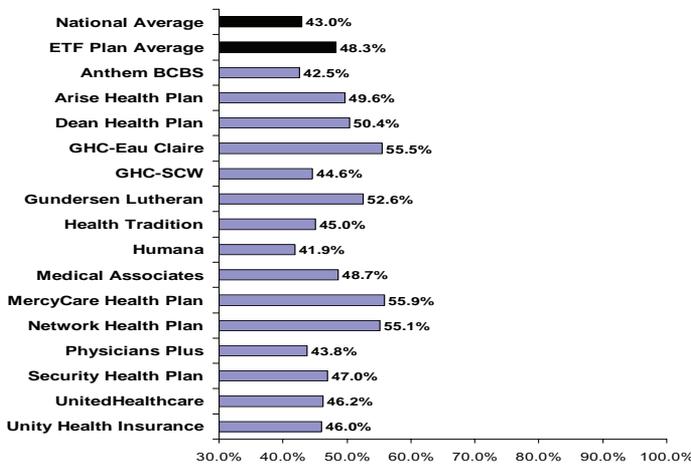
<http://www.alliancehealthcoop.com/diabetes/index.htm>

Although geared towards Wisconsin employers, this website includes many tools and guides for people affected by diabetes including personal care tools and information about managing diabetes in the work place.

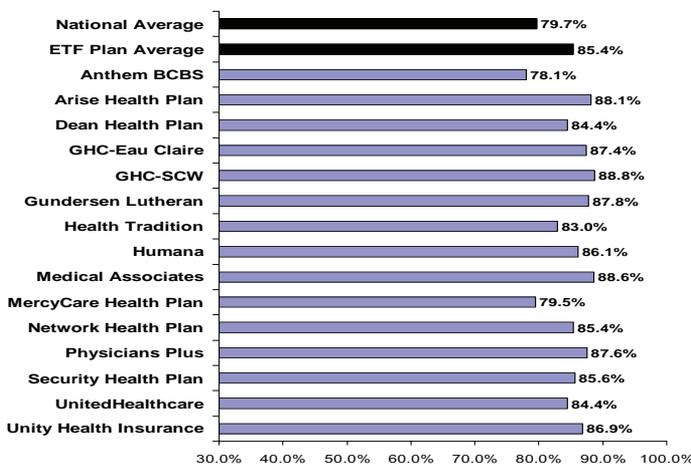
Diabetes Care: Cholesterol Screening



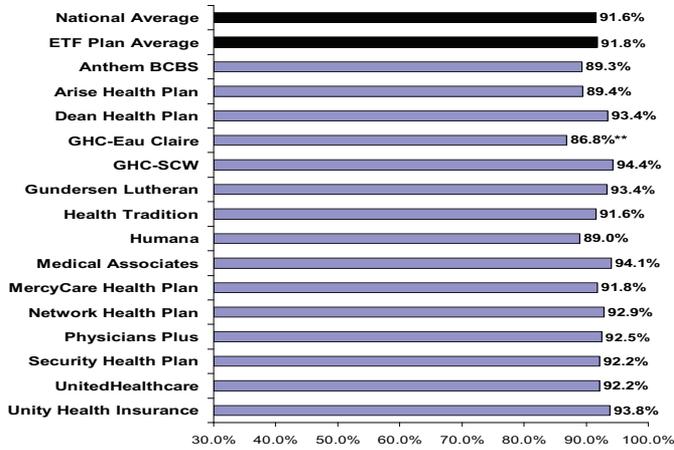
Diabetes Care: LDL-C Level <100



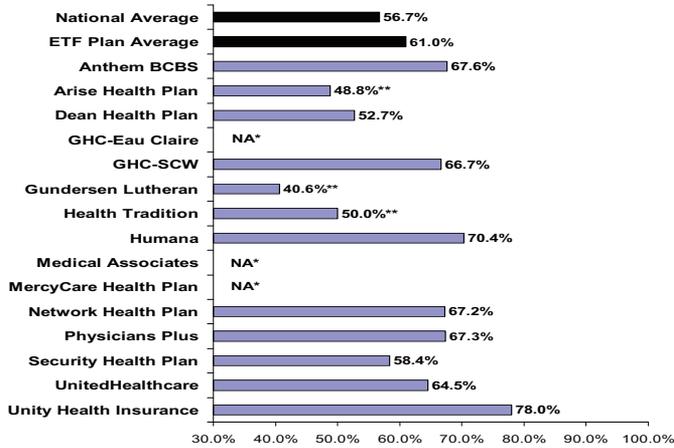
Diabetes Care: Medical Attention for Kidney Disease



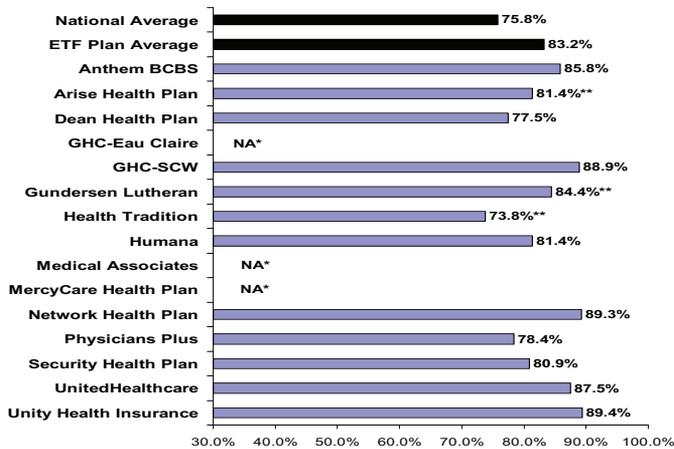
Use of Appropriate Medications for People with Asthma



7-Day Follow Up after Hospitalization for Mental Illness



30-Day Follow-Up after Hospitalization for Mental Illness



What percentage of members age 5 to 56 with persistent asthma is being prescribed medications acceptable as primary therapy for long-term control of asthma?

Asthma is the most common chronic childhood disease, affecting an estimated 5 million children. Overall, approximately 15 million people in the United States have asthma. People with asthma collectively have more than 100 million days of restricted activity and 5,000 deaths annually. Successful management of asthma can be achieved for most asthmatics if they take medications that provide long-term control. In addition, patient education regarding medication use, symptom management and avoidance of asthma triggers can greatly reduce the impact of the disease.

What percentage of members age 6 and older were hospitalized for selected mental disorders and were seen on an outpatient basis by a mental health provider within 7 days or within 30 days after their discharge?

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient’s transition to the home or work environment is supported and gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems, and provide continuing care. In 2001, 51.3 percent of members nationwide who had been hospitalized for mental illness received follow-up care within seven days of discharge, and 73.2 percent received follow-up care within 30 days. Managed Care Organizations need to make a practice of scheduling follow-up appointments when a patient is discharged and should also educate patients and practitioners about the importance of follow-up visits. Systems should be established to generate reminder or “reschedule” notices that are mailed to patients in the event that a follow-up visit is missed or canceled. In many cases, it may also be necessary to develop outreach systems or to assign case managers to encourage recently released patients to keep follow-up appointments or reschedule missed appointments.

* HEDIS® scores are not available because the sample size is too small to be meaningful. N<30.

**HEDIS® scores are derived from a denominator <100. Only differences of 20 percentage points or more from this score should be interpreted as meaningful.

Behavioral Health Care

Did members age 18 years and older, treated with antidepressants for a new diagnosis of depression receive the necessary care, including:

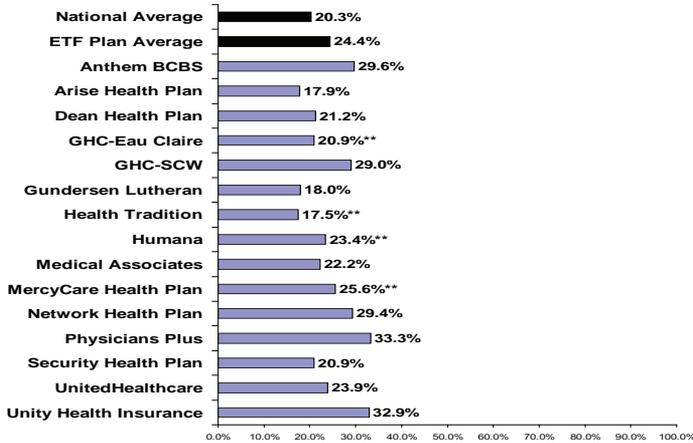
- Adequate clinical management of new treatment episodes (at least three follow-up office visits during the first 12 weeks after diagnosis and start of medications)
- Adequate acute phase trial medications (stayed on medication for 12 weeks)
- Completion of a period of continuous treatment for major depression (stayed on medication for 180 days)

Based on current treatment protocols outlined in the 1993 Agency for Healthcare Research and Quality (AHRQ) *Depression in Primary Care* guideline, these measures address clinical management and pharmacological treatment of depression. In any given year, an estimated 18.8 million American adults suffer from a depressive disorder or depression. Without treatment, symptoms associated with these disorders can last for years, or can eventually lead to death by suicide or other causes. Fortunately, many people can improve through treatment with appropriate medications.

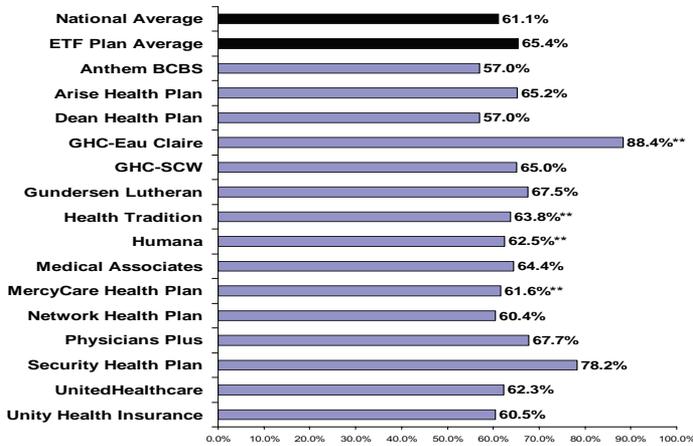
Patients who have a moderate to severe case of major depression are generally good candidates for treatment with antidepressant medication. If pharmacological therapy is initiated, the AHRQ *Depression in Primary Care* guideline defines three phases of treatment: acute, continuation and maintenance.

The acute phase, lasting through the first 12 weeks of treatment, allows the clinician to monitor drug response and assure a full remission of symptoms. However, the attainment of remission may be followed by relapse unless a continuation phase (4 to 9 months) is instituted. Finally, for a select group of patients with major depressive disorder, a maintenance phase must be adopted to prevent future recurrences of symptoms and distress.

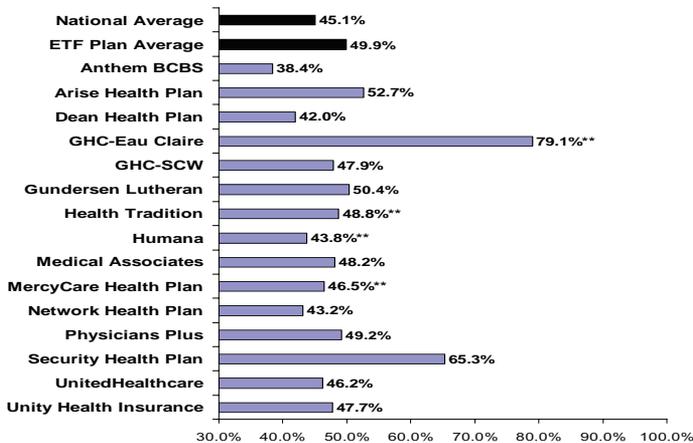
Optimal Practitioner Contacts for Antidepressant Medication Management



Effective Acute Phase Treatment for Antidepressant Medication Management



Effective Continuation Phase Treatment for Antidepressant Medication Management



* HEDIS® scores are not available because the sample size is too small to be meaningful. N<30.

**HEDIS® scores are derived from a denominator <100. Only differences of 20 percentage points or more from this score should be interpreted as meaningful.



CAHPS[®]
Health Care Quality Information
From the Consumer Perspective

HEDIS[®]
Health Care Quality Information
Based on Health Plan Performance

It's Your Choice 2008

Health Plan Report Card

Supplemental Information

Please refer to **Section E** (health plan report card) in the *It's Your Choice 2008* booklet for comprehensive results of the annual member satisfaction survey and clinical evidence of health plan performance. Selected survey questions and results as well as measures of actual care given to prevent and manage illness are included for members to review.

Respondent's Age

This chart shows:

- The percentage of people who responded “18 to 24”, “25 to 34”, “35 to 44”, “45 to 54”, “55 to 64”, “65 to 74”, or “75 or older” to the question, “What is your age?”

Due to rounding, total percentages may not add up to exactly 100 percent.

Health Plan Name	18 to 24 Years	25 to 34 Years	35 to 44 Years	45 to 54 Years	55 to 64 Years	65 to 74 Years	75 years or older
Average—All Health Plans	1.7%	12.9%	16.2%	25.9%	25.6%	10.4%	7.3%
Anthem BCBS Northwest	0.5%	5.8%	8.3%	16.0%	35.0%	22.3%	12.1%
Anthem BCBS Southeast	2.6%	18.8%	19.1%	29.9%	19.6%	8.2%	1.8%
Arise Health Plan	0.0%	8.1%	14.0%	19.3%	29.1%	18.6%	10.9%
Dean Health Plan	1.8%	9.3%	17.5%	30.7%	24.2%	11.3%	5.2%
GHC Eau Claire	0.5%	8.8%	15.9%	34.8%	31.5%	6.3%	2.2%
GHC-SCW	6.6%	38.5%	13.9%	18.6%	18.9%	2.2%	1.4%
Gundersen Lutheran	1.2%	9.0%	15.5%	25.8%	27.3%	12.4%	8.7%
Health Tradition	2.6%	15.0%	22.5%	26.5%	23.5%	7.2%	2.6%
Humana Eastern	1.4%	17.0%	19.3%	29.2%	25.2%	6.5%	1.4%
Humana Western	0.0%	7.7%	11.1%	29.1%	32.5%	13.0%	6.5%
Medical Associates	0.5%	10.4%	18.4%	28.9%	24.4%	11.4%	6.0%
MercyCare Health Plan	0.4%	14.8%	23.2%	29.6%	24.4%	4.8%	2.8%
Network Health Plan	0.6%	10.4%	23.7%	29.0%	28.7%	5.6%	2.0%
Physicians Plus	2.4%	11.1%	11.4%	26.8%	30.5%	9.0%	8.8%
Standard Plan	0.7%	1.7%	1.2%	4.9%	11.2%	32.3%	47.9%
State Maintenance Plan	1.5%	14.6%	19.2%	26.9%	30.0%	6.9%	0.8%
UnitedHealthCare NE	1.1%	5.6%	19.8%	33.7%	29.2%	8.6%	1.9%
UnitedHealthCare SE	3.1%	20.5%	15.7%	15.0%	37.0%	6.3%	2.4%
Unity Community	1.4%	15.8%	18.6%	30.2%	22.3%	7.0%	4.7%
Unity UW Health	3.2%	19.0%	18.8%	27.2%	20.9%	6.9%	4.0%
WPS Patient Choice	2.5%	13.2%	20.7%	31.4%	28.9%	3.3%	0.0%

Self-Reported Health Status

This chart shows:

- The percentage of people who responded "poor", "fair", "good", "very good", or "excellent" to the question, "In general, how would you rate your overall health now?"

Due to rounding, total percentages may not add up to exactly 100 percent.

Health Plan Name	Poor	Fair	Good	Very Good	Excellent
Average—All Health Plans	15.4%	45.3%	30.8%	7.5%	1.0%
Anthem BCBS Northwest	12.7%	45.9%	30.7%	7.8%	2.9%
Anthem BCBS Southeast	13.2%	40.8%	34.9%	10.0%	1.2%
Arise Health Plan	15.7%	44.3%	32.4%	7.7%	0.0%
Dean Health Plan	16.3%	41.5%	33.4%	8.3%	0.5%
GHC Eau Claire	16.6%	47.6%	31.3%	4.3%	0.3%
GHC-SCW	21.6%	50.8%	22.1%	5.2%	0.3%
Gundersen Lutheran	14.6%	44.6%	32.8%	7.1%	0.9%
Health Tradition	15.4%	51.0%	29.4%	3.9%	0.3%
Humana Eastern	13.3%	47.3%	28.0%	10.5%	0.8%
Humana Western	15.9%	47.0%	29.9%	6.7%	0.6%
Medical Associates	19.7%	43.3%	29.1%	6.9%	1.0%
MercyCare Health Plan	14.0%	45.2%	33.2%	6.8%	0.8%
Network Health Plan	10.6%	47.3%	31.7%	9.8%	0.6%
Physicians Plus	16.7%	46.9%	29.4%	5.8%	1.1%
Standard Plan	13.6%	36.9%	33.0%	13.3%	3.2%
State Maintenance Plan	12.3%	46.2%	36.2%	4.6%	0.8%
UnitedHealthCare NE	13.1%	46.0%	32.0%	7.2%	1.7%
UnitedHealthCare SE	16.4%	46.1%	28.1%	8.6%	0.8%
Unity Community	13.0%	44.4%	35.2%	6.9%	0.5%
Unity UW Health	22.4%	44.2%	27.4%	4.7%	1.3%
WPS Patient Choice	13.2%	47.1%	29.8%	9.1%	0.8%

Respondent's Education Level

This chart shows:

- The percentage of people who responded "8th grade or less", "some high school but did not graduate", "high school graduate or GED", "some college or 2-year degree", "4-year college graduate", or "more than 4-year college degree" to the question, "What is the highest grade or level of school that you have completed?"

Due to rounding, total percentages may not add up to exactly 100 percent.

Health Plan Name	8 th grade or less	Some high school	High school graduate or GED	Some college or 2-year degree	4-year college graduate	More than 4-year college degree
Average—All Health Plans	0.2%	0.5%	13.0%	25.6%	21.3%	39.5%
Anthem BCBS Northwest	0.0%	0.0%	20.4%	22.8%	18.0%	38.8%
Anthem BCBS Southeast	0.0%	0.0%	10.6%	24.9%	26.7%	37.8%
Arise Health Plan	0.4%	0.4%	14.1%	22.5%	25.0%	37.7%
Dean Health Plan	0.3%	0.5%	16.8%	32.9%	21.2%	28.2%
GHC Eau Claire	0.0%	0.3%	16.2%	32.4%	19.2%	31.9%
GHC-SCW	0.0%	0.0%	5.5%	14.2%	18.0%	62.3%
Gundersen Lutheran	0.0%	1.2%	15.9%	28.7%	17.8%	36.4%
Health Tradition	0.0%	0.7%	15.7%	27.8%	21.6%	34.3%
Humana Eastern	0.0%	0.3%	5.4%	24.7%	29.5%	40.1%
Humana Western	0.6%	0.3%	8.0%	20.6%	18.8%	51.7%
Medical Associates	0.5%	0.5%	22.0%	23.5%	13.0%	40.5%
MercyCare Health Plan	0.0%	0.4%	14.0%	36.0%	23.2%	26.4%
Network Health Plan	0.0%	0.8%	17.2%	35.2%	18.6%	28.2%
Physicians Plus	0.0%	0.5%	14.6%	25.2%	21.5%	38.2%
Standard Plan	2.2%	0.7%	15.9%	15.9%	13.2%	52.1%
State Maintenance Plan	0.0%	0.0%	11.5%	20.0%	30.8%	37.7%
UnitedHealthCare NE	0.3%	0.8%	14.6%	29.4%	26.1%	28.9%
UnitedHealthCare SE	0.0%	0.0%	7.9%	15.0%	33.1%	44.1%
Unity Community	0.0%	0.9%	13.9%	36.1%	20.8%	28.2%
Unity UW Health	0.0%	0.3%	6.9%	22.8%	19.3%	50.8%
WPS Patient Choice	0.0%	0.0%	1.7%	14.0%	24.0%	60.3%

Where To Get More Information

If you have questions about Dual-Choice or any coverage issue, this section directs you to the most appropriate source of information. These include:

- Who to contact for answers to the questions you have.
- The Department of Employee Trust Funds' (ETF's) address, telephone number, fax number and web site address.
- A menu of health insurance messages offered through the ETF Telephone Message Center.
- Locations and dates of Dual-Choice Health Fairs.
- Information on other health-related benefit programs offered, such as the Employee Reimbursement Account (ERA) and the Group Life Insurance programs.

WHO TO CONTACT REGARDING HEALTH INSURANCE

If you need additional information regarding:

Benefits
Exclusions
Limitations
Participating Providers



Contact the plan or Pharmacy Benefit Manager (PBM) directly. Addresses, web sites, and telephone numbers are listed on the inside back cover.

- When using health plan web sites for benefit and provider data, ensure that you are accessing State of Wisconsin program specific information. If you are not sure, call the plan.

Applications
Eligibility
Enrollment
General Information



If you are an annuitant or are on continuation coverage, contact:

Employee Trust Funds
P. O. Box 7931
Madison, WI 53707-7931
1-877-533-5020 (toll free)
(608) 266-3285 (local Madison)

Fax (608) 267-4549

- All changes in your subscriber information, family status, or providers must be made through the Department of Employee Trust Funds, and submitted on approved forms.
- Additional information is available on ETF's web site at etf.wi.gov.
- Comments and suggestions regarding the *It's Your Choice* booklet should be directed to the Program Manager – Health Plans, Division of Insurance Services.

INFORMATION ABOUT OTHER HEALTH-RELATED BENEFIT PROGRAMS

In addition to the State of Wisconsin Group Health Insurance Program, other health-related benefit programs are available to employees. This provides general information regarding these programs and directs you to the appropriate source to obtain additional information.

Employee Reimbursement Accounts Program (ERA)

The Employee Reimbursement Accounts (ERA) Program is an optional benefit that allows active employees to earmark a part of their pre-tax gross salary to pay for certain IRS-approved expenses. Fringe Benefits Management Company (FBMC) administers the program. Employees may enroll in the Medical Expense and/or Dependent Care Reimbursement Accounts during an open enrollment period held each October. Contributions are made on a pre-tax basis to individual accounts established by participants. Eligible dependent day care and/or medical expenses are reimbursed as expenses are incurred. The Medical Expense Reimbursement Account covers most out-of-pocket medical expenses not reimbursable by any insurance coverage (e.g., co-pays, deductibles, glasses, etc.). The Dependent Care Expense Reimbursement Account reimburses employees for dependent care expenses that allow the employee and spouse to work.

The annual enrollment period for 2008 is October 8 – November 16, 2007. Watch for your annual ERA enrollment booklet prior to open enrollment to find out more about enrolling in the ERA program. If you have questions about the ERA program, call FBMC Customer Service Department at 1-800-342-8017.

Group Life Insurance

Minnesota Life Insurance Company (MLIC) administers the Group Life Insurance program. Active employees may elect up to five times their annual earnings in group term life insurance coverage, and may elect coverage for their dependents. Retirees who have life insurance through this program and have reached age 66 may be eligible to convert the present value of the life insurance to pay health insurance premiums.

