It's Your Choice

Group Health Insurance Plans & Provisions

Certificate of Coverage

Dual-Choice Enrollment Period
October 6–24, 2008

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

ET-2108 (Rev 10/2008)

ANNUITANTS/CONTINUANTS - 2009

2009

Annuitants/Continuants

(Retired State of Wisconsin Employees & Participants with Continuation Coverage)

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NOTABLE PLAN AND PROGRAM CHANGES
EFFECTIVE JANUARY 1, 2009

All Dual-Choice plan changes and coverage changes take effect on January 1, 2009. To change health plans, the Department of Employee Trust Funds (ETF) must receive your application with a postmark no later than Friday, October 24, 2008. 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 Burnett County.** Subscribers using providers in this county must consider selecting another plan or will be limited to the SMP providers remaining in other areas. GHC-Eau Claire is now the qualified plan in Burnett county.

➔ HEALTH PLANS NEWLY AVAILABLE

- **Anthem has developed a new network in Northeast Wisconsin:** Anthem Northeast will be available in Brown, Fond du Lac, Manitowoc, Marinette, Outagamie, Shawano, Sheboygan, Waupaca and Waushara Counties. Anthem has additional providers in Calumet, Door, Kewaunee, Oconto and Winnebago counties.

➔ HEALTH PLAN CHANGE

- **WPS Patient Choice Plans 1 and 2 have combined and are now called WPS Metro Choice.** Members enrolled in either of these plans will be automatically enrolled in WPS Metro Choice unless a Dual-Choice application is submitted. WPS Metro Choice will remain a preferred provider plan. The plan will send information to current members prior to Dual-Choice and distribute new identification cards at the end of this year.

➔ SIGNIFICANT PLAN PROVIDER NETWORK CHANGES

- **SMP will be newly available in Crawford and Pierce Counties** effective January 1, 2009. This network change will include some providers in counties bordering Wisconsin, for example in Minnesota and Michigan, in order to support the network for SMP counties.

- A number of health plans have changed service areas. **Some plans have made significant changes by adding or terminating contracts with provider groups. Anthem, Gundersen Lutheran and Health Tradition are examples of plans with such changes this year.** Please refer to the map on page A-3 and the Plan Descriptions in Section G. *Verify with your health plan* that your provider(s) is still available to you in 2009.

- **Note:** Your current health plan is required to give you either a list of all plan providers that will not be available to you or a provider directory listing only those providers available in 2009. Contact your plan and request this information if you have not received it by October 4.

➔ CHANGES TO PHARMACY BENEFITS

For most plans, the annual prescription drug out-of-pocket amount will increase to $385 per individual and $770 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 MEDICARE PLUS $1,000,000 BENEFITS

- Immunization coverage has been added to this plan to allow vaccinations that include, but are not limited to: shingles, diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, hemophilus influenza B, and hepatitis B.

- The skilled nursing facility benefit has been changed to more closely align with Uniform Benefits. The benefit now allows a maximum of 120 days per benefit period. A benefit period is a standard designation under Medicare equal to the total duration of all confinements that are separated from each other by less than 60 days. Custodial care is not covered.

➔ CHANGES TO DENTAL COVERAGE

See Section G, the Plan Description Pages for more information. Plans will send information to current members prior to Dual-Choice.

- **Medical Associates** is increasing dental coverage. For 2009 the plan is adding some basic restorative and orthodontic benefits up to specific benefit maximums.

- **Group Health Cooperative - South Central Wisconsin** is eliminating coverage for prosthodontic, endodontic and periodontic services.

Also note that **Unity Community** is clarifying that root canal therapy is not covered.

➔ NOTE TO MEDICARE ELIGIBLE RETIREES IN HUMANA DURING 2009

Humana enrolls those members with Medicare Parts A and B into its Humana administered Medicare Advantage Private Fee-For-Service (MA-PFFS) plan that offers Uniform Benefits. Continuing this year, such members will have increased access to providers both inside and outside of Wisconsin compared to the non-Medicare Humana network. However, members will need to ensure their providers accept them as a MA-PFFS member. We cannot guarantee that all available providers within the regular Humana plan will also be available in the MA-PFFS plan. Contact Humana at 1-866-396-8810 with questions. Retirees who will become eligible for Medicare during 2009 should pay special note, since there will not be another enrollment opportunity until next the Dual-Choice period.

➔ INFORMATION ON PROVIDER QUALITY

Two new comparison charts appear on pages G-5 through G-9, to recognize participating hospitals and physician groups that have reported information to several quality and safety reporting organizations including the Leapfrog Group, CheckPoint, and the Wisconsin Collaborative for Healthcare Quality. You can get more detail on the results on-line at: www.leapfroggroup.org www.wicheckpoint.org www.wchq.org

➔ ONLINE HELP

Are you not sure where to start when you get the *It's Your Choice* booklet? Review the Department's newest online video, *It's Your Choice: Your Health Insurance Benefits for 2009*. The program explains how the book is organized, where to find specific information, and highlights important factors to consider when choosing a health plan for 2009. Find it in the Department's video library at http://etf.wi.gov/webcasts.htm. In addition, our website includes information on any known booklet printing discrepancies and on other insurance programs.

Important Considerations Flowchart

A quick reference on how to select a plan and use this book.

What's new this year?

Page ii

Have your premium rates changed?

Section A

Is your physician still affiliated with your plan?

Contact the plan, see inside back cover

Have your medical benefits changed?

Page D-2

Does the plan include dental benefits?

Section G starting on page G-2

How do plans compare on services & quality?

Page G-2 through G-4 and Section E

Are you concerned about coverage of a current treatment?

Contact the plan, see inside back cover

Do you want to change plans or change from single to family coverage for January 1?

Act on or before October 24, 2008

Do you have a dependent over age 19 and covered on your family plan?

Section C

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. However, you should review the following checklist.

- **What's new this year?**

Sometimes HMOs drop out of the program, merge with other HMOs, or split off to form new HMOs. These changes are listed on pages ii and iii. 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 premium rates 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, specialist, 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 your medical or dental benefits changed with your plan?**

If your plan offers dental benefits, you should check whether there are any changes in Section G. Changes to the Uniform Benefits are the same for all alternate plans and are described on page D-2.

- **How do plans compare on service & quality?**

Plans offer various programs for disease management, wellness, and on-line services. Plans vary in quality and customer satisfaction. A plan comparison grid is included for your reference on pages G-2 through G-4, and detail is available on the plan pages in section G. Also review and compare the health plan report card and information in Section E.

- **Are you concerned that a current treatment that may not be covered under your new plan?**

Please contact customer service of the plan you are considering. If your current provider is not with your new plan, do not expect to a get a referral to that provider. In most cases, you will need to see a provider affiliated with the new plan.

- **Do you want to change health plans or change from single to family coverage for 2009?**

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 24, 2008. Coverage changes will be effective on January 1, 2009.

- **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 rely or the dependent's coverage may terminate. See the Question and Answer section on dependent children for more information.

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Premium Rates for 2009

Some plans have limited providers in certain areas. For this reason they appear without underlining or bold type on the map on page A-3. 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.

All Health Insurance Applications filed during Dual-Choice are for coverage effective January 1, 2009. If you decide to change plans you need to fill out a form. **If you want to remain with your current plan, do nothing.**

State of Wisconsin
Annuitants / Continuants