Questions regarding life insurance coverage should be directed to ETF, toll free 1-877-533-5020 or 266-3285 (local Madison).

Medicare

For information on **Medicare** benefits and how to enroll, contact your local Social Security Administration office or call **1-800-772-1213**.

You, and your dependents that are eligible for Medicare, must enroll for the hospital (Part A) and medical (Part B) portions of Medicare at the time of your retirement. Enrollment in the prescription drug portion (Part D) is voluntary. Upon enrollment in Medicare parts A & B, your coverage will be transferred to a health plan integrated with Medicare and your monthly premium will be reduced when you or a dependent becomes covered by Medicare.

You and your dependents are not required to enroll in Medicare until you, the subscriber, terminates employment or health insurance coverage as an active employee ceases.

Additional information about Medicare can be found in the *Common Questions & Answers* section of the "Annuitant/Continuant It's Your Choice" book (ET-2108, Section C). A copy of this book is available online at <http://etf.wi.gov/> or by calling the Department of Employee Trust Funds as 1-877-533-5020 (toll-free).

Employee Trust Funds

Telephone Message Center

**For Recorded Messages Call 1-800-991-5540
or 264-6633 (Local Madison)**

General Introduction to the Telephone Message Center

The Department of Employee Trust Funds offers a toll-free Telephone Message Center, to provide answers to the questions that participants ask most. The message center has recorded messages which provide detailed information on the various benefits available from the Wisconsin Retirement System (WRS), information about health, life and income continuation insurance, plus information that applies to persons who are receiving a monthly benefit from the WRS.

You can use the Telephone Message Center if you have a touch-tone phone; the system cannot be accessed with a rotary phone. To reach the message center, dial 1-800-991-5540, or if you are calling from the Madison area dial 264-6633. Once you reach the message center, you will be given menu options to follow. You can hang up at any time and the system will automatically disconnect. Messages are 30 seconds to two minutes in length.

The following is a list of the health insurance messages that are available by pressing the associated number on your telephone key pad. You can press the 5-digit message number that follows the topic to access a specific message.

- 1 - Listen to messages
 - 8 - Insurance Benefits (10800)
 - 1 Health Insurance for Non-Annuitants (10805)
 - 2 - Health Insurance for Annuitants (10820)
 - 1 - State Employees Sick Leave Credits to Pay for Health Insurance Premiums (10821)
 - 2 - Age-65 Medicare Coverage (10822)
 - 3 - Annual Dual-Choice Enrollment Period and Changes in Family Status (10823)
 - 4 - Dual-Choice Health Fair Locations (10812)

Dual-Choice Health Fairs - Fall 2007

Representatives from the area health plans will be available during the 2007 Dual-Choice Enrollment Period at the following locations to answer your questions. At other times of the year, contact the plans directly for information.

¹ Health Fairs where representatives from ETF anticipate being available to answer questions. Please contact the payroll representative hosting the health fair to learn the times ETF will be available.

² The Pharmacy Benefit Manager (PBM) anticipates being available to answer questions at these health fairs.

City	Date	Time	Location
Eau Claire	October 10 Wednesday	9:00 a.m. – 12:00 p.m.	Dept. of Transportation 718 W. Clairemont Ave. Chippewa Valley Conference Room
Eau Claire	October 15 Monday	11:00 a.m. – 2:00 p.m.	UW – Eau Claire 105 Garfield Davies Center – Council Fire Room
Green Bay ²	October 17 Wednesday	11:00 a.m. – 3:00 p.m.	UW – Green Bay 2420 Nicolet Dr. Phoenix Rooms A & B
Green Bay	October 17 Wednesday	8:00 a.m. – 12:00 p.m.	Dept of Transportation 944 Vanderperren Way Lake Michigan/Green Bay conference rooms
Kenosha	October 11 Thursday	10:00 a.m. – 2:00 p.m.	UW – Parkside 900 Wood Rd., Campus Willey Upper Main Place
King ^{1,2}	October 16 Tuesday	10:00 a.m. – 2:00 p.m.	WI Veterans Home N2665 Cty QQ Marden Memorial Center, Multi-Purpose Room
La Crosse	October 18 Thursday	10:00 a.m. – 4:00 p.m.	UW-LaCrosse, Cartwright Center 1725 State St. Valhalla Hall (adjacent to Main Hall)
Madison	October 8 Monday	10:00 a.m. – 2:00 p.m.	Dept. of Corrections 3099 E. Washington Ave. Central Office - Kansas Room
Madison	October 9 Tuesday	10:00 a.m. – 2:00 p.m.	Dept. of Justice, Risser Justice Center/ DOA/H&FS/DNR/DPI/DWD/Commerce 17 W. Main St. Room 150A (use MLK Blvd. Entrance)
Madison ^{1,2}	October 11 Thursday	9:00 a.m. – 3:00 p.m.	UW-Madison, Memorial Union 800 Langdon St. Great Hall
Madison	October 17 Wednesday	10:00 a.m. – 2:00 p.m.	Dept. of Health & Family Services/ DOA/DNR/DPI/DWD/DOJ/Commerce 1 W. Wilson Street Room 751 (use middle stairway entrance)
Madison	October 18 Thursday	11:00 a.m. – 1:00 p.m.	Dept. of Agriculture, Trade & Consumer Protection 2811 Agriculture Dr., Room 172 Lobby of Prairie Oaks Bldg.
Madison ¹	October 18 Thursday	9:00 a.m. – 2:00 p.m.	Dept. of Transportation Hill Farms State Office Bldg. 4802 Sheboygan Ave., Room 421

City	Date	Time	Location
Menomonie	October 16 Tuesday	11:00 a.m. – 2:00 p.m.	UW – Stout 302 10th Ave. Memorial Student Center – Ball Room BC
Milwaukee ²	October 9 Tuesday	10:00 a.m. – 3:30 p.m.	UW – Milwaukee Student Union 2200 E Kenwood Blvd. Wisconsin Room
Milwaukee	October 10 Wednesday	10:00 a.m. – 1:00 p.m.	Dept. of Natural Resources 2300 North Martin Luther King Jr. Dr Room 140 & 141
Milwaukee	October 16 Tuesday	10:00 a.m. – 1:00 p.m.	Dept. of Administration Milwaukee State Office Bldg. 819 N. 6 th Street Room 40
Oshkosh ¹	October 17 Wednesday	1:00 p.m. – 3:30 p.m.	UW – Oshkosh 748 Algoma Blvd. Reeve Memorial Union Ballroom- 227 ABC
Platteville	October 10 Wednesday	12:00 p.m. – 4:00 p.m.	UW – Platteville University Plaza Pioneer Center – Pioneer Rooms
Rhineland	October 18 Thursday	9:00 a.m. – 2:00 p.m.	Dept. of Transportation 510 N. Hanson Lake Rd. Oneida Room
River Falls	October 17 Wednesday	10:00 a.m. – 2:00 p.m.	UW-River Falls University Center St. Croix River Room (321)
Stevens Point	October 16 Tuesday	10:30 a.m. – 4:00 p.m.	UW-Stevens Point Old Main Founders Room
Superior	October 11 Thursday	9:00 a.m. – 12:00 p.m.	Dept. of Transportation 1701 N. 4 th Street Lake Superior Conference Room
Waukesha	October 10 Wednesday	8:00 a.m. – 12:00 p.m.	Dept. of Transportation 141 NW Barstow St. Room 151
Waukesha	October 16 Tuesday	10:30 a.m. – 3:00 p.m.	UW – Waukesha 1500 N University Dr. Student Lounge
Whitewater	October 10 Wednesday	10:00 a.m. – 2:00 p.m.	UW – Whitewater 800 W Main St. Roseman Gym
Wisconsin Rapids	October 16 Tuesday	9:00 a.m. – 2:00 p.m.	Dept. of Transportation 1681 2 nd Ave South Room 124

IMPORTANT: There may be Dual-Choice Health Fairs or meetings scheduled that are not listed here. If none are listed in your area, contact your payroll/personnel office. If no fair or meeting is scheduled, you should contact the individual health plans for specific information.

Educational Teleconference: There will be no teleconference this year.

Plan Descriptions: Plans With Uniform Benefits

This section includes information provided by each health plan to help you in selecting your plan for the coming year. Although health plans administer Uniform Benefits, they differ in other ways. The categories on the following pages describe some of the differences between the health plans.

Health plans may provide you with additional information through mailings during Dual-Choice and member information in mailings throughout the year. Contact the health plan for more information.

Health Care Quality and Safety Information

The quality and safety of health care services is important to us. We are involved in a number of state and national initiatives focused on reducing medical errors and saving lives through voluntary public reporting. In the following pages, the quality and safety efforts of hospitals and provider groups affiliated with our health plans are displayed for your review. This information may be useful as you make important health care decisions for you and your family.

Hospital Quality and Safety



A FROG symbol is awarded to a hospital who has recently submitted data to the Leapfrog Hospital Survey. The Leapfrog Group measures progress of hospitals nation-wide on four quality and safety “leaps”. The first three leaps, when fully implemented by urban hospitals, are projected to avoid 65,000 unnecessary deaths and 907,000 medical errors annually.

S A “S” or SAFETY symbol is awarded to a hospital who has achieved a full pie-or full implementation-on Leapfrog’s fourth “leap”. The fourth leap is focused on patient safety measures, which have been endorsed by the National Quality Forum (NQF), and applies to both urban and rural hospital care. When you visit the Leapfrog website and click on the pie for this fourth measure, you are able to see the progress of that hospital for each of the individual 27 NQF safety measures.

A “S” or SAFETY symbol is also awarded to a hospital that has received Joint Commission accreditation. The Joint Commission is a non-profit organization formed in 1951 with a mission to maintain and elevate the standards of health care delivery, including patient safety. Healthcare organizations are accredited when they are compliant with all applicable evaluation standards.

✓ A CHECKMARK is awarded to a hospital that has provided data to CheckPoint to facilitate reporting on error prevention measures (less Medication Reconciliation measure) and 3 out of 4 best practice measure sets for heart attack, heart failure, pneumonia and surgical infection prevention.

R_x A Rx symbol is awarded to a hospital that is at or above the state average for the CheckPoint error prevention measure, Medication Reconciliation, in addition to meeting the criteria for a CHECKMARK. The Medication Reconciliation measure indicates the hospital’s progress toward identifying the most complete and accurate list of medications a patient is taking when admitted to the hospital and using that list to provide correct medications for the patient anywhere within the health care system.

Physician Group Quality and Safety



The Wisconsin Collaborative for Healthcare Quality (WCHQ) compares the performance of health care providers on more than 22 clinical intervention, such as diabetes management and heart care. Provider groups, with fifty or more providers, are awarded a WCHQ symbol for their participation in WCHQ measurement and reporting initiatives.

Web Resources for Quality and Safety Information

Please see Section C, questions 33-37, for further information on the websites and data used in this publication:

www.leapfroggroup.org

www.checkpoint.org

www.jointcommission.org

www.wchq.org

The following websites may provide useful and valuable information on additional quality and safety resources:

www.wisconsinhealthreports.org

www.medlineplus.gov

PLANS OFFERING ROUTINE DENTAL CARE

The Uniform Benefits package provides health insurance coverage to eligible employees, annuitants, and dependents. *The Uniform Benefits package does not include coverage for routine dental care.* The Group Insurance Board permits participating health plans the option to offer dental coverage to its members. The plans listed below have elected to provide some level of dental benefits. The benefits vary from plan to plan. There are no requirements regarding the minimum levels of coverage offered.

Please refer to Plan Description pages found in this Section for a more detailed explanation of dental benefits offered by the health plan you are interested in. Contact the plan directly if you have specific questions regarding the dental coverage or dental providers.

Remember that there will be restrictions on dental providers that you may use, just as there are restrictions on providers you may access for medical care under the plan you select. It is possible that the plan does not have a participating dentist in your county. In that case, the plan will not be "qualified" in that county and you may have to travel to see a plan dentist.

In 2008, all alternate plans (except SMP) are offering dental coverage. They are:

- Anthem BCBS (formerly CompCareBlue)
- Arise Health Plan (formerly WPS Prevea)
- Dean Health Plan
- GHC Eau Claire
- GHC – SCW
- Gundersen Lutheran Health Plan
- Health Tradition
- Humana
- Medical Associates
- MercyCare Health Plan
- Network Health Plan
- Physicians Plus – Meriter & UW
- Security Health Plan
- UnitedHealthcare
- Unity Health Insurance
- WPS Patient Choice Plan 1
- WPS Patient Choice Plan 2

2008 Health Plan Features Comparison

HEALTH PLAN	Tier	24-Hour Nurse Line*	Referral, certification or authorization needed for outpatient mental health or out-patient alcohol and other drug abuse from a plan provider*	Does the Plan have an Electronic Diabetes Registry that is used to send reminders to people with diabetes*	Tobacco Cessation Incentives and/or Counseling*	Offers Dental Benefit	ETF Specific Information Available on Plan Website*	Does the health plan or the health plan's major provider groups allow members access to their medical and insurance information online?
Anthem BCBS Northwest	2	YES*	NO*	YES*	YES*	YES	YES*	SOME*
Anthem BCBS Southeast	1	YES*	NO*	YES*	YES*	YES	YES*	SOME*
Arise Health Plan	1	NO*	NO*	YES*	YES*	YES	YES*	YES*
Dean Health Plan	1	YES*	NO*	YES*	NO*	YES	YES*	YES*
GHC Eau Claire	1	YES*	NO*	YES*	NO*	YES	YES*	YES*
GHC-SCW	1	NO*	NO*	YES*	YES*	YES	YES*	YES*
Gundersen Lutheran	1	YES*	NO*	YES*	YES*	YES	NO*	SOME*
Health Tradition	1	YES*	NO*	NO*	YES*	YES	NO*	SOME*
Humana Eastern	1	YES*	YES*	YES*	YES*	YES	YES*	SOME*
Humana Western	1	YES*	YES*	YES*	YES*	YES	YES*	SOME*
Medical Associates	1	YES*	NO*	YES*	YES*	YES	YES*	SOME*
MercyCare Health Plan	1	YES*	NO*	YES*	YES*	YES	NO*	NO*
Network Health Plan	1	YES*	NO*	YES*	YES*	YES	YES*	SOME*
Physicians Plus – Meriter & UW	1	YES*	YES*	YES*	YES*	YES	YES*	SOME*
Security Health Plan	1	YES*	NO*	YES*	YES*	YES	YES*	SOME*
UnitedHealthcare NE	1	YES*	YES*	NO*	NO*	YES	NO*	SOME*
UnitedHealthcare SE	1	YES*	YES*	NO*	NO*	YES	NO*	SOME*
Unity Community	1	NO*	YES*	YES*	YES*	YES	YES*	SOME*
Unity UW Health	1	NO*	YES*	YES*	YES*	YES	YES*	SOME*
WPS Patient Choice Plan 1	1	NO*	NO*	YES*	NO*	YES	YES*	SOME*
WPS Patient Choice Plan 2	2	NO*	NO*	YES*	NO*	YES	YES*	SOME*

*The response to this question was self-reported by each individual health plan.

Health Plan Features Descriptions

<p>Tier <i>Health plans are placed into employee contribution tiers based on how efficiently they provide care to their population relative to the premium cost. The most efficient health plans are placed into tier 1 while health plans that are less efficient are placed into tier 2. Tiers are also used to determine placement of the State Maintenance Plan (SMP) throughout the state. SMP is a health plan option for subscribers who reside in a county that does not have a qualified tier-1 health plan.</i></p>
<p>24-Hour Nurse Line available to members? <i>A help line that is staffed by a registered nurse 24-hours a day to provide members with information and assessment of emerging medical needs. (Not an “on call” answering service). Please see the inside back cover of this booklet for the 24-nurse line phone numbers for each health plan that makes this feature available to their members.</i></p>
<p>Referral needed for mental health services and Alcohol and Other Drug Abuse (AODA) services? <i>A referral, certification or authorization is required prior to obtaining OUTPATIENT mental health services or prior to obtaining OUTPATIENT AODA services from a plan provider.</i></p>
<p>Does the Plan have an Electronic Diabetes Registry that is used it to send screening reminders to people with Diabetes? <i>In order to receive a “YES”, health plans must have a software/computer based diabetes registry (a database) that at minimum, tracks name, contact information, last visit and physician. The registry should be used by the health plan to alert patients and their physicians about needed tests and clinical visits. Plans must send screening notices (by mail, email or phone) to all patients with diabetes at least twice a year. For more information on how successful each health plan has been in providing care to their members with diabetes, please see pages E-41 and E-42 of the Health Plan Report Cards in this booklet.</i></p>
<p>Tobacco Cessation Incentives and/or Counseling <i>In order to receive a “YES”, health plans must offer a financial incentive such as a class discount or a covered counseling benefit such as Quit line.</i></p>
<p>Offers Dental Benefit? <i>Dental benefits can include preventive services, restorative services, orthodontic services, and oral surgery. Covered benefits, deductibles and co-insurance vary from health plan to health plan. Members who place a high value on dental services should check covered benefits and provider availability carefully before making a health plan selection.</i></p>
<p>ETF Specific Information Available on Health Plan Website? <i>Health plans may have information such as covered benefits or providers listings that that is specific to state and local employees, continuants, and retirees on the health plan website. In order to receive a “YES”, the health plan must at minimum have provider listing on its website that is easy to identify and access.</i></p>
<p>Does the health plan or the health plan’s major provider groups allow members access to their medical and insurance information online? <i>In order to receive a “YES”, the majority of a health plan’s members must be offered the opportunity to log on to a secure Web site with 24 hours a day access to at least 5 of the 8 features listed below:</i></p> <ul style="list-style-type: none"> • view electronic health records such as immunizations and drug prescriptions • health insurance information • request and view appointments • access results to preventive tests such as cholesterol screenings • communicate with member services through a message center • communicate with providers through a message center • update member contact information • access online health tools such as Health Risk Assessments <p><i>Health plans receive a “SOME” designation if online access is available but with less than 5 features listed above OR if access is not available to a large number of members. Participants should check with health plans and provider groups for details on what information is available to members online. A member may be able to access comprehensive online access in a health plan with a “SOME” designation, depending on the provider that the member selects.</i></p>

COMPARISON OF STATE PLAN TYPES FOR 2008

The Chart below is designed to help you compare between Uniform Benefits and the Standard Plan.

- Both programs listed below are substantially equivalent in the value of their benefits.
- Health Plan administration can vary and in places any one plan may contain a benefit that is better than that of a different plan (such as dental or wellness programs).
- Although plans offering Uniform Benefits may appear in either tier 1, 2 or 3, plans in tier 1 have the most cost effective contracts with their providers. Plans with less cost effective contracts fall into other tiers.
- SMP, which offers Uniform Benefits, is designated as a tier 1 plan in counties where no qualified tier 1 plan is available.

This outline is not intended to be a complete description of coverage. For details, see specific language in Uniform Benefits section D and the Standard Plan booklet (ET-2112). Wherever percentage of payment is listed, it means percent of charges. Out-of-network charges may be subject to Usual, Customary and Reasonable (UCR) determination. All services subject to medical necessity.

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN	
		In Network	Out of Network
Annual Deductible ¹ (ded)	No deductible	\$100 individual / \$200 family	\$500 individual / \$1,000 family
Annual Co-insurance ² (coins)	As described below	None	80% / 20% <i>Annual OOP maximum (includes deductible):</i> \$2,000 individual / \$4,000 family
Lifetime Maximum	\$2 Million	\$2 Million	\$2 Million
Hospital Days	As medically necessary, plan providers only. No day limit	365 per admission	365 per admission
Emergency Room	\$60 copay per visit	100%, no copay	100%, no copay
Ambulance Service	100%	100%	100%
Transplants <i>(May cover these and others listed)</i>	Lifetime benefit of \$1,000,000 <i>Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung</i>	100% <i>Bone marrow, parathyroid, musculoskeletal, corneal, and kidney</i>	80% <i>Bone marrow, parathyroid, musculoskeletal, corneal, and kidney</i>
Mental Health ³	Inpatient 30 days Outpatient 100% Transitional 100%	Inpatient 120 days Outpatient 90% Transitional 90%	Inpatient 120 days Outpatient 90% Transitional 90%
Alcohol, & Drug Abuse ³	Inpatient 100% to \$6,300 Outpatient 100% to \$1,800 Transitional 100% to \$2,700	Inpatient 90% to \$6,300 Outpatient 90% to \$1,800 Transitional 90% to \$2,700	Inpatient 90% to \$6,300 Outpatient 90% to \$1,800 Transitional 90% to \$2,700
Hearing Exam	100%	Benefit for illness or disease, 100%	Benefit for illness or disease, 80%

coins = Coinsurance; ded = deductible; OOP = out-of-pocket

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN	
		In Network	Out of Network
Hearing Aid	80% up to \$1,000 per ear, every 3 years	No benefit	No benefit
Routine Vision Exam	One per year	No benefit for routine	No benefit for routine
Skilled Nursing Facility <i>(non custodial care)</i>	120 days per benefit period	100% for 730 days per admission less hospital days used	80% for 730 days per admission less hospital days used
Home Health <i>(non custodial care)</i>	50 per year; Plan may approve an additional 50	100% for 365 days less hospital days used	80% for 365 days less hospital days used
Physical / Speech / Occupational Therapy	50 per year; Plan may approve an additional 50	100%, no limit on visits or days	80%, no limit on visits or days
Durable Medical Equipment	20% co-insurance, \$500 OOP maximum	100%	80%
Hospital Pre-Certification	Varies by plan	Value Care for inpatient stays. Voluntary 2 nd surgical opinion	Value Care for inpatient stays. Voluntary 2 nd surgical opinion
Referrals	In-network varies by plan. Out-of-network required.	Not required	Not required
Primary Care Provider	Varies by plan	Not required	Not required
Treatment for Morbid Obesity	Excluded	100% at Center of Excellence in-network provider	80%
Oral Surgery	11 procedures	23 procedures. 100%	23 procedures. 80%
Dental Care	Varies by plan	No benefit	No benefit
Prescription Out-of-Pocket Maximum ⁴	\$350 individual / \$700 family	\$1,000 individual / \$2,000 family	\$1,000 individual / \$2,000 family

¹ Deductible applies to all services except mental health. Note that Preferred Provider Plans who offer Uniform Benefits have separate out-of-network deductibles.

² Coinsurance applies to all services up to the listed out-of-pocket maximum, then 100%. Note that Preferred Provider Plans who offer Uniform Benefits have separate out-of-network coinsurance percentages and amounts.

³ Any benefits paid for mental health during the year will be applied toward the alcohol and drug abuse maximums.

⁴ Separate from other out-of-pocket maximums, such as the medical

coins = Coinsurance; **ded** = deductible; **OOP** = out-of-pocket



BLUE PREFERRED NORTHWEST NETWORK

PO Box 34210
 Louisville, KY 40232-4210
 Phone: 1-800-490-6201
www.anthem.com

During the Dual Choice Enrollment period, please call (800) 490-6201

Type of Plan	Health Maintenance Organization
Total Number of Members	6,567
Years of Operating Experience.....	23
Total Number of Primary Care Physicians (PCPs)	235
Total Number of Hospitals Affiliated with Plan	20
Total Number of Urgent Care Facilities.....	3
Total Number of Dentists	77

ADDITIONAL INFORMATION

PCP Requirements	A primary care physician (or PCP) includes general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, and geriatricians. Blue Preferred members are not required to select a PCP and Anthem Blue Cross and Blue Shield will not auto-assign one. However, a PCP is the physician who customarily provides, coordinates, and arranges your health care services and we encourage members to select and establish a relationship with their PCP. Each member of a family may select a different PCP. If you want to change your PCP, contact customer service or refer to our website, www.anthem.com .
Referral Requirements	You do not need a referral from your primary care physician (PCP) to see any of the in-network specialists who are part of the Northwest Network. You need a written referral from your PCP and authorization from Anthem Blue Cross and Blue Shield to obtain services from a specialist who is not participating in the Northwest Network. Anthem Blue Cross and Blue Shield will provide a written response to the referral request to you and your PCP.
Prior Authorization Requirements	Certain healthcare procedures require pre-authorization as initiated by your PCP or specialist. Pre-certification is required for non-emergency hospital stays. Contact Anthem Blue Cross and Blue Shield for more information about procedures that require pre-certification by calling the number on the back of your I.D. card. Anthem Blue Cross and Blue Shield will provide a written response to you and your provider.
Online Provider Directory	To access the State of Wisconsin Blue Preferred Northwest provider directory: <ol style="list-style-type: none"> 1. Go to www.anthem.com 2. Click on "Find a Doctor". 3. Under "State/Directory Selection" select Wisconsin and click "Next". 4. Under the "Plan Information" pull-down menu, select Blue Preferred HMO Northwest – State of Wisconsin. 5. Select the Provider Type and Specialty, Then click "Next". 6. Search for providers near a location or download the entire provider directory.
Other Online Services	Our web site is a valuable resource for both information and services. Go to www.anthem.com , you can: <ul style="list-style-type: none"> ▪ Once you are a member, you can access secure online member information at MyAnthem. Find a doctor or hospital, check the status of a claim, order a new ID card or print a temporary ID card, change your address, change your primary care physician, view your benefits, learn about which services need prior approval, and much more. ▪ Access health and wellness resources at MyAnthem including WebMD and Submio health care support tools. Receive discounts on health and wellness products at SpecialOffers@Anthem. Access preventative care guidelines and recommendations, including immunizations and health screening schedules..
Outpatient Mental Health Network/Policy	You do not need a referral to see a Northwest Network mental health provider. Pre-certification is only required for inpatient hospital stays.

ADDITIONAL INFORMATION

Dental Benefits If Provided

Dental benefits provided through your health plan are: 100% coverage for comprehensive and periodic exams, diagnostic x-rays and preventative cleanings (as dentally necessary) with no more than one of each in a six month period; and fluoride treatments for children to age 12. Orthodontia is not covered; however, where available, child and adult members receive a 20% discount off participating orthodontists' usual fees, to a maximum discount of \$1,250 per person. Where available, specific dental offices may offer a 20% discount on amalgam fillings. Please refer to the Dental Directory listing for a participating dental provider. All family members must utilize the same dental clinic. Members must select a dental clinic or one will be auto-assigned. Dental Directories will be provided during the Dual Choice Health Fairs or by calling Customer Service. Member will not receive a separate dental card.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Ashland		•	•		Memorial Medical Center		Ashland Clinic Chequamegon Clinic
Barron		•	•	•	Cumberland Memorial Hospital Lakeview Medical Center		Northland Mayo Health System
Burnett					Burnett Medical Center		
Chippewa	•	•	•		St. Joseph's Hospital – Chippewa Falls Our Lady of Victory		Ministry
Douglas			•	•	St. Mary's of Superior		SMDC Mariner Medical Clinic St. Mary's Hospital of Superior
Dunn					N/A		
Eau Claire	•	•	•	•	Sacred Heart Hospital – Eau Claire Oak Leaf Surgical Hospital		Chippewa Valley Emergency Care Chippewa Valley Eye Clinic Marshfield Clinic-Oakwood Center • Marshfield Clinic-Riverview Center • UW Health-Eau Claire Family Medicine • Clinic
Pepin					Chippewa Valley Hospital		Chippewa Valley Hospital Urgent Care/Emergency
Pierce	•		•		River Falls Area Hospital		St. Croix Orthopaedics
Polk					Ladd Memorial Hospital (Osceola Medical Center)		Amery Regional Medical Center Frederic Regional Medical Clinic Osceola Medical Center
Sawyer	•	•			St. Croix Regional Medical Center Amery Regional Medical Center Hayward Area Memorial		St. Croix Orthopaedics Hayward Clinic
St. Croix	•	•	•		Hudson Hospital		Baldwin Area Medical Center
	•	•		•	Westfields Hospital Baldwin Area Medical Center		Hudson Hospital Hudson Hospital-Hudson Specialty Clinic Hudson Physicians Inc. New Richmond Clinic SC River Falls Medical Clinic Ltd. Somerset Clinic St. Croix Orthopaedics
Washburn			•	•	Spooner Health System Indianhead Medical Center, Inc.		Spooner Clinic

* This column provides only a general summary of major provider groups. For a complete listing, please call the Blue Preferred Northwest Network Customer Service Department at 1-800-490-6201 or visit our web site www.anthem.com.



BLUE PREFERRED SOUTHEAST NETWORK

PO Box 34210
 Louisville, KY 40232-4210
 Phone: 1-800-490-6201
 www.anthem.com

During the Dual Choice Enrollment period, please call (800) 490-6201

Type of Plan	Health Maintenance Organization
Total Number of Members	76,071
Years of Operating Experience	23
Total Number of Primary Care Physicians (PCPs)	1,355
Total Number of Hospitals Affiliated with Plan	33
Total Number of Urgent Care Facilities	37
Total Number of Dentists	42

ADDITIONAL INFORMATION

PCP Requirements A primary care physician (or PCP) includes general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, and geriatricians. Blue Preferred members are not required to select a PCP and Anthem Blue Cross and Blue Shield will not auto-assign one. However, a PCP is the physician who customarily provides, coordinates, and arranges your health care services and we encourage members to select and establish a relationship with their PCP. Each member of a family may select a different PCP. If you want to change your PCP, contact customer service or refer to our website, www.anthem.com.

Referral Requirements You do not need a referral from your primary care physician (PCP) to see any of the in-network specialists who are part of the Southeast Network. You need a written referral from your PCP and authorization from Anthem Blue Cross and Blue Shield to obtain services from a specialist who is not participating in the Southeast Network. Anthem Blue Cross and Blue Shield will provide a written response to the referral request to you and your PCP. Although you do not need a referral to see in-network Southeast specialists, in some circumstances you must use specific or designated specialists associated with your PCP. Please refer to your provider directory for more information.

Prior Authorization Requirements Certain healthcare procedures require pre-authorization as initiated by your PCP or specialist. Pre-certification is required for non-emergency hospital stays. Contact Anthem Blue Cross and Blue Shield for more information about procedures that require pre-certification by calling the phone number on the back of your I.D. card. Anthem Blue Cross and Blue Shield will provide a written response to you and your provider.

Online Provider Directory To access the State of Wisconsin Blue Preferred Southeast provider directories:

1. Go to www.anthem.com
2. Click on "Find a Doctor".
3. Under "State/Directory Selection" select Wisconsin and click "Next".
4. Under the "Plan Information" pull-down menu, select Blue Preferred HMO Southeast – State of Wisconsin.
5. Select the Provider Type and Specialty, Then click "Next".
6. Search for providers near a location or download the entire provider directory.

Other Online Services Our web site is a valuable resource for both information and services. Go to www.anthem.com, you can:

- Once you are a member, you can access secure online member information at **MyAnthem**. Find a doctor or hospital, check the status of a claim, order a new ID card or print a temporary ID card, change your address, change your primary care physician, view your benefits, learn about which services need prior approval, and much more.
- Access health and wellness resources at **MyAnthem** including WebMD and Submio health care support tools. Receive discounts on health and wellness products at SpecialOffers@Anthem. Access preventative care guidelines and recommendations, including immunizations and health screening schedules..

ADDITIONAL INFORMATION

Outpatient Mental Health Network/Policy You do not need a referral to see a Southeast Network mental health provider. Pre-certification is only required for inpatient hospital stays.

Dental Benefits If Provided Dental benefits provided through your health plan are: 100% coverage for comprehensive and periodic exams, diagnostic x-rays and preventative cleanings (as dentally necessary) with no more than one of each in a six month period; and fluoride treatments for children to age 12. Orthodontia is not covered; however, where available, child and adult members receive a 20% discount off participating orthodontists' usual fees, to a maximum discount of \$1,250 per person. Where available, specific dental offices may offer a 20% discount on amalgam fillings. Please refer to the Dental Directory listing for a participating dental provider. All family members must utilize the same dental clinic. Members must select a dental clinic or one will be auto-assigned. Dental Directories will be provided during the Dual Choice Health Fairs or by calling Customer Service. Member will not receive a separate dental card.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Kenosha	•	•	•	•	Aurora Medical Center Children's Hospital of Wisconsin United Hospital Kenosha United Hospital Pleasant Prairie	•	Aurora Medical Group Children's Medical Group Kenosha Medical Center Clinic
Milwaukee	•	•	•	•	Aurora Sinai Medical Center Aurora St. Luke's Medical Center Children's Hospital of Wisconsin Columbia Center Columbia St. Mary's Hospital Columbia Columbia St. Mary's Hospital Milwaukee Froedtert Memorial Lutheran Hospital Lifecare Hospital of Milwaukee Orthopaedic Hospital of Wisconsin Select Specialty Hospital Milwaukee Select Specialty Hospital West Allis St. Luke's South Shore The Wisconsin Heart Hospital West Allis Memorial Hospital Wheaton Franciscan Healthcare St. Francis Wheaton Franciscan Healthcare St. Joseph	•	Advanced Healthcare Aurora Medical Group Children's Medical Group Commonwealth Medical Group Covenant Medical Group Columbia St. Mary's Clinics Lakeshore Medical Clinic Medical College of Wisconsin St. Luke's Family Practice Center
Ozaukee	•	•	•	•	Columbia St. Mary's Hospital Ozaukee-Mequon Columbia St. Mary's Hospital Ozaukee-Thiensville	•	Advanced Healthcare Aurora Medical Group Family Practice Associates of Cedarburg
Racine	•	•	•	•	Lakeview Specialty Hospital & Rehab Ctr Memorial Hospital of Burlington Wheaton Franciscan All Saints	•	Wheaton Medical Group AMG Burlington Aurora Health Center
Walworth	•	•	•	•	Aurora Lakeland Medical Center Mercy Walworth Hospital and Medical Center	•	Aurora Health Center
Washington	•	•	•	•	Aurora Medical Center St. Joseph's Hospital	•	Aurora Health Center West Bend Clinic
Waukesha	•	•	•	•	Community Memorial Hospitals Oconomowoc Memorial Hospital Waukesha Memorial Hospital Wheaton Franciscan Healthcare Elmbrook Memorial Hospital	•	Advanced Healthcare Aurora Health Center Medical Associates ProHealth Medical Center Wheaton Medical Group

* This column provides only a general summary of major provider groups. For a complete listing, please call the Blue Preferred Southeast Network Customer Service Department at 1-800-490-6201 or visit our web site www.anthem.com.



UNDERWRITTEN BY WPS HEALTH PLAN, INC.

Arise Health Plan

P.O. Box 11625
 Green Bay, WI 54307-1625
 Phone 1-888-711-1444 or 920-490-6900
www.WeCareForWisconsin.com



Excellent for HMO/POS
 Commercial Product Only

HEALTH INSURANCE CARRIER OF THE GREEN BAY PACKERS

Type of Plan	Health Maintenance Organization
Total Number of Members	30,000
Years of Operating Experience	11 years
Total Number of Primary Care Practitioners (PCPs)	336
Total Number of Hospitals Affiliated With Plan	12
Total Number of Urgent Care Facilities	28
Total Number of Dentists	930

ADDITIONAL INFORMATION

PCP Requirements	Members must select a Primary Care Practitioner for each family member from one of the Primary Care departments (general practice, family practice, OB/GYN, internal medicine, and pediatrics). Members may select or change (unlimited) their PCP by using the online services on our website or by calling our member services department. Arise Health Plan will auto-assign a PCP, if a PCP is not selected.
Referral Requirements	No written referrals are required when receiving medically necessary care from participating providers. Pre-service authorization is required for all non-participating providers and tertiary care specialists. Please refer to the Prior Authorization Requirements below.
Prior Authorization Requirements	<ul style="list-style-type: none"> • Pre-service authorization is required for all non-participating providers and tertiary care specialists. • Pre-service authorization is required for specialized services including: <ol style="list-style-type: none"> 1. Inpatient stay in a Hospital or Skilled Nursing Facility 2. Transplants 3. Home Health Care 4. Hospice Care 5. Durable Medical Equipment over \$500 or rental 6. Home infusion 7. Prosthetics over \$1,000 8. New Medical or biomedical technology 9. New surgical methods or techniques <p>A pre-service authorization request form must be submitted by your participating provider. Notification of the decision will be sent via mail to you, your Primary Care Practitioner (PCP) and/or the specialist. The pre-service authorization must be approved prior to services being rendered.</p>
Online Provider Directory	<p>At www.WeCareForWisconsin.com you can print a provider directory:</p> <ul style="list-style-type: none"> • Select "Member" • Click on "Find-A-Doc" • Select group "State of Wisconsin" • Enter group number "087889"

ADDITIONAL INFORMATION

Other Online Services	At www.WeCareForWisconsin.com you can: <ul style="list-style-type: none"> • Designate or change your Primary Care Practitioner (PCP). • Order ID Cards • View newsletters, providers, and benefits • Review and print privacy practices notice and consent forms • Use interactive consumer health tools
Outpatient Mental Health Network/Policy	Members must use participating providers for all mental health and AODA services. Pre-service authorization is not required for outpatient services.
Dental Benefits If Provided	Individual Annual Maximum \$1,000 Deductible \$25 single/\$75 family Diagnostic & Preventative Services (subject to deductible)..... 100% Basic Restorative Services (subject to deductible) 80% Dependent Lifetime Orthodontic Maximum\$1,500 Orthodontic Services for dependents (subject to deductible)50% Dental services provided by a non –Delta Dental premier provider will be limited to the usual & customary rate as determined by Delta Dental. For any coverage questions, please call Delta Dental at 1-800-236-3712. Visit www.WeCareForWisconsin.com to find a network dentist by selecting member, click on Find-A-Doc, select group: State of Wisconsin, enter group # 087889.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Brown	•	•	•	•	St. Vincent Hospital St. Mary's Hospital	•	Prevea Health
Door		•	•		Door County Memorial Hospital		Northshore Medical Clinic
Kewaunee							Luxemburg Medical Clinic Northshore Medical Clinic
Langlade			•		Langlade Memorial Hospital		Aspirus Network
Lincoln							Aspirus Network
Manitowoc	•	•	•		Holy Family Memorial Medical Center	•	Lakeshore Womens Health Lakeshore Pediatrics Lakeshore Family Medicine Woodland Clinic
Marathon	•	•	•		Aspirus Wausau Hospital		Aspirus Network
Marinette	•	•	•	•	Bay Area Medical Center		Northern Lights Clinic NorthReach Health Care Wisconsin/Michigan Physicians
Oconto					Community Memorial Hospital	•	Prevea Health CMH Primary Care Clinics Nicolet Medical Clinic
Oneida							Aspirus Network
Portage							Aspirus Network
Sheboygan		•	•		St. Nicholas Hospital		Physicians' Health Network
Taylor		•	•		Memorial Health Center Hospital		Aspirus Network
Vilas							Aspirus Network
Waupaca			•		New London Family Medical Center		
Wood		•	•		Riverview Hospital		Aspirus Network

* This column provides only a general summary of major provider groups. For a complete listing, please contact our Member Services Department at 1-888-711-1444 or visit our web site at www.WeCareForWisconsin.com.



Dean Health Plan, Inc.

1277 Deming Way
 Madison, WI 53717
 (608) 828-1301 (800) 279-1301
 Fax: (608) 827-4152
 TDD: (608) 827-4086
 www.deancare.com



Type of Plan.....	Health Maintenance Organization
Total Number of Members.....	266,587
Total Years of Operating Experience	24 years
Total Number of Primary Care Physicians (PCPs).....	597 (includes some OB/GYN)
Total Number of Hospitals Affiliated with Plan.....	26
Total Number of Urgent Care Facilities	30
Total Number of Dentists	Provider of your choice

ADDITIONAL INFORMATION

PCP Requirements	<p>Members must select a Primary Care Provider (PCP) from one of the following specialties: Family Practice, General Practice, Pediatrics, Obstetrics/Gynecology or Internal Medicine. Each family member may choose his/her own PCP. If a PCP is not selected, one will automatically be assigned.</p> <p>You can change your PCP by contacting our Customer Service Department or by utilizing our website www.deancare.com and accessing DeanConnect, Dean Health Plan's member portal. You can access our Online Provider Directory to search for a physician.</p> <p>There are no limitations on the number of times a member changes their PCP.</p>
Referral Requirements	<p>No written referrals are required when receiving care from Plan Providers for covered services. Referrals to non-Plan Providers must be approved by Dean Health Plan before services are received. The physician referring you to a non-plan provider must submit a referral/request to Dean Health Plan. After reviewing the referral request, Dean Health Plan will notify you and your provider in writing of the decision.</p>
Prior Authorization Requirements	<p>Some services, treatments or procedures require prior authorization to determine the medical necessity of the service. If you are not sure if a service or procedure requires prior authorization, you may contact the Dean Health Plan Customer Service Department. If you go to a Plan Provider, the provider is responsible for requesting any required prior authorization for services. After reviewing the prior authorization request, Dean Health Plan will notify you and your provider in writing of the decision.</p>
Online Provider Directory	<p>Finding a provider is quick and easy by using our Online Provider Directory.</p> <ol style="list-style-type: none"> 1. Go the www.deancare.com. Choose Find a Doctor. 2. Select Dean Health Plan Providers (insurance/HMO). 3. Select Commercial HMO Insurance (Group or Individual Coverage) 4. Search by provider name, specialty or location.
Other Online Services	<p>Visit www.deancare.com to find valuable information about Dean Health Plan.</p> <ul style="list-style-type: none"> • Select DeanConnect to access our self-service portal, which allows members to review their claims information and status, print claims itemizations and EOBs, order ID cards, check status of authorizations, change PCPs and more. • Select MyChart® to email your provider and to access medical information, including lab results, instructions from appointments, and appointment scheduling details. (See the website for a list of Dean Health System clinics that have this available.) • Select Find a Doctor to locate participating doctors, hospitals and urgent care centers by city. • Up to date details on all programs including Complementary Health are also available.
Outpatient Mental Health Network/Policy	<p>No referral is required for outpatient mental health care or for treatment of alcohol or other drug abuse if services are performed by a Plan Provider.</p>

ADDITIONAL INFORMATION

Dental Benefits If Provided

NEW FOR 2008!

Improved dental benefits and freedom to use the provider of your choice!

With dental benefits now offered through Ameritas Group, you are free to use any dental provider, plus the deductible does not apply when using an Ameritas contracted dentist. Benefit details and network provider listing available at our website, www.deancare.com. Separate dental ID cards will be provided.

Coverage

	In Network	Out of Network
Individual Annual Deductible, applies to all services	\$0	\$25
Family Annual Deductible	\$0	\$75
Individual Annual Maximum	\$2,000*	\$2,000*
Individual Lifetime Orthodontic Maximum	\$1,750*	\$1,750**

Orthodontics is a benefit for dependent children if the orthodontic treatment begins before 19 years of age.

***Improved from 2007!**

****Usual & Customary (U&C) charges apply.**

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Adams					Moundview Memorial Hospital, Friendship		
Columbia	•	•	•	•	Columbus Community Hospital Divine Savior Hospital, Portage	•	Dean Specialty Clinics, Dean/St. Mary's Regional Clinics
Dane	•	•	•	•	St. Mary's Hospital, Madison Stoughton Hospital, Stoughton		Dean Clinic Locations
Dodge	•	•	•	•	Beaver Dam Community Hospital Watertown Memorial Hospital Waupun Memorial Hospital	•	Dean Specialty Clinics, Dean/St. Mary's Regional Clinics
Dubuque, IA					Finley Hospital		
Fond du Lac	•	•	•	•	St. Agnes Hospital		Fond du Lac Regional Clinics
Grant	•	•	•	•	Boscobel Area Health Care Grant Regional Health Center Southwest Health Center, Platteville	•	Dean Specialty Clinics, Dean/St. Mary's Regional Clinics
Green	•	•	•	•	Monroe Clinic Hospital		Monroe Clinic
Green Lake							
Iowa	•	•		•	Upland Hills Health, Dodgeville	•	Dean Specialty Clinics, Dean/St. Mary's Regional Clinics
Jefferson	•	•	•		Fort Health Care, Inc.	•	Dean Specialty Clinics, Dean/St. Mary's Regional Clinics
Juneau							
Lafayette	•	•			Memorial Hospital of Lafayette County, Darlington	•	Dean Specialty Clinic
Marquette							
Richland		•	•		Richland Hospital	•	Dean Specialty Clinic
Rock	•	•	•		Beloit Memorial Hospital Edgerton Hospital & Health Services Mercy Hospital, Janesville	•	Dean Clinic Locations Beloit Clinic
Sauk	•	•	•	•	Reedsburg Area Medical Center Sauk Prairie Memorial Hospital, Prairie du Sac St. Clare Hospital & Health Services, Baraboo	•	Dean Specialty Clinics, Dean/St. Mary's Regional Clinics
Vernon	•	•			St. Joseph's Memorial Hospital, Hillsboro		
Walworth						•	Dean Specialty Clinic Dean/St. Mary's Regional Clinic
Waukesha	•	•	•		Oconomowoc Memorial Hospital		

* This column provides only a general summary of major provider groups. For a complete listing, please visit our website at www.deancare.com or contact our Customer Service Department at (608) 828-1301 or (800) 279-1301 to request a provider directory.



**Cooperative of Eau Claire
PO BOX 3217**

**Eau Claire, WI 54702-3217
Phone: (888) 203-7770 FAX: (715) 552-3500
www.group-health.com**

Type of Plan	Health Maintenance Organization
Total Number of Members.....	35,119
Years of Operating Experience	33
Total Number of Primary Care Physicians (PCPs)	451
Total Number of Hospitals Affiliated with Plan.....	33
Total Number of Urgent Care Facilities	18
Total Number of Dentists.....	51

ADDITIONAL INFORMATION

PCP Requirements	You must choose a Primary Care Clinic (PCC) within the GHC network. Each family member may choose a different PCC within the GHC network. If you do not choose a PCC, we will assign one to you based on your location. You can change your PCC by contacting our Member Services Department at (888) 203-7770.
Referral Requirements	A member may seek care for medically necessary covered services from any GHC contracted provider without a referral. Prior to receiving out-of-network care you must obtain an approved referral event authorization from the GHC Health Management Department. GHC will notify you and the ordering Physician of approval or denial in writing.
Prior Authorization Requirements	Event Authorization (authorization for a referral, service, or admission) is required for all admissions, selected outpatient services, and all out-of-network care. Please visit our web site at www.group-health.com to reference GHC's Authorization Guidelines. GHC will notify you and the ordering Physician of approval or denial in writing. For further information regarding Authorization Guidelines, please contact a Member Service Representative at (715) 552-4300 or (888) 203-7770.
Online Provider Directory	You can access our Provider Directory online at www.group-health.com . Simply click on the <i>Provider Directory</i> tab and choose <i>Physicians and Clinics</i> . This will take you to the <i>State of WI Employees</i> section specifically customized for your group.
Other Online Services	As a GHC member you have access to excellent resources that will help you optimize your health care. Visit www.group-health.com for the following services available to you: <ul style="list-style-type: none"> • Policy and Benefit Information • Temporary ID Cards • My Health Zone – offers health and wellness information • Journey Program – offers discounts on health and wellness products • Health Risk Assessment (HRA) – a user-friendly tool that encourages members to learn about their personal health risks and to take action on improving their health, quality of life and longevity
Outpatient Mental Health Network/Policy	No referral is required for services received from a GHC contracted provider. Please refer to the GHC Provider Directory for a listing of our participating mental health providers.
Dental Benefits If Provided	Preventive dental coverage is available to all State members through GHC participating providers. Dental benefits include: <ul style="list-style-type: none"> • 100% coverage for routine exams and cleanings (twice a year), fluoride treatments, routine x-rays and sealants. • 50% orthodontic coverage; limited to \$600 per member per calendar year and \$1,200 per member per lifetime; coverage limited to covered dependent children through age 18. Please call our Member Services Department at (888) 203-7770 for more specific benefit information. You can access our Dental Provider Directory online at www.group-health.com . Members should use their medical ID card when receiving preventive dental services.

ADDITIONAL INFORMATION

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Ashland		•	•		Memorial Medical Center		Ashland Clinic Chequamegon Clinic Ashland Mainstreet Clinic
Barron		• •	• •	• •	Lakeview Medical Center Cumberland Memorial Hospital Barron Medical Center	•	Marshfield Clinic (Indianhead, Lakewoods, Lake Country) Center Turtle Lake Medical Clinic Cumberland Medical Clinic Midelfort Clinic (Barron, Cameron, Chetek, Prairie Farm)
Chippewa	•	• •	•		St. Joseph's Hospital Our Lady of Victory Hospital Bloomer Memorial Medical Center	•	Family Health Associates Marshfield Clinic (Chippewa, Cadott, Cornell) Midelfort Clinic (Bloomer, Chippewa) Victory Medical Group Stanley Center
Clark		•			Memorial Medical Center- Neillsville		Greenwood Medical Center Loyal Clinic Marshfield Clinic Thorp Center Neillsville Memorial Medical Center Victory Medical Group (Thorp, Owen-Withee)
Douglas			•	•	St. Mary's Hospital-Superior		Mariner Clinic, Superior Clinic
Dunn		•	•		Red Cedar Medical Center	•	Marshfield Clinic Menomonie Center Midelfort Clinic Colfax Red Cedar Medical Center
Eau Claire	• •	• •	• •	•	Sacred Heart Hospital Luther Hospital OakLeaf Surgical Hospital	•	Augusta Family Medicine Clinic Eau Claire Family Medicine Clinic Eau Claire Medical Clinic Eau Claire Women's Care A. Javaherian, M.D. Marshfield Clinic (Oakwood, Riverview, Eau Claire) Midelfort Clinic Eau Claire OakLeaf Pediatrics OB/GYN Clinic Pine Grove Family Practice Southside Medical Clinic Stenzel Clinic for Women's Health
Jackson		•	•		Black River Memorial Hospital		Krohn Clinic
Polk	•	•			Amery Regional Medical Center St. Croix Regional Medical Center		Amery Regional Medical Center Luck Medical Clinic Clear Lake Clinic St. Croix Falls Clinic Frederic Clinic Unity Clinic
Rusk Sawyer		•			Rusk County Memorial Hospital Hayward Area Memorial Hospital	•	Marshfield Clinic (Ladysmith, Bruce) Marshfield Clinic Radisson Center Hayward Clinic Northwoods Community Health Center
St. Croix Trempealeau	•	•			Baldwin Area Medical Center Osseo Medical Center	•	Baldwin Area Medical Clinic Buffalo River Clinic Midelfort Clinic Osseo Osseo Medical Clinic
Washburn					Spooner Health System		Shell Lake Clinic Spooner Clinic

* This column provides only a general summary of major provider groups. For a complete listing, please contact our Member Services Department at (888) 203-7770 or visit our website at www.group-health.com.



SOUTHCENTRAL

PO Box 44971
 1265 John Q. Hammons Drive
 Madison, WI 53744-4971
 Phone (608) 828-4853 or (800) 605-4327 Fax (608) 662-4186
<http://www.ghc-hmo.com>

Type of Plan	Health Maintenance Organization
Total Number of Members.....	58,000
Years of Operating Experience	31
Total Number of Primary Care Physicians (PCPs).....	69
Total Number of Hospitals Affiliated with Plan.....	4
Total Number of Urgent Care Facilities	3
Total Number of Dentists.....	23

ADDITIONAL INFORMATION

PCP Requirements A strong relationship between the patient and Primary Care Practitioner (PCP) is the basis of good health care. All GHC-SCW members choose a personal PCP from amongst our high-quality group of medical professional. Members may select their PCP from Internal Medicine, Family Practice, or Pediatrics. Each covered family member selects a PCP. If you do not have a preference, the GHC-SCW Member Services staff is available to help you evaluate your options and choose one. You may also want to base your selection on clinic location. If a PCP selection is not made, GHC-SCW will automatically assign one.

Members may change their PCP or request a Provider Directory by contacting GHC-SCW Member Services at (608) 828-4853 or (800) 605-4327. Members may visit www.ghc-hmo.com for a complete listing of GHC-SCW practitioners along with their professional qualifications. PCP changes are limited to once per month.

Referral Requirements The **Referral** is a written recommendation submitted to the GHC-SCW Care Management Department by your Primary Care Practitioner (PCP), advising that you receive services outside of a GHC-SCW Clinic or through a specialty care area. Your PCP will send a referral request to certified Case Managers in the GHC-SCW Care Management Department. A team of experienced nursing staff will evaluate the PCP's request to determine if the referral meets the benefits covered under your health insurance plan. Most referral requests are approved in 48 hours. Some referral requests may need to be reviewed by the GHC-SCW Physician Reviewer and Care Management Team, which may take up to 15 days. Some referrals to plan providers and all referrals to non-plan providers require Prior Authorization from GHC-SCW. Please refer to the Prior Authorization Requirement Section.

Prior Authorization Requirements Upon approval of the referral request, the Care Management Department will mail you a written **Prior Authorization** letter. Once you receive the Prior Authorization letter, you may then contact the referred specialist to make an appointment. If you schedule a specialty appointment without Prior Authorization from GHC-SCW, you may be responsible for full payment of services. It is helpful to bring your Prior Authorization letter to your specialty appointment.

Note: If you are a registered GHCMYChart user, you may view and print your Prior Authorizations through www.ghcmychart.com.

In the event of a denial of services, you will receive a follow-up letter from the Care Management Department which explains your appeal rights. Should the appointment be occurring on the same or next day from the time of the referral placement, a call will be placed to you by the Care Management Department.



1836 South Avenue
 La Crosse WI 54601
 Phone (608) 775-8007 (800) 897-1923 Fax (608) 775-8042
 www.glhealthplan.org

Type of Plan	Health Maintenance Organization
Total Number of Members.....	54,477
Years of Operating Experience	11
Total Number of Primary Care Physicians (PCPs).....	308
Total Number of Hospitals Affiliated with Plan.....	15
Total Number of Urgent Care Facilities	20
Total Number of Dentists.....	Provider of Your Choice

ADDITIONAL INFORMATION

PCP Requirements	Members are not required to select a Primary Care Provider. However, GLHP encourages members to see a Primary Care Physician (PCP) to coordinate all of their health care needs. Each family member is allowed to designate their own PCP.
Referral Requirements	A member may seek services from any GLHP provider without a referral. If your GLHP provider feels that you require specialty care outside of the GLHP network, he/she may complete a referral request form and submit it to GLHP. GLHP will respond to the referral request by mail to both you and the provider to whom you were referred for services. Medical care, treatment, services or supplies that are received through a referral are subject to the exclusions and limitations of your benefits.
Prior Authorization Requirements	Selected medical procedures covered by GLHP require you to obtain prior written authorization. Procedures and services requiring prior authorization include, but are not limited to, the following: DENTAL AND ORAL SURGERY: alveolectomy, or alveoloplasty, replacement of congenitally missing teeth, gingivectomy, osteotomies, periodontal surgical procedures, TMJ surgical and non-surgical correction, vestibuloplasty, oral appliance for treatment of obstructive sleep apnea syndrome, DIABETES SERVICES: insulin infusion pumps, DURABLE MEDICAL EQUIPMENT: purchases or repairs over \$750 and all rentals, prothrombin (INR) time home testing system, home infusion therapy, mattresses, TENS/Neurostimulators, wheelchairs, or power operated vehicles, Enteral Feedings, Genetic Testing, HEARING SERVICES: cochlear implants, HOME CARE: part-time or intermittent home skilled nursing care, Physical, respiratory, occupational, speech therapy, or nutritional counseling, home infusion therapy, medical supplies, drugs, and laboratory services, covered to the same extent they would have been covered if you were confined in a hospital, KIDNEY DISEASE TREATMENT: Kidney dialysis out-of-network, MATERNITY/NEWBORN: rental of electric breast pumps, MENTAL HEALTH, ALCOHOL & OTHER DRUG ADDICTIONS (MH.AODA), transitional treatment, SKILLED NURSING CARE, SURGERY OR PROCEDURES: reduction mammoplasty, eyelid revision, rhinoplasty or rhino portion of septorhinoplasty, sclerotherapy/endovenous laser treatment of spahenous vein reflux, laser assisted uvulopalatoplasty somnoplasty, hypertrophic scar treatment, PET SCANS. The provider should submit a written prior authorization request to GLHP for review before any recommended treatment or services are obtained. GLHP will respond by mail to you and the provider.
Online Provider Directory	Network providers are listed on our web site. Type in www.glhealthplan.org , select Member from the left side menu, select Employer Group Member, select Provider Directory from the left side menu. On the next screen, from the top menu bar, your selection options are: Location, Facility, Specialty, Provider Type, Map or Index. Select one of these options to locate a participating provider.

ADDITIONAL INFORMATION

Other Online Services GLHP provides members with online services at www.glhealthplan.org. Once you access our web site you'll have access to:

- Customer Service
- Disease Management
- Health and Wellness
- Newsletters
- Quality Projects
- Telephone Nurse Advisor
- Your Explanation of Benefits (EOB)
- Your Privacy Rights

Outpatient Mental Health Network/Policy Referrals are not required for services received from a GLHP provider. Prior Authorization is required for transitional treatment. You may obtain written prior authorization by contacting your participating provider. The provider must submit a written prior authorization request to GLHP for review before any recommended treatment or services are obtained.

Dental Benefits If Provided GLHP offers a dental benefit for preventative and basic dental services. These services can be obtained from any dental provider. You should present your regular medical ID card for dental services. Dental benefits are not subject to a Usual and Customary Fee Schedule. This dental plan does not contain a Coordination of Benefits provision and will be the primary payer for dental services. Coverage details are available from GLHP (800-897-1923). Some limitations may apply.
 Calendar Year Maximum - \$500.00 per person
 Preventative Services – No deductible, 100% coverage (two per calendar year)
 Basic (Restorative Services) – No deductible, 80% coverage
 No Orthodontia coverage.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Crawford		•	•	•	Prairie du Chien Memorial Hospital	•	Gundersen Clinic - Prairie du Chien Kickapoo Valley Medical Clinic
Grant	•	•		•	Boscobel Area Health Care		Boscobel Clinic Bluff Street Clinic Muscodia Health Center
Jackson		•	•		Black River Falls Memorial Hospital		Krohn Clinic
Juneau	•	•	•		Hess Memorial Hospital	•	Mile Bluff Gundersen Clinic – Wonewoc Elroy Family Medical Center St. Joseph Family Clinic-Elroy & Wonewoc
La Crosse	•	•	•		Gundersen-Lutheran Medical Center	•	Gundersen Luthern Clinic-LaCrosse Gundersen Lutheran Clinic - Onalaska
Monroe		•	•		Tomah Memorial Hospital	•	Gundersen Clinic – Sparta Gundersen Clinic – Tomah Scenic Bluff Community Health
Richland		•	•		Richland Hospital		Richland Medical Center Viola Health Center
Trempealeau					Tri-County Memorial Hospital	•	Gundersen Clinic- Blair, Independence, Whitehall
Vernon	•	•			Vernon Memorial Hospital St. Joseph's Memorial Hospital	•	Bland Clinic Gundersen Clinic-Viroqua Hirsch Clinic Gundersen Clinic-Hillsboro La Farge Medical Clinic St. Joseph Family Clinic-Hillsboro

* This column provides only a general summary of major provider groups. For a complete listing, please contact GLHP at 800-897-1923 or visit our web page at www.glhealthplan.org.

Health Tradition

A Mayo Health System Choice in Wisconsin

PO Box 188
 La Crosse, WI 54602-0188
 Phone 1-608-781-9692
 Toll-Free 1-888-459-3020
 www.healthtradition.com
 Customer Service
 1-877-832-1823

Type of Plan	Health Maintenance Organization
Total Number of Members.....	31,357
Years of Operating Experience	22
Total Number of Primary Care Physicians (PCPs).....	262
Total Number of Hospitals Affiliated with Plan.....	17
Total Number of Urgent Care Facilities	15
Total Number of Dentists.....	Provider of Your Choice

ADDITIONAL INFORMATION

PCP Requirements	You are not required to select a PCP, however, Health Tradition encourages you to choose a provider and visit him or her for your routine care.
Referral Requirements	<p>A Member may make a direct appointment with any in-network Health Tradition provider, primary care or specialist without a referral. Members must obtain a written referral and receive Health Traditions authorization before visiting an out-of-network provider. All referrals to non-Health Tradition providers, and referrals for certain specified services, must be prior authorized by Health Tradition before those services are received to be covered. Your primary care provider will request a referral on your behalf. Health Tradition will notify you in writing of approvals or denials.</p> <p>Many in-network facilities use outreach specialists that are considered out-of-network by Health Tradition. These outreach specialists require an approved referral from Health Tradition. Call Customer Service to determine if the provider is in your network.</p> <p>If services cannot be provided at an in-network facility by an in-network provider, Health Tradition requires you to receive services at Franciscan Skemp-LaCrosse. Health Tradition utilizes Mayo Clinic as its tertiary referral center, if needed.</p>
Prior Authorization Requirements	<p>Certain services requiring Prior Authorization by Health Tradition include, but are not limited to, the following:</p> <ol style="list-style-type: none"> 1. Ambulance Services (non-emergency only) 2. Durable medical equipment/prosthesis/orthotics 3. Experimental/investigational services 4. Home healthcare and hospice services 5. Inpatient hospitalization 6. Out-of-area services 7. Skilled nursing facility care 8. Mental Health – Transitional services, group therapy and psychiatric testing 9. Additional rehab services (PT, OT, and speech) beyond the benefit limit <p>Your Health Tradition Provider will assist you with prior authorization. However, it is your responsibility to obtain prior authorization for certain services. Contact Health Tradition at 608-781-2118 to request prior authorization. You and your provider will receive notification as to whether a service has been approved or denied.</p>
Online Provider Directory	<p>To access the online Health Tradition provider directory, go to: www.healthtradition.com, click on "Members" in the upper toolbar, select "Choosing a Provider," then select the "State of Wisconsin medical providers" file.</p>

ADDITIONAL INFORMATION

- Other Online Services**
- www.healthtradition.com is a new easy way to get information, whenever members need it. Information available includes: how to access benefits, provider directory, service area maps, and member newsletters.
 - www.mayoclinic.com for health and wellness information.
 - www.mmsiservices.com to check eligibility status, claim status, search for providers or request an I.D. card.

Outpatient Mental Health Network/Policy All mental health and substance abuse services must be provided by a network provider. The participating network provider will seek prior authorization for services on the member's behalf. If assistance is needed in selecting a network provider, members may contact Customer Service at 1-877-832-1823.

Dental Benefits If Provided Health Tradition has an open dental network to allow members to go anywhere for their dental services. Our Preferred Dental Network is also available. In most cases, when using our Preferred Dental Network, the member will not be responsible for charges in excess of the Usual and Customary Charges. However, in some cases, a patient balance may result. In our open Dental Network, coverage is limited to the Usual and Customary Charges. We encourage members to continue to see those providers with whom they already have a relationship. Coverage details are available from Health Tradition.

Preventive & Diagnostic - No deductible, 100% coverage.

Basic (Restorative) Services - No deductible, 80% coverage.

Maximum Benefit - Up to \$500 per person per year.

You will not receive a separate dental ID card. To find out which dentists are in our Preferred Dental Network, please visit: www.healthtradition.com, click on "Members" in the upper toolbar, select "Choosing a Provider," click on the file titled: State of WI Employee Group Dental Providers.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County **
Crawford		•	•	•	Prairie du Chien Memorial Hospital	•	*FSH - Prairie du Chien Clinic Kickapoo Valley Medical Clinic
Grant	•	•		•	Boscobel Area Health Care		Bluff Street Clinic, Fennimore Family Medicine Muscodah Health Center Riverside Family Practice
Jackson		•	•		Black River Falls Memorial Hospital		Krohn Clinic, Ltd.
Juneau	•	•	•		Hess Memorial Hospital		Elroy Family Medical Center Mile Bluff Clinic, LLP Necedah Family Medical Center New Lisbon Community Clinic
La Crosse	•	•	•	•	Franciscan Skemp Healthcare La Crosse Medical Center	•	*FSH - La Crosse Clinic • *FSH - Holmen Clinic • *FSH - Onalaska Clinic • *FSH - West Salem Clinic
Monroe	•		•	•	Franciscan Skemp Healthcare - Sparta Medical Center Tomah Memorial Hospital	•	*FSH - Sparta Clinic Scenic Bluffs Community Health Center *FSH - Lake Tomah Clinic
Richland	•	•	•	•	Richland Hospital Reedsburg Area Medical Center		Richland Medical Center Reedsburg Physicians Group
Trempealeau	•		•	•	Franciscan Skemp Healthcare Arcadia Medical Center	•	*FSH - Arcadia Clinic • *FSH - Galesville Clinic
Vernon	•	•	•		St. Joseph's Memorial Hospital Vernon Memorial Hospital		St. Joseph's Clinic LaFarge Clinic Hirsch Clinic Bland Clinic Viola Health Services Center

* FSH - Franciscan Skemp Healthcare.

** This column provides only a general summary of major provider groups. For a complete listing, please contact Health Tradition at 1-877-832-1823 or visit www.healthtradition.com.



HUMANA EASTERN REGION PREMIER NETWORK

N19 W24133 Riverwood Drive – Suite 300
Waukesha, WI 53188
800-4HUMANA (800-448-6262)
Humana Group Medicare – 1-866-396-8810 (TTY 1-800-833-3301)
www.humana.com



Humana Group Medicare Benefits and Enrollment, call 1-866-396-8810
For Benefit & Enrollment questions, call Enrollment Hotline at 1-888-393-6765 or email to
oe@humana.com for response within 2 business days. (TDD 1-800-526-0844)
Service issues call 1-800-448-6262 or email via MyHumana, a confidential web page.

Type of Plan	Health Maintenance Organization
Total Number of Members	Over 8 Million Nationwide
Years of Operating Experience	21 years
Total Number of Primary Care Physicians (PCPs)	2,103
Total Number of Hospitals	25
Total number of Urgent Cares	49
Total Number of Dentists	Provider of your choice

ADDITIONAL INFORMATION

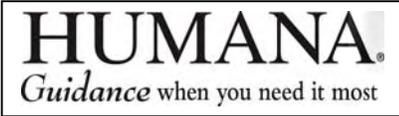
PCP Requirements	Each family member must select any Humana Premier Network PCP. If no selection is made, members will be assigned a PCP based on zip code. PCP selection may be changed at any time by calling customer service (1-800-4HUMANA); or on line (see information below).
Referral Requirements	Referrals are not required to see any Premier network specialist. Referrals are required for non network providers as well as oral surgery and all therapy services. Please see the Member Handbook for details. Humana will send you and your provider written notification of any denied referral. Members may check on whether a referral has been submitted and its review status by using MyHumana or calling Customer Service at 1-800-4Humana.
Prior Authorization Requirements	Providers must telephone Humana to pre-authorize hospitalizations and durable medical equipment purchases. Members may also check on whether a prior authorization has been submitted and its review status by using MyHumana or calling Customer Service at 1-800-4Humana.
Online Provider Directory	You can check which providers are in the Premier network by going to www.humana.com . Select 'members'; then 'Provider Search' on right hand side of screen. Best search method for current members: Search by Member ID number, the appropriate network will be represented. For perspective members: Search by Coverage and Network, select Employer Group Plan, enter zip code then select PREMIER HMO & POS . Agree to 'terms of use'. You may search by provider name or by zip code. <i>Humana Group Medicare will offer a Private Fee-For-Service plan (PFFS) that combines Original Medicare and Uniform Benefits. There are no requirements to use a network provider. For more information call Humana's Medicare provider relations and customer service line at 1-866-291-9714 (TTY 1-800-833-3301).</i>
Other Online Services	Humana has a web "landing page" customized to your group. Go to the URL below or access through the Related Links on the ETF web page. This site has information unique to your group. You can set up a MyHumana web page that offers a wide range of services and tools, including: <ul style="list-style-type: none"> • Health risk assessment (a phone option is also available to members that do not have access to the internet) and Condition Centers identify your at-risk issues. • Create your own health records tracking immunizations and medications. • View your Humana medical claims plus status of authorizations & referrals. • Search provider networks, replace ID Cards or print a Certificate of Coverage. Additional information: visit the "landing page", Member Handbook or www.humana.com . Custom landing page: http://apps.humana.com/egroups/wisconsin/home.asp .
Outpatient Mental Health Network/Policy	Before seeking outpatient mental health services, you must call our 24-hour, 7 day a week access line, toll-free at 1-877-948-6262, for assessment and access to care.
Dental Benefits If Provided	Included in the Humana plan is a HumanaDental supplemental benefit that provides 100% preventive care; 50% after deductible basic care; 50% orthodontic coverage (up to an individual orthodontic lifetime maximum benefit of \$1,200). Orthodontic coverage is limited to covered dependent children under age 18. You get additional savings from Humana network dentists. You will receive a separate HumanaDental ID card to use for dental care. To get 100% coverage of Uniform Benefits oral surgery, you must use medical network providers for oral surgery benefits. More information on dental benefits is in the member handbook & on the "landing page".

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Brown	•	•	•	•	Aurora Baycare Medical Center Bellin Memorial Hospital	•	Aurora Medical Group Bellin PHO
Dodge	•	•	•	•	Watertown Memorial Hospital Waupun Memorial	•	Aurora Medical Group Watertown PHO
Fond du Lac	•	•	•	•	St. Agnes Hospital	•	Agnesian Health Care Aurora Medical Group
Jefferson	•	•	•	•	Fort Memorial Hospital	•	Fort Healthcare Watertown PHO
Kenosha	•	•	•	•	Aurora Health Center Kenosha Children's Hospital of Wisconsin UHS Kenosha Medical Center Campus UHS St. Catherine's Campus	•	Aurora Medical Group UHS Physicians Clinic
Manitowoc	•	•	•	•	Aurora Medical Center Manitowoc Holy Family Memorial Medical Center	•	Aurora Medical Group Holy Family Memorial
Milwaukee	•	•	•	•	Aurora-Sinai Medical Center AMC-St. Luke's Medical Center AMC- West Allis Memorial Hospital Aurora Women's Pavilion Children's Hospital of Wisconsin Columbia Center LLC Columbia St. Mary's Milwaukee (Lake Dr) Columbia St. Mary's Milwaukee (Newport Dr) Froedtert Hospital Kindred Hospital Milwaukee (LTAC) Orthopaedic Hospital of Wisconsin St. Francis Hospital St. Joseph Regional Medical Center St. Lukes South Shore Hospital The Wisconsin Heart Hospital	•	Aurora Medical Group Columbia St. Mary's Children's Medical Group Lakeshore Medical Clinic Advanced Healthcare Medical College of Wisconsin Wheaton Franciscan Medical Group
Oconto	•	•	•	•	Bond Health Center Community Memorial Hosp. of Oconto Falls	•	Bellin PHO
Outagamie	•	•	•	•	Appleton Medical Center	•	Aurora Medical Group Thedacare PHO
Ozaukee	•	•	•	•	St. Mary's Hospital – Ozaukee	•	Columbia St. Mary's Advanced Healthcare
Racine	•	•	•	•	All Saints Medical Center St. Lukes All Saints Medical Center St. Mary's Memorial Hospital of Burlington	•	Aurora Medical Group Wheaton Franciscan Medical Group
Rock	•	•	•	•	Beloit Memorial	•	Beloit PHO
Shawano	•	•	•	•	Shawano Medical Center	•	Thedacare PHO
Sheboygan	•	•	•	•	AMC – Valley View St. Nicholas Sheboygan Memorial	•	Aurora Medical Group Physicians' Health Network
Walworth	•	•	•	•	AMC-Lakeland	•	Aurora Medical Group
Washington	•	•	•	•	Aurora Medical Center Washington County St. Joseph Community Hospital of West Bend	•	Aurora Medical Center West Bend Clinic
Waukesha	•	•	•	•	Community Memorial Hospital of Menomonee Falls Elmbrook Memorial Hospital Oconomowoc Memorial Hospital Waukesha Memorial Hospital	•	Aurora Medical Group Advanced Healthcare Medical Assoc. Health Center
Waupaca	•	•	•	•	New London Family Medical Center Riverside Medical Center	•	Thedacare PHO
Winnebago	•	•	•	•	Aurora Medical Center Oshkosh Children's Hospital of Wisconsin Theda Clark Medical Center	•	Aurora Medical Group Thedacare PHO

*This column provides only a general summary of major provider groups. For a complete listing, please contact Customer Service at 1-800-4HUMANA or visit www.humana.com Provider Search.

Humana Group Medicare PFFS plan allows members to use any Healthcare provider that participates with Medicare (accepts Medicare payment), and accepts the terms, conditions and payment rate of Humana (which is based upon Original Medicare payment calculations). For more information call Humana's Medicare provider relations and customer service line at 1-866-291-9714.

**HUMANA WESTERN REGION
PREMIER NETWORK**



N19 W24133 Riverwood Drive – Suite 300
Waukesha, WI 53188
800-4HUMANA (800-448-6262)
www.humana.com



Humana Group Medicare – 1-866-396-8810 (TTY 1-800-833-3301)

Humana Group Medicare Benefits and Enrollment, call 1-866-396-8810
For Benefit & Enrollment questions, call Enrollment Hotline at 1-888-393-6765 or email to oe@humana.com for response within 2 business days. (TDD 1-800-526-0844)
Service issues call 1-800-448-6262 or email via MyHumana, a confidential web page.

Type of Plan	Health Maintenance Organization
Total Number of Members	Over 8 Million Nationwide
Years of Operating Experience.....	21 years
Total Number of Primary Care Physicians (PCPs)	390
Total Number of Hospitals	14
Total Number of Urgent Care Facilities.....	17
Total Number of Dentists	Provider of your choice

ADDITIONAL INFORMATION

PCP Requirements	Each family member must select a Humana Premier Network PCP. If no selection is made, members will be assigned a PCP based on zip code. PCP selection may be changed at any time by calling customer service (1-800-4HUMANA); or online (see information below).
Referral Requirements	Referrals are not required to see any Premier network specialist. Referrals are required for non network providers as well as oral surgery and all therapy services. Please see the Member Handbook for details. Humana will send you and your provider written notification of any denied referral. Members may check on whether a referral has been submitted and its review status by using MyHumana or calling Customer Service at 1-800-4Humana. Members may call for a referral by contacting Humana directly at 1-800-626-2698.
Prior Authorization Requirements	Providers must telephone Humana to pre-authorize hospitalizations and durable medical equipment purchases. Members may check on whether a prior authorization has been submitted and its review status by using MyHumana or calling Customer Service at 1-800-4Humana.
Online Provider Directory	Visit the landing page http://apps.humana.com/egroups/wiscinson/home.asp . In 2008, you can also check which providers are in the Premier network by going to www.humana.com . Select 'members'; then 'Provider Search' on right hand side of screen. Best search method for current members: Search by Member ID number, the appropriate network will be represented. For prospective members: Search by Coverage and Network, select Employer Group Plan, enter zip code then select PREMIER HMO & POS . Agree to 'terms of use'. You may search by provider name or by zip code. <i>Humana Group Medicare will offer a Private Fee-For-Service plan (PFFS) that combines Original Medicare and Uniform Benefits. There are no requirements to use a network provider. For more information call Humana's Medicare provider relations and customer service line at 1-866-291-9714 (TTY 1-800-833-3301).</i>

ADDITIONAL INFORMATION

Other Online Services Humana has a web "landing page" customized to your group. Go to the URL below or access through the Related Links on the ETF web page. This site has information unique to your group. You can set up a MyHumana web page that offers a wide range of services and tools, including:

- Health risk assessment (a phone option is also available for members that do not have access to internet) and Condition Centers identify your at-risk issues .
- Create your own health records tracking immunizations and medications.
- View your Humana medical claims plus status of authorizations & referrals.
- Search provider networks, replace ID Cards or print a Certificate of Coverage.

Additional information: visit the "landing page", Member Handbook or www.humana.com.
Customized web landing page: <http://apps.humana.com/egroups/wisconsin/home.asp>

Outpatient Mental Health Network/Policy Before seeking outpatient mental health services, you must call our 24-hour, 7 day a week access line, toll-free at 1-877-948-6262, for assessment and access to care.

Dental Benefits If Provided Included in the Humana plan is a HumanaDental supplemental benefit that provides 100% preventive care; 50% after deductible basic care; 50% orthodontic coverage (up to an individual ortho lifetime maximum of \$1,200). Orthodontic coverage is limited to covered dependent children under age 18. You get additional savings from Humana network dentists. You will receive a separate HumanaDental ID card to use for dental care. **To get 100% coverage of Uniform Benefits oral surgery, you must use medical network providers for oral surgery benefits. More custom information on Dental Benefits is in the member handbook & on the landing page.**

Counties in Service Area			S	R _x	Hospitals in County		Major Providers in County *
Barron			•	•	Cumberland Memorial Hospital Lakeview Medical Center		Cumberland Clinic Eau Claire Medical Clinic Marshfield Clinic
Chippewa	•	•	•		Our Lady of Victory Hospital St. Joseph Chippewa Falls	•	Family Health Associates Marshfield Clinic Victory Medical Group
Douglas			•	•	St. Mary's Hospital Superior		SMDC-Superior
Dunn							
Eau Claire	•	•	•		Oak Leaf Surgical Hospital Sacred Heart Hospital	•	Eau Claire Medical Clinic Eau Claire Women's Care Marshfield Clinic Oakleaf Pediatrics Pine Grove Family Practice Associates Southside Medical Clinic
Pepin					Chippewa Valley Hospital		Castleberg Clinic
Pierce	•		•		River Falls Area Hospital		River Falls Medical Clinic Spring Valley Medical Clinic Ellsworth Medical Clinic
Polk	•				Osceola Medical Center St. Croix Regional Medical Center		St. Croix Falls Clinic
St. Croix	•	•	•	•	Hudson Hospital Westfields Hospital		Hudson Physicians New Richmond Clinic

*This column provides only a general summary of major provider groups. For a complete listing, please contact Customer Service at 1-800-4HUMANA or visit www.humana.com Provider Search.

Humana Group Medicare PFFS plan allows members to use any Healthcare provider that participates with Medicare (accepts Medicare payment), and accepts the terms, conditions and payment rate of Humana (which is based upon Original Medicare payment calculations). For more information call Humana's Medicare provider relations and customer service line at 1-866-291-9714.

Medical Associates Health Plans



PO Box 5002
1605 Associates Drive
Dubuque, IA 52004-5002
Phone Number (563) 556-8070 or 800-747-8900
FAX Number (563) 556-5134
www.mahealthcare.com



Type of Plan Health Maintenance Organization
 Total Number of Members..... 30,123
 Years of Operating Experience 25
 Total Number of Primary Care Physicians (PCPs)..... 117
 Total Number of Hospitals Affiliated with Plan..... 15
 Total Number of Urgent Care Facilities 6
 Total Number of Dentists Open Access

ADDITIONAL INFORMATION

PCP Requirements	You are not required to select a Primary Care Physician.
Referral Requirements	Medical Associates Health Plans (MAHP) is an open access HMO. Members are able to seek the services from any MAHP Network Specialist without a referral from their Primary Care Physician (PCP) for covered services. Services received from Non-MAHP providers must have prior authorization. Please see below.
Prior Authorization Requirements	When services are needed by a Non-MAHP Network Specialist or Physician, members must obtain a written authorization from the MAHP Medical Director prior to receiving services. If services cannot be provided within the MAHP network, your physician will initiate a request for prior authorization. Responses are provided from MAHP in writing to you and your referring physician. Members are encouraged to call MAHP to confirm the status of their request prior to receiving services.
Online Provider Directory	<u>Members:</u> To view the State of Wisconsin provider directory online, visit our web site at www.mahealthcare.com You will need to select the “Members” button under My E Link. You will then be prompted to login. If you are a first time user, you will need to register by clicking “Signup” and create your new user name & password. <u>Prospective Members:</u> Please visit our web site at www.mahealthcare.com . To view the online directory you will need to click on Health Plans, then Provider Directory. You will then be prompted to enter an employer group number. Please enter the employer code wisesame to view the directory.
Other Online Services	Check out our web site at www.mahealthcare.com for: <ul style="list-style-type: none"> • Well Child Guide • New Physicians added to Medical Associates Health Plans Network • Phone Directory • Clinic & Health Plan News • Women’s Health Resource Guide • 24 Hour Help Nurse • Member based web portal “My E Link”
Outpatient Mental Health Network/Policy	Outpatient mental health services must be provided by MAHP participating physicians and providers.
Dental Benefit Provided	<ul style="list-style-type: none"> • Routine periodic exams at 6 months intervals - 100% coverage • Full mouth x-rays once in any 3 year interval – 100% coverage • Bite wing x-rays at 1 year intervals - 100% coverage. • Topical fluoride applications, once in any 6 month interval - 100% coverage • Open access to any dental provider • You will need to present your medical ID card for dental benefits

ADDITIONAL INFORMATION

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Crawford, WI		•	•	•	Prairie du Chien Memorial Hospital		Prairie Medicine
Grant, WI	•	•		•	Boscobel Area Health Care Grant Regional Health Center-Lancaster Southwest Health Center-Platteville		Associated Hearing and Balance Clinic (Audiologist) Boscobel Clinic Bluff Street Clinic Family Resource Center – Platteville (Behavioral Health) Fennimore Clinic Fennimore Family Medicine Grant Regional Family Practice Lancaster Family Medical Center • Medical Associates Clinic – Cuba City • Medical Associates Clinic – Platteville WKM Psychology Clinic - Fennimore (Behavioral Health) WKM Psychology Clinic – Lancaster (Behavioral Health) WKM Psychology Clinic – Platteville (Behavioral Health)
Iowa, WI	•	•		•	Upland Hills Health		Dodgeville Clinic Dr. McKenzie Optometry Office Mineral Point Medical Center
Lafayette, WI	•	•			Memorial Hospital of Lafayette County – Darlington		Argyle Clinic Eye Care Centre, Ltd. • Medical Associates Family Practice Clinic – Darlington Memorial Hospital of Lafayette County – Outpatient Clinic Shullsburg Clinic Family Resource Center - Darlington (Behavioral Health)
Dubuque, IA					Finley Hospital Mercy Medical Center-Dubuque Mercy Medical Center-Dyersville		• Medical Associates Clinic, P.C. East and West Campus and all • Medical Associates Clinics and satellites. Women’s Wellness Center
Out-of-State Providers					Available in Iowa and Illinois		See provider directory or our web site for complete listing of participating providers.

* This column provides only a general summary of major provider groups. For a complete listing, please contact MAHP at 800-747-8900 or www.mahealthcare.com.



MERCYCARE INSURANCE COMPANY
 MERCYCARE HMO, INC.
 P.O. BOX 2770, JANESVILLE, WI 53547-2770

MERCYCARE HEALTH PLAN

3430 Palmer Drive
 P. O. Box 2770
 Janesville, WI 53547-2770
 608-752-3431 or 800-752-3431
 Customer Service 1-800-895-2421
 FAX 608-752-3751
 www.mercycarehealthplans.com



Type of Plan	Health Maintenance Organization
Total Number of Members.....	31,500
Years of Operating Experience	14
Total Number of Primary Care Physicians (PCPs).....	116
Total Number of Hospitals Affiliated with Plan.....	9
Total Number of Urgent Care Facilities	11
Total Number of Dentists	Provider of Your Choice

ADDITIONAL INFORMATION

PCP Requirements	Members are requested to select a PCP to coordinate their care. Each family member may choose a different PCP. If a PCP is not chosen, your ID card will state "unassigned". You may change your PCP at any time by calling Customer Service at 1-800-895-2421.
Referral Requirements	MercyCare has an open access network of participating providers and specialists. If the specialty care your participating MercyCare Primary Care Physician (PCP) wants you to receive is available within MercyCare's provider network, he or she will direct you to a specialist in the network. If the care you require is not available from a participating provider, your PCP must request a prior authorization from MercyCare (please see Prior Authorization Requirements).
Prior Authorization Requirements	Prior authorization is required for specific services performed by a participating provider. MercyCare requires the participating provider to obtain prior authorization on your behalf. If prior authorization is not obtained for services by a participating provider, you the member, will be held harmless for charges related to covered services. Any services provided by a non-participating provider require a referral and prior approval from MercyCare. If prior authorization is not obtained for services from a non-participating provider, you the member, will be responsible for the charges. If you have a question about your prior authorization, please contact our Customer Service Department at 1-800-895-2421. MercyCare will notify you in writing whether your prior authorization is approved or denied.
Online Provider Directory	<ul style="list-style-type: none"> • www.mercycarehealthplans.com • Click on Find a Provider • Enter your group number or click on W1-HMO • You may choose to see providers by city, clinic, name or specialty • If you would like a printable provider directory, scroll to the bottom of the page and select Wisconsin
Other Online Services	<ul style="list-style-type: none"> • E-mail your questions to: mcare@mhsjvl.org or go to the contact us page at www.mercycarehealthplans.com
Outpatient Mental Health Network/Policy	All mental health and substance abuse services must be provided by a participating provider. If you need assistance in selecting a participating provider, please contact Customer Service at 1-800-895-2421.

ADDITIONAL INFORMATION

Dental Benefits If Provided

Call Delta Dental at 1-800-236-3712 with coverage questions. Members will receive a separate ID card for Dental. You may go online to find a PPO Dentist.

- www.deltadental.com
- Select Dentist Search under “Looking for a dentist”
- Select Delta Dental PPO and fill in your city and state or zip code
- Click on Search for a Dentist and all Delta PPO dentists in your area will be listed

Coverage: Individual Annual Maximum \$1,000

Individual Lifetime Orthodontic Maximum \$1,500

Diagnostic & Preventive Services no deductible applies 100%

**Examinations, teeth cleaning (prophylaxis), sealants, bitewing & full mouth x-rays, fluoride treatments, space maintainers (limited to one check-up every 6-months)*

Basic Restorative Services \$25 single/\$75 family deductible 80%

**Amalgam (silver) restorations on back teeth, simple extractions, oral surgery, composite restorations (white) fillings on front teeth, stainless steel crowns, local anesthetics, emergency treatment to relieve pain*

Endodontics and Periodontics \$25 single/\$75 family deductible 50%

Orthodontics no deductible applies 50%

** Orthodontics coverage for dependents to age 19.*

Benefit levels outside of Delta Dental Network subject to Maximum Plan Allowance. Your out-of-pocket expense will be less if you use a Delta PPO Dentist.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Dane							Cambridge Family Medical Clinic
Green							Brodhead Chiropractic Center, Mercy Brodhead Medical Center, Vision Clinic
Jefferson	•	•	•		Ft. Atkinson Memorial Hospital Watertown Hospital		Fort HealthCare Cambridge Clinic Fort HealthCare Center for Women's Health Fort HealthCare Surgical Associates Internal Medicine & Pediatrics • UW Health Ft. Atkinson
Rock		•	•		Edgerton Memorial Community Hospital Mercy Hospital		• Mercy Beloit Medical Center • Mercy Edgerton Medical Center • Mercy Evansville Medical Center • Mercy Clinic East • Mercy Clinic South • Mercy Clinic West • Mercy Health Mall • Mercy Hematology/Oncology Clinic • Mercy Options • Mercy Regional Cancer Center • Mercy Regional Heart & Vascular Center • Mercy Regional Neurosurgery Center • Mercy Sports Medicine & Rehab Center • Mercy Women's Health Center • Mercy Milton Medical Center
Walworth	•	•	•	•	Lakeland Medical Center - if admitted by a Mercy Physician		• Mercy Lake Geneva Medical Center • Mercy Walworth Hospital & Medical • Mercy Walworth Sports Med • Mercy Sharon Medical Center • Mercy Whitewater Medical Center • Mercy Whitewater Sports Med

* This column provides only a general summary of major provider groups. For a complete listing, please contact MercyCare Customer Service at 1-800-895-2421, or go to www.mercycarehealthplans.com (please refer to the online Provider Directory Section).

MercyCare also has a separate Northeastern Illinois Network. The counties represented are McHenry and Lake. Please call our Customer Service at 1-800-895-2421 for an Illinois provider directory.



Network Health Plan

1570 Midway Place

P.O. Box 120

Menasha, WI 54952

Phone: (920) 720-1300 (800) 826-0940

Fax: (920) 720-1900

Web site: www.networkhealth.com



Type of Plan	Health Maintenance Organization
Total Number of Members.....	69,555
Years of Operating Experience	25
Total Number of Primary Care Physicians (PCPs).....	432
Total Number of Hospitals Affiliated with Plan.....	15
Total Number of Urgent Care Facilities	8
Total Number of Dentists.....	688

ADDITIONAL INFORMATION

PCP Requirements	<ul style="list-style-type: none"> All members of Network Health Plan (NHP) are required to choose a PCP. You can choose your PCP from the following: family practice, general practice, internal medicine, pediatrician, or an allied health professional. You can find PCP information by calling NHP and requesting a directory, or going to the online provider directory. Directions for accessing the online provider directory are below. You can change your PCP at anytime by calling NHP's Customer Service. We do not have any restrictions on how often your PCP can be changed. NHP will automatically assign a PCP if one is not chosen.
Referral Requirements	If your PCP feels you need specialty care, your PCP will refer you to a specialist in the NHP network. However, if you or your PCP believe you should be seen by a specialist that is not in the NHP network, prior authorization must be obtained from NHP. Please refer to the prior authorization section below
Prior Authorization Requirements	NHP's Health Management Department utilizes pre-authorization requirements and pre-admission review to ensure that selected procedures, treatment plans, health services, particular providers or locations are medically necessary and constitute appropriate care based upon NHP's health management criteria and other nationally-recognized guidelines. Some health services will not be covered without prior written authorization from NHP's Health Management Department. Inpatient hospitalizations, out-of-plan services or care at tertiary facilities are a few examples of health services that require prior authorization from NHP. A member should contact his or her PCP or NHP Customer Service Department for information on specific health care services that require pre-authorization and/or pre-admission review, and for verification that NHP has approved an authorization prior to obtaining services. NHP will send written notification to the requesting provider, the authorized provider and the member informing them of the decision within 15 days of receiving the request for a prior authorization.
Online Provider Directory	<ul style="list-style-type: none"> Go to www.networkhealth.com Click on Find a Doctor Click on State of Wisconsin Fox Valley Network Provider Directory.
Other Online Services	<ul style="list-style-type: none"> At www.networkhealth.com, you can access NetworkConnect to view claims, explanation of benefits, overview of benefits, Certificate of Coverage, provider information, and request additional Customer Service. Also available online is Affinity NurseDirect, Privacy Practices, Member Rights and Responsibilities, clinic locations and health information.
Outpatient Mental Health Network/Policy	All mental health and substance abuse services must be provided by a plan provider. Please refer to the provider directory for a listing of our plan providers. If you need assistance please contact NHP's Care Management Behavioral Health Department at 800-555-3616.

ADDITIONAL INFORMATION

Dental Benefits If Provided

As a member of NHP, you will automatically be enrolled in the dental plan. You will also receive a separate ID card from Delta Dental.

Annual Deductible \$25 Individual/\$75 Family (applies only to basic restorative and orthodontic services)

Individual Annual Maximum	\$1,000
Individual Lifetime Orthodontic Maximum	\$1,500

Diagnostic and Preventative Services covered at 100% include: examinations, teeth cleanings (prophylaxis and periodontal maintenance), bitewing and x-rays all covered (twice per calendar year), full mouth x-rays (at three year intervals), fluoride treatments (twice per calendar year to age 19), and space maintainers.

Basic Restorative Services covered at 80% include: emergency treatment to relieve pain, fillings, and sealants.

Orthodontics are covered at 50% with an individual lifetime maximum of \$1500 for dependent children when the active treatment starts before age 19.

Please visit the Delta Dental web site for the most up to date listing of dentists at www.deltadentalwi.com or by calling Delta Dental at 1-800-236-3712. You can select Premier or PPO as the product selected. Then follow instructions for further search information.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Brown	•	•	•	•	St. Mary's Hospital Medical Center St. Vincent Hospital	•	Prevea Clinic Dousman Clinic SC
Calumet	•	•	•		Calumet Medical Center	•	Affinity Medical Group
Dodge	•	•	•	•	Waupun Memorial Hospital		Fond du Lac Regional Clinic
Door	•	•	•		Door County Memorial Hospital		North Shore Medical Clinic
Fond du Lac	•	•	•	•	Ripon Medical Center St. Agnes Hospital	•	Affinity Medical Group Fond du Lac Regional Clinic
Green Lake	•	•	•	•	Berlin Memorial Hospital		CHN Medical Center
Manitowoc	•	•	•		Holy Family Memorial, Inc.	•	Lakeshore Family Medicine Woodland Clinic
Outagamie		•	•		St. Elizabeth Hospital	•	Affinity Medical Group UW Health Fox Valley Family Practice Primary Care Associates of Appleton Kaukauna Clinic SC
Sheboygan		•	•		St. Nicholas Hospital		Marsho Family Medicine Group SC Sheboygan Internal Medicine
Waupaca			•	•	Riverside Medical Center New London Family Medical Center	•	Ministry Medical Group Affinity Medical Group
Waushara	•			•	Wild Rose Community Memorial Hospital		CHN Medical Center Waushara Family Physicians
Winnebago		•	•		Mercy Medical Center	•	Affinity Medical Group

* This column provides only a general summary of major providers groups. For a complete listing, please go to www.networkhealth.com or call Customer Service at 1-800-826-0940.



Physicians Plus – Meriter & UW

PO Box 2078
 Madison, WI 53701-2078
 (608) 282-8900 or 1-800-545-5015
 Web Site: www.HealthyChoicesBigRewards.com

Type of Plan	Health Maintenance Organization
Total Number of Members.....	102,475
Years of Operating Experience	21
Total Number of Primary Care Physicians (PCPs).....	383
Total Number of Hospitals Affiliated with Plan.....	16
Total Number of Urgent Care Facilities	16
Total Number of Dentists.....	60

ADDITIONAL INFORMATION

PCP Requirements	Members choose a Primary Care Physician (PCP) from the list of family practitioners, internal medicine doctors, pediatricians and obstetricians/gynecologists listed in our State of Wisconsin/Wisconsin Public Employees Provider Directory. Each family member can select a different PCP from our list of participating providers. If you do not select a PCP, one will be chosen for you automatically. Once selected, members can change their PCP any time using GO-TO at www.HealthyChoicesBigRewards.com or by calling Member Service.
Referral Requirements	No written referral requests are required when receiving medically necessary care from participating specialty care providers. Participating specialty care providers include all UW Health Physicians and other community physicians listed in the State of Wisconsin/Wisconsin Public Employees Provider Directory under “Specialty Care Providers.” Before receiving care from non-participating providers, members must have their Primary Care Physician submit a referral to Physicians Plus. Physicians Plus reviews these referrals and notifies members in writing of approval or denial.
Prior Authorization Requirements	Certain treatments, services, supplies and equipment, such as inpatient services, cardiac rehabilitation and durable medical equipment, require advance prior authorization from Physicians Plus. Primary Care Physicians submit the prior authorization requests, and Physicians Plus will notify members of approval or denial in writing.
Online Provider Directory	<ul style="list-style-type: none"> • Visit www.HealthyChoicesBigRewards.com • Click on “Find a Provider” at the top of the page. • Click the “State of Wisconsin/Wisconsin Public Employee” button • Click the button for the type of provider • Click “Continue” to access the directory
Other Online Services	<p>Members can connect to www.HealthyChoicesBigRewards.com and:</p> <ul style="list-style-type: none"> • Review benefit summaries • Download member materials • Find information on wellness initiatives <p>Click the GO-TOSM link for 24/7 health plan access to:</p> <ul style="list-style-type: none"> • Go-To Healthy Choices personal health manager • Review claims • Select a primary care provider • Print ID cards and more
Outpatient Mental Health Network/Policy	When you need a mental health provider, contact UWMF Behavioral Health Consultation System at (608) 282-8960 or (800) 683-2300 for prior authorization. A mental health professional will assess your situation and refer you to the appropriate provider.

ADDITIONAL INFORMATION

Dental Benefits Provided

Preventive dental coverage is available through participating dental providers including: 100% coverage for cleanings (two per calendar year), diagnostic, preventive and specific restorative procedures. *Extractions of primary teeth for orthodontic purposes* are covered at 50%. Orthodontic coverage is provided at 50% of the first \$3,000 in services. Treatment must be completed before the patient reaches age 19. All other services are covered at 50% up to \$100 per member per year. A complete list of participating dental providers is found in the State of Wisconsin/Wisconsin Public Employees Provider Directory. Members use their Physicians Plus ID card to receive benefits. Please call our Member Service department for more specific benefit information.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Adams					Moundview Memorial Hospital & Clinics		Moundview Clinic Roche-A-Cri Heart • UW Health Outreach Specialists
Columbia	•	•	•	•	Columbus Community Hospital Divine Savior Hospital	•	• UW Health Portage • UW Health Pardeville Divine Savior Poser Clinic Portage Clinic • UW Health Outreach Specialists Wisconsin Heart Wisconsin Dells Clinic
Dane	•	•	•	•	Meriter Hospital University of Wisconsin Hospital & Clinics Stoughton Hospital	•	Associated Physicians Meriter Medical Clinic Melius, Schurr & Cardwell • UW Health Wildwood Family Clinics Wisconsin Heart
Grant	•	•	•	•	Boscobel Area Health Care Grant Regional Health Center		Boscobel Clinic Bluff Street Clinic Family Medical Center Grant Regional Family Practice Muscoda Health Center Riverside Family Practice CHN Medical Clinics
Green Lake	•	•	•	•	Berlin Memorial Hospital		Dodgeville Medical Center Mineral Point Medical Center Family Practice Associates • UW Health Outreach Specialists
Iowa	•	•		•	Upland Hills Health		• Medical Health Associates Wisconsin Heart
Lafayette	•	•			Memorial Hospital of Lafayette County	•	• UW Health Crossroads Clinic CHN Medical Center Montello
Marquette						•	Richland Medical Center
Richland		•	•		Richland Hospital	•	• UW Health Outreach Specialist Wisconsin Heart
Rock					Edgerton Hospital and Health Services		Kenneth Betts, M.D. Edgerton Clinic Wisconsin Heart
Sauk	•	•	•	•	Sauk Prairie Memorial Hospital St. Clare Hospital - Baraboo	•	Prairie Clinic • Medical Associates Baraboo Internal Medicine Sauk Prairie Memorial Hospital Clinics • UW Health Outreach Specialists Wisconsin Heart River Valley Medical Center Spring Green Medical Center
Waushara	•			•	Wild Rose Community Memorial Hospital		CHN Medical Center Waushara Family Physicians

* This is only a general summary of major provider groups. For a complete listing, please visit www.HealthyChoicesBigRewards.com or consult the Physicians Plus State of Wisconsin/Wisconsin Public Employees Provider Directory. To obtain a Provider Directory, call Member Service at (608) 282-8900 or 800-545-5015.



Security Health Plan of Wisconsin, Inc.

1515 Saint Joseph Avenue, P.O. Box 8000

Marshfield, WI 54449-8000

1-800-472-2363 (715) 221-9555

www.securityhealth.org/state



Type of Plan.....	Health Maintenance Organization
Total Number of Members	143,500
Years of Operating Experience	21
Total Number of Primary Care Physicians (PCPs)	675
Total Number of Hospitals Affiliated with Plan	39
Total Number of Urgent Care Facilities.....	28
Total Number of Dentists	110

ADDITIONAL INFORMATION

PCP Requirements You are not required to select a PCP. You may receive services from any SHP network provider listed in the Provider Directory but are encouraged to establish a relationship with a PCP.

Referral Requirements As a member of Security Health Plan (SHP), you are free to see any provider in our network without a referral. **However, prior to seeing a non-network provider, you or your provider must submit a referral request in writing to SHP.** SHP will notify you in writing whether the referral request is approved or denied. If your referral is not approved, your services will not be covered.

Prior Authorization Requirements To ensure that services are covered, SHP recommends that you or your provider request prior authorization for the following:

- Services that may be considered cosmetic or otherwise not medically necessary
- Services that may be considered experimental/investigational
- Services from providers not affiliated with SHP

SHP will notify the person requesting the referral (you or the provider) whether the prior authorization is approved. If you are not sure if a service or procedure requires prior authorization, please call SHP.

Online Provider Directory Log onto www.securityhealth.org/state and click on Provider Directory to learn more about searching for network providers

Other Online Services Security Health Online offers a convenient and secure way to manage your health insurance. Log onto www.securityhealth.org/state to learn more about:

- Tracking personal benefit limits or claim status
- Requesting ID cards
- More

Security Health Online offers fast access to your personal health care information, any time, any day.

Outpatient Mental Health Network/Policy Please reference your Provider Directory or call SHP. You do not need a referral or prior authorization if you use a SHP network provider.

Dental Benefits If Provided

Class I – Preventive Care

Individual/Family deductible..... None

Preventive services per member:

Exams & cleanings (2/calendar year), x-rays (with frequency limits) 100%

Preventive services per dependent child under age 19

Fluoride (1/calendar year), space maintainers (for non-orthodontic Treatment) & sealants 100%

Members have the above dental benefits when they see a dentist that is in network. Contact SHP for a list of providers.

Class II – Child Orthodontic Care – covers children under age 19

Services50%, up to \$1,200 lifetime limit

Members can see a provider of their choice for orthodontic care.

Contact SHP for a Schedule of Dental Benefits. Members need to use their SHP ID cards for their dental benefit.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Adams					Moundview Memorial Hospital		Delton Family Medical Center Moundview Clinic Roche A Cri Clinic SC
Ashland		•	•		Memorial Medical Center		Main Street Clinic Duluth Clinic—Ashland St. Lukes – Chequamegon Medical Center
Barron		•	•	•	Cumberland Memorial Hospital Lakeview Medical Center	•	Cumberland Clinic Marshfield Clinic Centers
Chippewa	•	•	•		Our Lady of Victory Hospital St Joseph's Hospital	•	Cadott Medical Center SC Marshfield Clinic Center Family Health Associates
Clark		•			Memorial Hospital	•	Marshfield Clinic Centers Memorial Medical Centers Victory Medical Group
Douglas			•	•	St. Mary's Hospital of Superior		Duluth Clinic—Superior St. Lukes – Mariner Medical Center
Eau Claire	•	•	•		Oakleaf Surgical Hospital LLC Sacred Heart Hospital	•	Family Medicine Clinics Marshfield Clinic Centers Oakleaf Pediatrics Southside Medical Clinic
Jackson	•	•	•		Black River Memorial Hospital River Falls Hospital		Krohn Clinic
Juneau	•	•	•		Hess Memorial Hospital		Elroy Family Medical Center Mile Bluff Clinic Necedah Family Medical Center New Lisbon
Langlade			•		Langlade Memorial Hospital		Antigo Medical Building Aspirus Clinics
Lincoln		•	•	•	Good Samaritan Health Center Sacred Heart Hospital	•	Aspirus Clinic Marshfield Clinic Center Ministry Medical Group
Marathon	•	•	•	•	Aspirus Wausau Hospital Inc St. Clares Hospital of Weston Inc	•	Aspirus Clinics Bridge Community Health Clinic Marshfield Clinic Centers Ministry Medical Group UW Health Wausau Family Medicine
Oneida		•	•		Howard Young Medical Center St Mary's Hospital	•	Child Health Care Center Marshfield Clinic Center Ministry Medical Groups
Pepin					Chippewa Valley Hospital		Castleberg Clinic SC
Portage		•	•		St Michael's Hospital		Aspirus Clinics Juan B Lopez MD Ministry Medical Groups
Price					Flambeau Hospital Inc	•	Marshfield Clinic Centers Medford Clinic
Rusk					Rusk County Memorial Hospital	•	Marshfield Clinic Center
Sawyer		•			Hayward Area Memorial Hospital		North Woods Community Health Center Stone Lake Medical Clinic Duluth Clinic--Hayward
Taylor		•	•		Memorial Health Center		Medford Clinic
Vilas					Eagle River Memorial Hospital	•	Aspirus Clinics Marshfield Clinic Center Ministry Medical Group
Washburn		•	•		Indianhead Medical Center		North Woods Community Health Center Duluth Clinic—Spooner
Waupaca			•		Riverside Medical Center Spooner Health System	•	Ministry Medical Groups Robert L Peterson MD SC Thedacare Physicians
Wood	•	•	•		Riverview Hospital St Joseph's Hospital	•	Aspirus Clinic Marshfield Clinic Centers Riverview Family Clinic

Other providers in Bayfield, Burnett, Dunn, Forest, Iron, Monroe, Shawano, Trempealeau and Waushara counties.

* This column provides only a general summary of major provider groups. For a complete listing, please contact SHP at 800-472-2363 or 715-221-9555. This information is also available online at www.securityhealth.org/state under Provider Directory.



STATE MAINTENANCE PLAN

1717 West Broadway, PO Box 8190
 Madison WI 53708-8190
 1-800-634-6448
www.wpsic.com/state

Type of Plan	Self-Insured Health Plan
Total Number of Members	109,232
Total Years of Operating Experience	61 years
Total Number of Primary Care Physicians (PCPs)	74
Total Number of Hospitals Affiliated with Plan	7
Total Number of Urgent Care Facilities	N/A
Number of Dental Clinics	No Routine Dental Coverage

ADDITIONAL INFORMATION

PCP Requirements	Selection of a PCP is not required. You may use any provider who is a participating provider with the WPS SMP Network.
Referral Requirements	<p>A formal WPS approved referral is required from your participating provider when:</p> <ul style="list-style-type: none"> • Seeking care outside the WPS SMP network • Seeking behavior health services from an out-of-network behavioral health provider. For behavioral health services, WPS will request a treatment plan after 8 combined outpatient visits and monitor for medical necessity. <p>Retroactive referrals are not allowed. A referral is the written form from a participating physician requesting any out-of-network services, including behavioral health that WPS has approved. You should not utilize out-of-network providers until the request for referral has been reviewed and approved by WPS. Notification of the decision will be sent to you and your requesting participating physician. It is ultimately the member's responsibility to make sure the referral is submitted and approved prior to receiving services.</p>
Prior Authorization Requirements	<p>To ensure that services are covered, WPS recommends that members or treating providers request prior authorizations for the following types of services: New medical or biomedical technology, Methods of treatment by diet or exercise, New surgical methods or techniques, Acupuncture or similar methods, Organ transplants, Durable medical equipment over \$500, pain management injections.</p> <p>Without an approved prior authorization WPS may deny payment. Additional information may be submitted for further review of the denial. Please visit www.wpsic.com/state and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form. You or your provider may also call Member Services to request this form.</p>
Online Provider Directory	Access to WPS State of Wisconsin provider directories can be obtained by visiting www.wpsic.com/state and following the Find a Doctor link.
Other Online Services	We are able to answer questions about claims or benefits with our secure messaging via the web. The WPS State of Wisconsin web pages (www.wpsic.com/state) provide access to your plan benefits, member materials, and our "Find a Doctor" provider directories . Once enrolled in the plan, you can register online to gain access to comprehensive plan and health care information as well as timesaving account management tools.
Outpatient Mental Health Network/Policy	A formal WPS approved referral from your participating provider is required when seeking services from out-of-network behavior health providers. See "Referral Requirements" for details.
Dental Benefits if Provided	Not available.

ADDITIONAL INFORMATION

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Bayfield		•	•		Memorial Medical Center		Ashland Clinic, Mainstreet Clinic, Chequamegon Clinic, Red Cliff Health Center
Buffalo	•		•		River Falls Area Hospital	•	Midelfort Clinic-Mondovi River Falls Medical Clinic
Burnett					Burnett Medical Center		Ingalls Family Medical Center Shell Lake Clinic
Florence Forest					Dickinson Memorial Hospital Dickinson Memorial Hospital		Florence Medical Center-Dickinson Crandon Medical Group-Ministry Health Care
Iron					Grandview Hospital		Grandview Clinic – Hurley Marshfield Clinic – Mercer Center
Marquette	•	•	•	•	Berlin Memorial Hospital	•	Montello Family Practice UW Health CrossRoads Westfield Family Medical Center CHN Medical Center
Menominee Pepin	•		•		River Falls Area Hospital		River Falls Medical Clinic, Castleburg Clinic

* This column provides only a general summary of major provider groups. For a complete listing, please visit our web site at www.wpsic.com/state or call WPS Member Services Department at 1-800-634-6448.

Service Centers

We are able to answer questions about claims or benefits by letter, telephone, or secure messaging via the web. We also provide convenient walk-in service at each of our service centers located in Appleton, Eau Claire, Madison, Milwaukee and Wausau. Contact WPS Member Services (1-800-634-6448) for phone numbers and addresses.



UnitedHealthcare of Wisconsin Northeast

PO Box 13187

Green Bay, WI 54307-3187

Phone (800) 357-0974 Fax (920) 662-8349

For enrollment questions during Dual Choice, please call
the Enrollment Hotline toll free (866) 873-3903

Type of Plan	Health Maintenance Organization
Total Number of Members	882,000
Years of Operating Experience.....	19
Total Number of Primary Care Physicians (PCPs)	1,468
Total Number of Hospitals Affiliated with Plan	18
Total Number of Urgent Care Facilities	9
Total Number of Dentists	Provider of Your Choice

ADDITIONAL INFORMATION

PCP Requirements	Not required to select a PCP.
Referral Requirements	UnitedHealthcare (UHC) provides you the freedom to see any network physician from our broad network of physicians and other health care professionals for office visits, at any time, without a referral from a primary physician. If specific covered health services are not available from a network physician, you may be eligible for benefits when covered health services are received from non-network physicians. In this situation, your network physician must notify UHC Care Coordination to request a network gap exception. You and your physician will be notified in writing of UHC's decision.
Prior Authorization Requirements	In most cases, UHC does not require prior authorization before a physician can begin treatment. In general, network providers are responsible for notifying UHC's Care Coordination before they provide services to you. However, you are responsible for notifying UHC's Care Coordinator before obtaining dental/oral surgery services or if you are admitted to a non-network hospital due to an emergency. (Please refer to the Outpatient Mental Health Network Policy section for requirements pertaining to mental health and substance abuse treatment.) For in-network services, while the physician or other health care professional is responsible for notification to UHC, please verify with your physician that this notification has occurred. You and your physician will be notified in the writing of the coverage determination. Questions concerning Care Coordination can be answered by calling the telephone number on your medical ID card.
Online Provider Directory	Copies of the provider directories are available on –line in a PDF format at www.myuhc.com/groups/state . Log in: state
Other Online Services	As a UHC member, you will have access to www.myuhc.com for instant, convenient online access to health information. Once you receive your UnitedHealthcare ID card, you can register on www.myuhc.com and access services such as: <ul style="list-style-type: none"> • Review claims and history • Print an ID card • Get personalized health information • Personalized Health Risk Assessment with report card to print and share with your doctor.
Outpatient Mental Health Network/Policy	Members need to call for an initial assessment. The Managed Mental Health and Substance Abuse Program for UHC is administered by UnitedHealth Group's wholly owned subsidiary, United Behavioral Health (UBH). Simply call our 24 hour access line at 1-800-851-5188 for triage and authorization for Plan providers.

ADDITIONAL INFORMATION

Dental Benefits If Provided

Oral surgery under Uniform Benefits requires medical network providers. Included in the UHC plan is a UHC Dental supplemental benefit which provides coverage for preventive and basic dental care. The UHC Dental Plan has an open dental network to allow members to go to the dentist of their choice. However, charges are payable up to UHC's maximum allowable fees.

Deductible: \$50 per individual/\$100 family

Maximum Benefit:..... \$1,000 per person per calendar year

Preventive and Diagnostic Services: No deductible / 100%

Examinations limited to 2 times per calendar year, bitewing x-rays, complete series or panorex x-rays, prophylaxis (cleanings), fluoride treatments and sealants.

Basic Dental Services:50%

Amalgam restorations (fillings), Composite resin restorations (fillings), simple extractions, general anesthesia, palliative treatment (relief of pain), and space maintainers.

Orthodontic Services:.....No Deductible / 50%

Services must be completed before attaining age 19. Coverage up to an individual ortho lifetime maximum of \$1,200.

Please Note: You will receive a separate dental ID card. For more information please contact the customer service number on the back of your dental ID card.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Brown	•	•	•	•	Bellin Hospital Aurora Bay Care Medical Center	•	Bellin Medical Group Aurora Medical Group
Door		•	•		Door County Memorial Hospital		
Fond du Lac			•		Ripon Medical Center St. Agnes Hospital		Fond du Lac Regional Clinic
Green Lake	•	•	•	•	Berlin Memorial Hospital		
Kewaunee							
Manitowoc	•	•	•	•	Aurora Medical Center – Manitowoc County	•	Aurora Medical Group
Marinette	•	•	•	•	Bay Area Medical Center		
Oconto					Community Memorial Hospital		
Outagamie		•	•	•	Appleton Medical Center New London Family Medical Center	•	ThedaCare
Shawano		•	•	•	Shawano Medical Center		
Sheboygan	•	•	•	•	Aurora Sheboygan Memorial Medical Center	•	Aurora Medical Group
Waupaca			•		Riverside Medical Center		
Waushara	•			•	Wild Rose Community Hospital		
Winnebago	•	•	•	•	Theda Clark Medical Center Children's Hospital of WI-Fox Valley Aurora Medical Center - Oshkosh	•	ThedaCare Aurora Medical Group

* This column provides only a general summary of major provider groups. For a complete listing, please contact customer service and request form #FWOAH20WI-608.



UnitedHealthcare of Wisconsin Southeast

PO Box 13187

Green Bay, WI 54307-3187

Phone (800) 357-0974 Fax (920) 662-8349

For enrollment questions during Dual Choice, please call
the Enrollment Hotline toll free (866) 873-3903

Type of Plan	Health Maintenance Organization
Total Number of Members	882,000
Years of Operating Experience.....	19
Total Number of Primary Care Physicians (PCPs)	2,603
Total Number of Hospitals Affiliated with Plan	26
Total Number of Urgent Care Facilities	32
Total Number of Dentists	Provider of Your Choice

ADDITIONAL INFORMATION

PCP Requirements	Not required to select a PCP.
Referral Requirements	UnitedHealthcare (UHC) provides you the freedom to see any network physician from our broad network of physicians and other health care professionals for office visits, at any time, without a referral from a primary physician. If specific covered health services are not available from a network physician, you may be eligible for benefits when covered health services are received from non-network physicians. In this situation, your network physician must notify UHC's Care Coordination to request a network gap exception. You and your physician will be notified in writing of UHC's decision.
Prior Authorization Requirements	<p>In most cases, UHC does not require prior authorization before a physician can begin treatment. In general, network providers are responsible for notifying UHC's Care Coordination before they provide services to you. However you are responsible for notifying UHC's care coordination before obtaining dental/oral surgery services or if you are admitted to a non-network hospital due to an emergency. (Please refer to the Outpatient Mental Health Network Policy section for requirements pertaining to mental health and substance abuse treatment.)</p> <p>For in-network services, while the physician or other health care professional is responsible for notification to UHC, please verify with your physician that this notification has occurred. You and your physician will be notified in the writing of the coverage determination. Questions concerning Care Coordination can be answered by calling the telephone number on your medical ID card.</p>
Online Provider Directory	Copies of the provider directories are available on-line in a PDF format at www.myuhc.com/groups/state . Log in: state
Other Online Services	<p>As a UHC member, you will have access to www.myuhc.com for instant, convenient online access to health information. Once you receive your UnitedHealthcare ID card, you can register on www.myuhc.com and access services such as:</p> <ul style="list-style-type: none"> • Review claims and history • Print an ID card • Get personalized health information • Personalized Health Risk Assessment with report card to print and share with your doctor.
Outpatient Mental Health Network/Policy	Members need to call for an initial assessment. The Managed Mental Health and Substance Abuse Program for UHC is administered by UnitedHealth Group's wholly owned subsidiary, United Behavioral Health (UBH). Simply call our 24 hour access line at 1-800-851-5188 for triage and authorization for Plan providers.

ADDITIONAL INFORMATION

Dental Benefits If Provided

Oral surgery under Uniform Benefits requires medical network providers. Included in the UHC plan is a UHC Dental supplemental benefit which provides coverage for preventive and basic dental care. The UHC Dental Plan has an open dental network to allow members to go to the dentist of their choice. However, charges are payable up to UHC's maximum allowable fees.

Deductible: \$50 per individual/\$100 family

Maximum Benefit:..... \$1,000 per person per calendar year

Preventive and Diagnostic Services: No deductible / 100%

Examinations limited to 2 times per calendar year, bitewing x-rays, complete series or panorex x-rays, prophylaxis (cleanings), fluoride treatments and sealants.

Basic Dental Services:50%

Amalgam restorations (fillings), Composite resin restorations (fillings), simple extractions, general anesthesia, palliative treatment (relief of pain), and space maintainers.

Orthodontic Services:No Deductible / 50%

Services must be completed before attaining age 19. Coverage up to an individual ortho lifetime maximum of \$1,200.

Note: You will receive a separate dental ID card. For more information please contact the customer service number on the back of your dental ID card.

Counties in Service Area		✓	S	Rx	Hospitals in County		Major Providers in County *
Kenosha	•	•	•	•	<ul style="list-style-type: none"> • Aurora Medical Center • United-Kenosha Medical Center • United-St. Catherine's Medical Center 	•	<ul style="list-style-type: none"> • Aurora Medical Group • Wheaton Franciscan Medical Group
Milwaukee	•	•	•	•	<ul style="list-style-type: none"> • Aurora St. Luke's Hospital • Aurora Sinai Medical Center • Children's Hospital of Wisconsin • Columbia St. Mary's Hospital • Froedtert Memorial Lutheran Hospital • St. Francis Hospital • St. Joseph's Hospital • West Allis Memorial Hospital 	•	<ul style="list-style-type: none"> • Aurora Medical Group • Medical College of Wisconsin • Columbia St. Mary's Hospital of Milwaukee Physicians • Children's Medical Group • Wheaton Franciscan Medical Group
Ozaukee	•	•	•	•	<ul style="list-style-type: none"> • Columbia St. Mary's Hospital 	•	<ul style="list-style-type: none"> • Columbia St. Mary's Hospital of Ozaukee Physicians
Racine	•	•	•	•	<ul style="list-style-type: none"> • All Saints Medical Center 	•	<ul style="list-style-type: none"> • Wheaton Franciscan Medical Group
Walworth	•	•	•	•	<ul style="list-style-type: none"> • Aurora Lakeland Medical Center 		
Washington	•	•	•	•	<ul style="list-style-type: none"> • Aurora Medical Center of Washington • St. Joseph's Community Memorial Hospital West Bend 	•	<ul style="list-style-type: none"> • West Bend Clinic • Aurora Medical Group • Medical Associates Health Centers
Waukesha	•	•	•	•	<ul style="list-style-type: none"> • Elmbrook Memorial Hospital • Oconomowoc Memorial Hospital • Waukesha Memorial Hospital 	•	<ul style="list-style-type: none"> • Medical Associates Health Centers • Waukesha Health Care

*This column provides only a general summary of major provider groups. For a complete listing, please contact customer service and request form #FWOAH20WI-606.



Unity Health Plans Insurance Corporation
Community Network
 840 Carolina Street
 Sauk City, WI 53583
 (800) 362-3310 FAX (608) 643-2564
 unityhealth.com



Type of Plan	Health Maintenance Organization
Total Number of Members.....	75,300
Years of Operating Experience	24
Total Number of Primary Care Physicians (PCPs).....	379
Total Number of Hospitals Affiliated with Plan.....	34
Total Number of Urgent Care Facilities	32
Total Number of Dentists.....	378

ADDITIONAL INFORMATION

PCP Requirements	Each family member may select a different PCP within the Community Network. If you are not familiar with the practitioners, you may choose a clinic in the Community Network and Unity will assign you a PCP from your selected clinic. If you do not indicate a PCP or PCP Clinic on your application, Unity will assign you a PCP. Changes to your PCP are made by contacting Unity. The change will be effective the first day of the month following Unity's receipt of your request.
Referral Requirements	No written referral requests are needed when you seek care for medically necessary covered services from Unity Community providers. In addition, covered benefits for chiropractic care, dental care (except TMJ/TMD), one annual routine eye exam, and routine OB/GYN care do not require a written referral request from your Primary Care Physician (PCP), but you must use a participating network specialist. Out-of-plan provider requests do require a written referral request from your physician that must be approved by Unity and will be reviewed only for services that are not available from participating providers in the Community Network. You, your PCP and the specialist to whom you're being referred will receive notification in writing from Unity stating the decision on your referral request. Please contact Unity Customer Service at 1-800-362-3310 with any questions.
Prior Authorization Requirements	Some medical services, procedures and equipment require prior authorization and your physician must obtain approval from Unity for covered benefits to be paid. For behavioral health requirements, please refer to the Outpatient Mental Health Network/Policy on the next page. All prior authorized services are reviewed for medical necessity. Your physician submits the prior authorization request to Unity. You, your PCP, and the specialist requesting the service will receive notice in writing from Unity stating the decision on your prior authorization request.
Online Provider Directory	To find participating Community Network providers: <ul style="list-style-type: none"> • Click on <i>Find a Doctor</i> on the home page of Unity's web site, unityhealth.com. • Select State and Local Government Participant. • Select your PCP location of Community. You can now search for providers using a variety of criteria. You can even view the location of your selected providers on a map.
Other Online Services	Unity's web site is a valuable resource of information. Visit unityhealth.com to: <ul style="list-style-type: none"> • Learn more about Unity's health and wellness programs. Just click on the <i>Fitness and Wellness</i> icon on the home page. This will give you access to information on Unity's Fitness First and Fitness First for Kids programs, in addition to Health First, Wellness First and Weight Watchers® programs. • Access Benefits Assistant, a secure portal to your claim information and authorizations. With Benefits Assistant you can perform enhanced provider searches and view your eligibility and specific health plan benefits. In addition, you can change your PCP or request new ID cards. Benefits Assistant is a fast, easy, and convenient online service that places your health insurance information at your fingertips – 24 hours a day, 7 days a week. • Search the Healthwise® Knowledgebase to get answers to your medical questions.

ADDITIONAL INFORMATION

Outpatient Mental Health Network/Policy Unity offers a service to assist you with your behavioral health care needs. The Behavioral Health Consultation System (BHCS) is a triage line staffed by experienced mental health clinicians. They will help you make an appointment and ensure you see the correct type of behavioral health practitioner for your specific needs. You must call BHCS at 1-800-683-2300 for prior authorization of all mental health and AODA assessments and treatment. A referral from your PCP is not needed.

Dental Benefits If Provided Your dental benefits are offered through Delta Dental. You have access to both Delta Dental Premier and Delta Dental PPO provider networks and you will receive a Delta Dental ID card. Delta Dental will provide preventive and specified restorative care. Covered benefits will be paid at 100% up to \$1,000 per member each calendar year. Orthodontic care for dependent children up to 19 years is covered at 50% of the first \$3,000 in covered services for a lifetime maximum payment of \$1,500. Call Delta Dental at 1-800-236-3712 for more information about the benefits and visit www.deltadentalwi.com to find a network dentist near you.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Adams					Moundview Memorial Hospital and Clinics		Moundview Clinic Roche-A-Cri Clinic Riverview Family Clinic-Nekoosa
Columbia	•	•	•	•	Columbus Community Hospital Divine Savior Healthcare, Inc.	•	UW Health Clinics – Columbus & Portage Divine Savior Familycare Clinic Poser Clinic Randolph Community Clinic
Crawford		•	•	•	Prairie du Chien Memorial Hospital		Kickapoo Valley Medical Clinic
Dodge	•	•	•	•	Beaver Dam Community Hospital Watertown Memorial Hospital Waupun Memorial Hospital	•	UW Health Clinics-Beaver Dam & Horicon Fond du Lac Regional Clinics Watertown Physician Hospital Organization
Fond du Lac	•	•	•	•	Ripon Medical Center St. Agnes Hospital		CHN Medical Center – Ripon Fond du Lac Regional Clinics
Grant	•	•	•	•	Boscobel Area Health Care Grant Regional Health Center Southwest Health Center	•	Blackhawk Area Health Care Bluff Street Clinic Boscobel Clinic Family Medical Center Fennimore Family Medicine Medical Associates Clinic, PC Muscoda Health Center Riverside Family Practice
Green	•	•	•	•	The Monroe Clinic Hospital		Monroe Clinics
Iowa	•	•		•	Upland Hills Health		Dodgeville Clinic Mineral Point & Dodgeville Medical Centers
Jefferson	•	•	•		Fort Memorial Hospital	•	UW Health Clinics-Fort Atkinson & Palmyra Family Medical Clinics, S.C. Fort HealthCare
Marquette						•	UW Health – Crossroads Clinic CHN Medical Center – Montello Richland Medical Center
Richland		•	•		Richland Hospital		Richland Medical Center
Rock	•	•	•		Beloit Memorial Hospital Edgerton Hospital and Health Services Mercy Hospital	•	Beloit Physician Hospital Organization Mercy Health System Clinics
Sauk	•	•	•	•	Sauk Prairie Memorial Hospital & Clinics St. Clare Hospital and Health Services Reedsburg Area Medical Center		Prairie Clinic SC Reedsburg Physicians Group Sauk Prairie Internal Medical Group Spring Green Medical Center Spring Medical Associates LLC
Vernon		•			Vernon Memorial Hospital St. Joseph's Memorial Hospital and Home		Bland & Hirsch Clinics St. Joseph's Family Clinic
Walworth					Mercy Walworth Hospital	•	Fort Healthcare Mercy Health System Clinics

You also have access to UW Hospital, Meriter Hospital and the UW Health specialists in Madison.

* This column provides only a general summary of major provider groups. Clinics owned by participating Community Network hospitals are participating providers. For a complete listing of Community Network providers visit Unity's web site, unityhealth.com and click on *Find a Doctor* or call Unity Customer Service at 1-800-362-3310.



Unity Health Plans Insurance Corporation
UW Health Network
 840 Carolina Street
 Sauk City, WI 53583
 (800) 362-3310 FAX (608) 643-2564
 unityhealth.com



Type of Plan	Health Maintenance Organization
Total Number of Members.....	75,300
Years of Operating Experience	24
Total Number of Primary Care Physicians (PCPs).....	218
Total Number of Hospitals Affiliated with Plan.....	4
Total Number of Urgent Care Facilities	3
Total Number of Dentists.....	233

ADDITIONAL INFORMATION

PCP Requirements Each family member may select a different PCP within the UW Health Network. If you are not familiar with the practitioners, you may choose a clinic in the UW Health Network and Unity will assign you a PCP from your selected clinic. If you do not indicate a PCP or PCP Clinic on your application, Unity will assign you a PCP. Changes to your PCP are made by contacting Unity. The change will be effective the first day of the month following Unity's receipt of your request.

Referral Requirements No written referral requests are needed when you seek care for medically necessary covered services from UW Health providers in Dane County. In addition, covered benefits for chiropractic care, dental care (except TMJ/TMD), one annual routine eye exam, and routine OB/GYN care do not require a written referral request from your Primary Care Physician (PCP), but you must use a participating network specialist.

Out-of-plan provider requests do require a written referral request from your physician that must be approved by Unity and will be reviewed only for services that are not available from participating providers in the UW Health Network. You, your PCP and the specialist to whom you're being referred will receive notification in writing from Unity stating the decision on your referral request. Please contact Unity Customer Service at 1-800-362-3310 with any questions.

Prior Authorization Requirements Prior authorization from Unity is required to receive specialty care from Associated Physicians unless you have an Associated Physicians PCP. For behavioral health requirements, please refer to the Outpatient Mental Health Network/Policy on the next page. Also, some medical services, procedures and equipment require prior authorization and your physician must obtain approval from Unity for covered benefits to be paid. Your physician submits the prior authorization request to Unity. You, your PCP, and the specialist requesting the service will receive a notification in writing from Unity stating the decision on your prior authorization request.

Online Provider Directory To find participating UW Health Network providers:

- Click on *Find a Doctor* on the home page of Unity's website, unityhealth.com.
- Select State and Local Government Participant.
- Select your PCP location of either a UW Health Clinic or Associated Physicians.

You can now search for providers using a variety of criteria. You can even view the location of your selected providers on a map or create a customized provider directory.

ADDITIONAL INFORMATION

Other Online Services

Unity's web site is a valuable resource of information. Visit unityhealth.com to:

- Learn more about Unity's health and wellness programs. Just click on the *Fitness and Wellness* icon on the home page. This will give you access to information on Unity's Fitness First and Fitness First for Kids programs, in addition to Health First, Wellness First and Weight Watchers® programs.
- Access Benefits Assistant, a secure portal to your claim information and authorizations. With Benefits Assistant you can perform enhanced provider searches and view your eligibility and specific health plan benefits. In addition, you can change your PCP or request new ID cards. Benefits Assistant is a fast, easy, and convenient online service that places your health insurance information at your fingertips – 24 hours a day, 7 days a week.
- Search the Healthwise® Knowledgebase to get answers to your medical questions.
- Find several Self-Service forms in the Member Section that allow you to request or submit information to Unity at any time. These Self-Service forms include a request for additional ID cards, PCP change form, and a form to order printed materials.

Outpatient Mental Health Network/Policy

Unity offers a service to assist you with your behavioral health care needs. The Behavioral Health Consultation System (BHCS) is a triage line staffed by experienced mental health clinicians. They will help you make an appointment and ensure that you see the correct type of behavioral health practitioner for your specific needs. You must call BHCS at (608) 282-8960 or toll free 1-800-683-2300 for prior authorization of all mental health assessments and treatment. For AODA needs, call Gateway Recovery at (608) 278-8200 or toll free 1-800-785-1720. A referral from your PCP is not needed for either mental health or AODA care.

Dental Benefits If Provided

Your dental benefits are offered through Delta Dental. You have access to both Delta Dental Premier and Delta Dental PPO provider networks and you will receive a Delta Dental ID card. Delta Dental will provide preventive and specified restorative care. Covered benefits will be paid at 100% up to \$1,000 per member each calendar year. Orthodontic care for dependent children up to 19 years is covered at 50% of the first \$3,000 in covered services for a lifetime maximum payment of \$1,500. Call Delta Dental at 1-800-236-3712 for more information about the benefits and visit www.deltadentalwi.com to find a network dentist near you.

Counties in Service Area		✓	S	R _x	Hospitals in County		Major Providers in County *
Dane	• • • •	•	•	•	UW Health – UW Hospital & Clinics UW Health – American Family Children's Hospital Meriter Hospital Stoughton Hospital	•	Associated Physicians and UW Health providers.

* Please refer to the Unity-UW Health Provider Directory for a complete listing of participating providers. Visit our web site at unityhealth.com and click on the *Find a Doctor* icon, or call Unity Customer Service at 1-800-362-3310 to obtain information.



Patient Choice Plan 1
 1717 West Broadway, PO Box 8190
 Madison WI 53708
 1-800-634-6448
 www.wpsic.com/state

Patient Choice also offers a Plan 2 with expanded provider choices.

Type of Plan	Preferred Provider Plan
Total Number of Members	12,766
Total Years of Operating Experience	4 years
Total Number of Primary Care Physicians (PCPs)	1215
Total Number of Hospitals Affiliated with Plan	18
Total Number of Urgent Care Facilities.....	23
Total Number of Dentists	Provider of Your Choice

ADDITIONAL INFORMATION

PCP Requirements	Each member of your family must select the Patient Choice Care System of their choice. Please see the listing on the next page for available Care Systems. You will be asked to list each family member's selected Care System on your application form. If no Care System is selected, you will be sent a letter requesting a selection be made. If you want to obtain care at a clinic in a different Care System, simply call Member Services at (800) 634-6448 to change your selection prior to receiving services. You can change your Care System selection as often as once a month. If you request a Care System change by the 20 th of the month, your new selection will be effective the first day of the following month.
In-Care System and Out-of-Care System Benefits	This preferred provider plan includes benefits for services received both in and outside of your Care System. You will receive coverage as stated in the Uniform Benefits by utilizing in-Care System providers or by receiving a referral from your physician. See below for additional information regarding referrals. Services received within your chosen Care System do not require a referral. Medical services received outside your chosen Care System without an approved referral are payable subject to a deductible of \$1,000 individual/\$2,000 family. After deductible is met, benefits are payable at 70%.
Referral Requirements	Medical services received from providers outside of your Care System may be payable at the in-Care System benefit level with a physician referral . Your Care System physician will notify WPS of the referral, which will be specific to an illness/condition and will remain active for the specified time. No retroactive referrals are allowed. If you wish to confirm whether your physician submitted a referral, call WPS Member Services at (800) 634-6448.
Prior Authorization Requirements for Non-Care System Providers	To ensure that services are covered, WPS recommends that members or treating providers request prior authorizations for the following types of services: New medical or biomedical technology; Methods of treatment by diet or exercise; New surgical methods or techniques; and Organ transplants. WPS will notify you and your requesting provider in writing on whether your prior authorization was approved or denied. Please visit www.wpsic.com/state and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form. You or your provider may also call Member Services to request this form.
Online Provider Directory	Access to WPS State of Wisconsin provider directories can be obtained by visiting www.wpsic.com/state and following the Find a Doctor link. From there, scroll down to the applicable Patient Choice plan and click on your selected Care System.
Other Online Services	The WPS State of Wisconsin web pages (www.wpsic.com/state) provide access to plan documents and materials. Once you're enrolled in the plan, you can register to gain access to our Members area which provides comprehensive plan and health care information as well as time-saving account management tools.
Outpatient Behavioral Health Network/Policy	Benefits are available for services received by any in-Care System provider without a referral. Services provided by a non-Care System provider are payable at the in-Care System benefit level with a physician referral. (See Referral Requirements above.)

ADDITIONAL INFORMATION

Dental Benefits Provided	Individual Annual Maximum.....\$500 Deductible.....\$25 single/\$75 family Individual Lifetime Orthodontic Maximum.....\$1,200 Orthodontics coverage for dependents to age 19 (subject to deductible)...50% Diagnostic & Preventive Services (subject to deductible).....100% Basic Restorative Services (subject to deductible).....50% Dental services provided by a non-Delta Dental preferred provider will be limited to the usual and customary rate as determined by Delta. Call Delta Dental at 1-800-236-3712 with coverage questions. Visit www.deltadentalwi.com to find a network dentist by clicking "Dentist Search" and then selecting Delta Dental Premier. Your Delta ID card will be sent with your WPS member materials.
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Patient Choice Plan 1 Network

Service Area: Milwaukee, Ozaukee, Racine, Washington, Waukesha Counties

Care System		✓	S	R _x	Hospitals in County		Major Providers in County *
Advanced Healthcare	•	•	•	•	Columbia St. Mary's-Columbia and Ozaukee Campuses Columbia Center Community Memorial Hospital	•	Advanced Healthcare
Children's Hospital and Health System	•	•	•	•	Froedtert Memorial Lutheran Hospital Orthopaedic Hospital of Wisconsin Children's Hospital of Wisconsin		Children's Medical Group
Columbia St. Mary's Physician Network	•	•	•	•	Columbia St. Mary's-Columbia Milwaukee and Ozaukee Campuses Columbia Center Sacred Heart Rehabilitation Institute Orthopaedic Hospital of Wisconsin Children's Hospital of Wisconsin	•	Columbia St. Mary's Community Physicians
Medical Associates	•	•	•	•	Community Memorial Hospital Froedtert Memorial Lutheran Hospital Oconomowoc Memorial Hospital Waukesha Memorial Hospital Children's Hospital of Wisconsin	•	Medical Associates
Quad-Med	•	•	•	•	Elmbrook Memorial Hospital St. Francis Hospital St. Joseph's Regional Medical Center The Wisconsin Heart Hospital Children's Hospital of Wisconsin		Quad-Med Physicians
SynergyHealth	•	•	•	•	St. Joseph's Hospital Children's Hospital of Wisconsin		West Bend Clinics
Wheaton Franciscan Provider Network	•	•	•	•	All Saints – St. Luke's All Saints – St. Mary's Elmbrook Memorial Hospital St. Francis Hospital St. Joseph's Regional Medical Center The Wisconsin Heart Hospital Children's Hospital of Wisconsin	•	Wheaton Franciscan Clinics including All Saints Providers

The Medical College of Wisconsin specialists participate with all Care Systems.

* This column provides only a general summary of major provider groups. For a complete listing, please visit our web site at www.wpsic.com/state or call WPS Member Services Department at 1-800-634-6448.



Patient Choice Plan 2

1717 West Broadway, PO Box 8190
 Madison WI 53708
 1-800-634-6448
www.wpsic.com/state

Patient Choice also offers a Plan 1 with more limited provider choices.

Type of Plan	Preferred Provider Plan
Total Number of Members.....	12,766
Total Years of Operating Experience	4 years
Total Number of Primary Care Physicians (PCPs)	2001
Total Number of Hospitals Affiliated with Plan	18
Total Number of Urgent Care Facilities	28
Total Number of Dentists.....	Provider of Your Choice

ADDITIONAL INFORMATION

PCP Requirements	Each member of your family must select the Patient Choice Care System of their choice. Please see the listing on the next page for available Care Systems. You will be asked to list each family member's selected Care System on your application form. If no Care System is selected, you will be sent a letter requesting a selection be made. If you want to obtain care at a clinic in a different Care System, simply call Member Services at (800) 634-6448 to change your selection prior to receiving services. You can change your Care System selection as often as once a month. If you request a Care System change by the 20 th of the month, your new selection will be effective the first day of the following month.
In-Care System and Out-of-Care System Benefits	This preferred provider plan includes benefits for services received both in and outside of your Care System. You will receive coverage as stated in the Uniform Benefits by utilizing in-Care System providers or by receiving a referral from your physician. See below for additional information regarding referrals. Services received within your chosen Care System do not require a referral. Medical services received outside your chosen Care System without an approved referral are payable subject to a deductible of \$1,000 individual/\$2,000 family. After deductible is met, benefits are payable at 70%.
Referral Requirements	Medical services received from providers outside of your Care System may be payable at the in-Care System benefit level with a physician referral . Your Care System physician will notify WPS of the referral, which will be specific to an illness/condition and will remain active for the specified time. No retroactive referrals are allowed. If you wish to confirm whether your physician submitted a referral, call WPS Member Services at (800) 634-6448.
Prior Authorization Requirements for Non-Care System Providers	To ensure that services are covered, WPS recommends that members or treating providers request prior authorizations for the following types of services: New medical or biomedical technology; Methods of treatment by diet or exercise; New surgical methods or techniques; and Organ transplants. WPS will notify you and your requesting provider in writing on whether your prior authorization was approved or denied. Please visit www.wpsic.com/state and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form. You or your provider may also call Member Services to request this form.
Online Provider Directory	Access to WPS State of Wisconsin provider directories can be obtained by visiting www.wpsic.com/state and following the Find a Doctor link. From there, scroll down to the applicable Patient Choice plan and click on your selected Care System.
Other Online Services	The WPS State of Wisconsin web pages (www.wpsic.com/state) provide access to plan documents and materials. Once you're enrolled in the plan, you can register to gain access to our Members area which provides comprehensive plan and health care information as well as time-saving account management tools.
Outpatient Behavioral Health Network/Policy	Benefits are available for services received by any in-Care System provider without a referral. Services provided by a non-Care System provider are payable at the in-Care System benefit level with a physician referral. (See Referral Requirements above.)
Dental Benefits Provided	Individual Annual Maximum.....\$500 Deductible.....\$25 single/\$75 family Individual Lifetime Orthodontic Maximum..... \$1,200 Orthodontics coverage for dependents to age 19 (subject to deductible)....50% Diagnostic & Preventive Services (subject to deductible).....100% Basic Restorative Services (subject to deductible).....50% Dental services provided by a non-Delta Dental preferred provider will be limited to the usual and customary rate as determined by Delta. Call Delta Dental at 1-800-236-3712 with coverage questions. Visit www.deltadentalwi.com to find a network dentist by clicking "Dentist Search" and then selecting Delta Dental Premier. Your Delta ID card will be sent with your WPS member materials.

Patient Choice Plan 2 Network
Service Area: Milwaukee, Ozaukee, Racine, Washington, Waukesha Counties

Care System		✓	S	R _x	Hospitals in County		Major Providers in County *
Advanced Healthcare	•	•	•	•	Columbia St. Mary's-Columbia and Ozaukee Campuses Columbia Center Community Memorial Hospital Froedtert Memorial Lutheran Hospital Orthopaedic Hospital of Wisconsin Children's Hospital of Wisconsin	•	Advanced Healthcare
Children's Hospital and Health System	•				Children's Hospital of Wisconsin		Children's Medical Group
Columbia St. Mary's Physician Network	•	•	•	•	Columbia St. Mary's-Columbia, Milwaukee & Ozaukee Campuses Columbia Center Sacred Heart Rehabilitation Institute Orthopaedic Hospital of Wisconsin Children's Hospital of Wisconsin	•	Columbia St. Mary's Physician Network
Independent Physicians Network	•	•	•	•	All Saints St. Luke's All Saints St. Mary's Children's Hospital of Wisconsin Columbia St. Mary's Columbia, Milwaukee & Ozaukee Campuses Elmbrook Memorial Hospital Oconomowoc Memorial Hospital Orthopaedic Hospital of Wisconsin St. Francis Hospital St. Joseph's Regional Medical Center The Wisconsin Heart Hospital Waukesha Memorial Hospital		Various Providers
Medical Associates	•	•	•	•	Community Memorial Hospital Froedtert Memorial Lutheran Hospital Oconomowoc Memorial Hospital Waukesha Memorial Hospital Children's Hospital of Wisconsin	•	Medical Associates
Quad-Med	•	•	•	•	Elmbrook Memorial Hospital St. Francis Hospital St. Joseph's Regional Medical Center The Wisconsin Heart Hospital Children's Hospital of Wisconsin		Quad-Med Physicians
SynergyHealth	•	•	•	•	St. Joseph's Hospital Children's Hospital of Wisconsin		West Bend Clinics
Waukesha Integrated Delivery System	•	•	•	•	Waukesha Memorial Hospital Oconomowoc Memorial Hospital Children's Hospital of Wisconsin	•	ProHealth Care
Wheaton Franciscan Provider Network	•	•	•	•	All Saints – St. Luke's All Saints – St. Mary's Elmbrook Memorial Hospital St. Francis Hospital St. Joseph's Regional Medical Center The Wisconsin Heart Hospital Children's Hospital of Wisconsin	•	Wheaton Franciscan Clinics All Saints providers

The Medical College of Wisconsin specialists participate with all Care Systems.

*This column provides only a general summary of major provider groups. For a complete listing, please visit our Web site at www.wpsic.com/state or call WPS Member Services Department at 1-800-634-6448.

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Plan Descriptions:
The PBM and Plans Without
Uniform Benefits

Navitus™ Health Solutions

(866) 333-2757
 Fax: (920) 831-1930
 TTY: (920) 225-7005
 www.navitus.com

NAVITUS™
 HEALTH SOLUTIONS



Appleton Campus:

5 Innovation Court Suite B
 Appleton WI 54914

Madison Campus:

999 Fourier Drive Suite 301
 Madison WI 53717

Type of Plan..... Pharmacy Benefits Manager (PBM)
 Total Number of Members..... 600,000
 Number of Pharmacies in Wisconsin..... 1,200
 Number of Pharmacies Nationwide..... 45,000
 Days Supply (Retail Pharmacy)..... Up to 30 days
 Days Supply (Mail Order)..... Up to 90 days

ADDITIONAL INFORMATION

On-Line Services	Visit our Web site, www.navitus.com , for additional information about the programs and services listed here and more!
Formulary Information	Formulary information is available on the Navitus Web site, www.navitus.com , or you can call Navitus Customer Care toll-free at (866) 333-2757 Monday-Friday 7:00 a.m. - 9:00 p.m. CST.
Changes in Your Information	Changes in your personal information must be reported to your employer, or to ETF if you are an annuitant. Changes include, but are not limited to: <ul style="list-style-type: none"> • Name change • Address change • Adding or deleting dependents from your policy (including change in student status) Report changes in other insurance coverage to your health plan.
Prior Authorization Requirements	Drugs which the Navitus Pharmacy and Therapeutics (P&T) Committee determines to have medical appropriateness for a selected group of patients require authorization before coverage is approved. Prior Authorization is initiated by the prescribing physician on behalf of the member. More information about which medications require prior authorization, as well as the prior authorization process, is available on the Navitus Web site, www.navitus.com . Medications that require prior authorization can be identified on the Navitus Drug Formulary by a notation of “ PA ”. Navitus will review the prior authorization request within two business days of receiving complete information from your physician.
Tablet Splitting (RxCENTS)	The RxCENTS program lets you pay up to one-half of your usual cost for a select group of prescription medications. Medications included in the RxCENTS Program are denoted with “¢” in the Navitus Formulary. Members may obtain tablet splitting devices at no cost by calling Navitus Customer Care toll-free at (866) 333-2757.
Generic Copay Waiver Program	The Generic Copay Waiver Program is designed to allow you to sample a select group of medications as alternatives to using high cost, brand name counterparts. Medications included in the Navitus Generic Copay Waiver Program are denoted with “ GW ” in the Navitus Formulary. Your physician needs only to write a prescription for one of the program medications, and if this is the first time you are filling a prescription for the medication, you will receive the medication at no cost from your pharmacist.

ADDITIONAL INFORMATION

Mail Order	<p>Mail order prescription service is available through Prescription Solutions. This program is generally recommended for maintenance medications, rather than for medications that are only needed on a short-term basis (e.g. antibiotics). Up to a 90-day supply of Level 1 and Level 2 medications can be purchased for only two copayments. To register for mail order service you can:</p> <ul style="list-style-type: none"> • Complete the mail order service enrollment form provided with your enrollment materials. • Call Prescription Solutions Customer Service at 1-800-908-9097 Monday through Friday, 8:00 AM - 11:00 PM CST and 9:00 AM to 9:00 PM CST on weekends. If you are hearing impaired, you can call 1-800-498-5428.
Specialty Drug Program (For self-injectables and specialty medications)	<p>Navitus SpecialtyRX was designed in conjunction with SpecialtyScripts Pharmacy to help members and their health care providers with specialty pharmacy needs (e.g., growth hormones and drugs to treat multiple sclerosis and rheumatoid arthritis). Medications available through this program are denoted with “SP” in the Navitus Formulary.</p> <p>To begin receiving your self-injectable and other specialty medications from the specialty pharmacy, please contact Navitus SpecialtyRX toll-free at 1-800-218-1488.</p>
Diabetic Supply Coverage	<p>Diabetic supplies are covered with a 20% coinsurance. This coinsurance applies to your out-of-pocket maximum, unless other coverage picks up the 20% coinsurance. Covered glucometers are provided at no cost.</p>
Medicare Part B	<p>Medicare Part B is responsible for providing primary coverage for certain prescription drugs and supplies including, but not limited to: test strips; lancets; oral chemotherapy agents; inhalation drugs; and IV drugs requiring a pump. It is important for you to show your Medicare Part B card to your pharmacist.</p> <p>Claims for these drugs must first be submitted to Medicare Part B (primary coverage). Then Navitus will cover the remaining cost up to the allowed amount under your policy (secondary coverage). Your pharmacist may be able to electronically submit claims to Medicare Part B and Navitus. If your pharmacist is unable to electronically process the claim, submit a <i>Direct Member Reimbursement Claim Form</i> to Navitus. This form is available on the Navitus Web site, www.navitus.com, or you can call Navitus Customer Care toll free at (866) 333-2757.</p>
Medicare Part D	<p>Prescription drug coverage, administered through Navitus Health Solutions, is “creditable coverage” in comparison to the Medicare Part D prescription drug benefit. This will allow you to defer enrollment in Part D without penalty. Nevertheless, you should carefully consider all options before making any kind of enrollment decision. Participation in Medicare Part D is voluntary. If you would like to maintain your current level of prescription drug benefits under our program, it is not necessary to enroll in Medicare Part D at this time.</p> <p>The Department of Employee Trust Funds (ETF) is eligible to receive a reimbursement, or subsidy, from the Centers for Medicare and Medicaid Services (CMS) for a portion of the pharmacy claims paid for eligible participants that DO NOT enroll in a Medicare Part D plan. The monthly premium you pay for the State program is already reduced to reflect this subsidy payment.</p>
Coordination of Benefits (COB)	<p>COB applies when you have coverage under another policy and it is determined your other policy is your primary coverage and Navitus is your secondary coverage. All claims need to be submitted to your other policy first. Navitus covers the remaining cost of any covered prescriptions up to the allowed amount under your policy. It is important for you to report any changes in other coverage to your health plan.</p>

Standard Plan

Administered by WPS Health Insurance



1717 West Broadway, PO Box 8190
Madison, WI 53708
1-800-634-6448
www.wpsic.com/state

What we are

The Standard Plan is a comprehensive health plan that provides you with freedom of choice among hospitals and physicians in Wisconsin and nationwide. It is administered by WPS Health Insurance – one of the largest health benefits providers in the state. With offices in Madison, Milwaukee, Wausau, Appleton, and Eau Claire, and over 4,000 employees, we're deeply committed to this state and its citizens.

Standard Plan

The Standard Plan is a Preferred Provider Plan (PPP). The amount paid for covered benefits varies depending upon the provider selected. A higher level of benefits is available by using a preferred provider.

Prior Authorizations

WPS recommends that members or providers request prior authorization for the following types of services:

- New medical or biomedical technology
- New surgical methods or techniques
- Organ transplants
- Methods of treatment by diet or exercise
- Acupuncture or similar methods
- Durable medical equipment over \$500

Without an approved prior authorization, WPS may deny payment. Additional information may be submitted for further review of the denial. Please visit www.wpsic.com/state and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form. You or your provider may also call Member Services to request this form.

Covered Services

- Hospital Services (Utilization Management requires prior notice of non-emergency admissions, or within 48 hours after an emergency admission, or a penalty will be assessed)
- Physical, speech, and occupational therapy when necessitated by illness
- Maternity Care
- X-ray and laboratory services
- Office Visits
- Home Care
- Surgery
- Extended Care Facility (except custodial Care)
- Routine physical exams

Exclusions and Limitations

- Physical exams requested by third parties (i.e. school, insurance, etc.)
- Services or supplies for custodial care or rest cures as defined by the contract
- Services, supplies or equipment that are not medically necessary, or that are experimental/investigational
- Eyeglasses, contact lenses or examinations for their prescription or fitting
- Hearing aids or examinations for their prescription or fitting
- In vitro fertilization or artificial insemination
- Dental services except as specifically provided
- Organ transplants except as specifically provided
- Cosmetic surgery
- Reversals of sterilization
- Care covered by worker's compensation

Online Provider Directory

Access to WPS State of Wisconsin provider directories can be obtained by visiting www.wpsic.com/state and following the Find a Doctor link.

Other Online Services

We are able to answer questions about claims or benefits with our secure messaging via the web. The WPS State of Wisconsin web pages (www.wpsic.com/state) provide access to your plan benefits, member materials, and our "Find a Doctor" **provider directories**. Once enrolled in the plan, you can register online to gain access to comprehensive plan and health care information as well as timesaving account management tools.

This is intended as a general outline of benefits, not a complete description of coverage/exclusions and not a legal document. For a complete listing of benefits, limitations, and exclusions, please refer to the Standard Plan booklet (ET-2112) available through your personnel representative or call WPS.

Service Centers

Appleton

1500 N. Casaloma Dr., Suite 202
Appleton, WI 54912-7216

Wausau

1800 W. Bridge St., Suite 200
Wausau, WI 54401

Madison

1751 W. Broadway
Madison, WI 53713
(800) 634-6448

Milwaukee

111 W. Pleasant St., Suite 110
Milwaukee, WI 53212

Eau Claire

2519 N. Hillcrest Pkwy., Suite 200
Eau Claire, WI 54702

Standard Plan

Administered by WPS Health Insurance

Deductible is a separate single \$100 in-network/\$500 out-of-network, not to exceed family deductible of \$200 in-network/\$1,000 out-of-network per calendar year. After deductible, the plan pays 100% on in-network services and 80% on out-of-network services (you pay 20%) up to the reasonable charge until your plan out-of-pocket maximum has been reached, \$2,000 per individual/\$4,000 per family. \$2,000,000 lifetime per participant maximum benefit (includes prescription drugs paid under PBM).

Health Benefits	In- /Out-of-Network	Plan Pays	Limitations (see exclusions & limitations on previous page)
Physician & Chiropractic Care	In	100%	Subject to in-network deductible.
	Out	80%	Subject to out-of-network deductible and coinsurance.
Hospital	In	100%	365 days in semi-private room. Subject to in-network deductible. Pre-admission certification required.
	Out	80%	365 days in semi-private room. Subject to out-of-network deductible. Pre-admission certification required.
Lab and X-rays	In & Out	100%	Subject to in-network deductible
Behavioral Health (Combined w/Alcohol & Drug Abuse)	In & Out	100%	<i>In 2008, Annual dollar maximums for Behavioral Health services are suspended.</i> Deductible does not apply. INPATIENT—120 days or \$6,300 per calendar year, whichever is less.
90%		OUTPATIENT—of the first \$2,000 per calendar year.	
90%		TRANSITIONAL—of the first \$3,000 per calendar year.	
Alcohol & Drug Abuse (Combined w/Behavioral Health)	In & Out	100%	<i>Annual combined benefit is \$7,000.</i> Deductible does not apply. INPATIENT—30 days or \$6,300 per calendar year, whichever is less.
90%		OUTPATIENT—of the first \$2,000 per calendar year.	
90%		TRANSITIONAL—of first \$3,000 per calendar years	
Emergency Room	In & Out	100%	Subject to in-network deductible.
Extended Care Facility	In	100%	730 days per admission less hospital days used. Deductible. Excludes custodial care per the contract.
	Out	80%	730 days per admission less hospital days used. Deductible. Excludes custodial care per the contract.
Vision Care	In	100%	For illness/disease. Subject to deductible.
	Out	80%	For illness/disease. Subject to deductible.
Prescribed Medical Services/Supplies	In	100%	Subject to deductible.
	Out	80%	Subject to deductible.
Transplants	In	100%	Kidney, cornea, bone marrow, parathyroid, musculoskeletal. Subject to deductible. Excludes all services related to non-covered transplants.
	Out	80%	Subject to deductible; transplants listed above.
Ambulance	In & Out	100%	Subject to in-network deductible.
Prescription Drugs			Separate PBM administration through Navitus. Annual out-of-pocket maximums are \$1,000 single/\$2,000 family.

The Standard Plan pays the percent of charge(s) shown above. Charge(s) means usual, customary, and reasonable (UCR) demands for payment for services or other items for which benefits are available, as determined by WPS Health Insurance. In some cases, the amount WPS determines as reasonable may be less than the amount billed by your provider. Some providers are not contractually obligated to write off the balance and, as a result, may choose to balance bill the subscriber. Should such a situation arise, 'hold harmless' protections apply. WPS will protect the subscriber against collection agencies and a court of law. WPS has contracted providers in Wisconsin and throughout the nation. For more information on 'hold harmless' please call a Member Services representative at the number above or visit our Web site. If such a charge dispute arises, contact WPS.

How to Contact the Health Plans

Anthem BCBS
(formerly CompCareBlue)
P.O. Box 34210
Louisville, KY 40233-4210
Tele: (800) 490-6201
NurseAssist: (888) 854-0618
Web site: www.anthem.com

Arise Health Plan
(formerly WPS Prevea Health Plan)
P.O. Box 11625
Green Bay, WI 54307-1625
Tele: (920) 490-6900
(888) 711-1444
Fax: (920) 490-6942
Web site:
www.WeCareForWisconsin.com

Dean Health Plan
1277 Deming Way
Madison, WI 53717
Tele: (608) 828-1301
(800) 279-1301
Fax: (608) 827-4212
Dean On Call: (800) 576-8773
Web site: www.deancare.com

Group Health Cooperative of
Eau Claire (GHC-EC)
P.O. Box 3217
Eau Claire, WI 54702
Tele: (715) 552-4300
(888) 203-7770
Fax: (715) 552-3500
FirstCare Nurseline: (800) 586-5473
Web site: www.group-health.com

Group Health Cooperative of South
Central Wisconsin (GHC-SCW)
1265 John Q. Hammons Dr.
P.O. Box 44971
Madison, WI 53744-4971
Tele: (608) 828-4853
(800) 605-4327
Fax: (608) 662-4186
GHC HealthLine: (888) 203-3504
Web site: www.ghc-hmo.com

Gundersen Lutheran Health Plan
1836 South Ave.
LaCrosse, WI 54601
Tele: (608) 775-8007
(800) 897-1923
Fax: (608) 775-8042
Nurse Advisor: (800) 362-9567
ext. 54454
Web site: www.glhealthplan.org

Health Tradition Health Plan
P.O. Box 188
La Crosse, WI 54602-0188
Tele: (608) 781-9692
(888) 459-3020
Fax: (608) 781-9653
Ask Mayo Clinic: (877) 817-0936
Web site: www.healthtradition.com

Humana
N19 W24133 Riverwood Dr. #300
Waukesha, WI 53188
Tele: (800) 448-6262
HumanaFirst Nurse Advice:
(800) 622-9529
Web site: www.humana.com
or direct at
<http://apps.humana.com/egroups/wisconsin/home.asp>

Medical Associates Health Plan
1605 Associates Dr., Suite 101
P.O. Box 5002
Dubuque, IA 52004-5002
Tele: (563) 556-8070
(800) 747-8900
Fax: (563) 556-5134
Nurse Line: (800) 325-7442
Web site: www.mahealthcare.com

MercyCare Health Plan
3430 Palmer Dr.
P.O. Box 2770
Janesville, WI 53547-2770
Tele: (608) 752-3431
(800) 752-3431
Fax: (608) 752-3751
Nurse Line: (888) 756-6060
Web site:
www.mercycarehealthplans.com

Navitus Health Solutions
5 Innovation Court Ste B
Appleton, WI 54914
Tele: (866) 333-2757
Fax: (920) 831-1930
Web site: www.navitus.com

Network Health Plan
1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Tele: (920) 720-1300
(800) 826-0940
Fax: (920) 720-1900
Nurse Direct: (800) 362-9900
Web site: www.networkhealth.com

Physician Plus Insurance Corp.
22 E. Mifflin St., Suite 200
P.O. Box 2078
Madison, WI 53701-2078
Tele: (608) 282-8900
(800) 545-5015
Fax: (608) 258-1902
NursePlus: (866) 775-8776
Web site:
www.healthychoicesbigrewards.com

Security Health Plan of Wisconsin
1515 Saint Joseph Ave.
P.O. Box 8000
Marshfield, WI 54449-8000
Tele: (800) 472-2363
(715) 221-9555
Fax: (715) 221-9500
Nurse Line: (800) 549-3174
Web site: www.securityhealth.org/state

Standard Plans and SMP
WPS Health Insurance
1717 W. Broadway
P.O. Box 8190
Madison, WI 53707-8190
Tele: (800) 634-6448
Fax: (608) 243-6139
Web site: www.wpsic.com/state

UnitedHealthcare of Wisconsin, Inc.
P.O. Box 13187
3100 AMS Blvd.
Green Bay, WI 54307-3187
Tele: (800) 357-0974
Fax: (920) 662-8349
Web site: www.unitedhealthcare.com

Unity Health Insurance
840 Carolina Street
Sauk City, WI 53583-1374
Tele: (800) 362-3310
Fax: (608) 643-2564
Web site: www.unityhealth.com

WPS Patient Choice
1717 W Broadway
PO Box 8190
Madison, WI 53707-8190
Tele: (800) 634-6448
Fax: (608) 243-6139
Web site: www.wpsic.com/state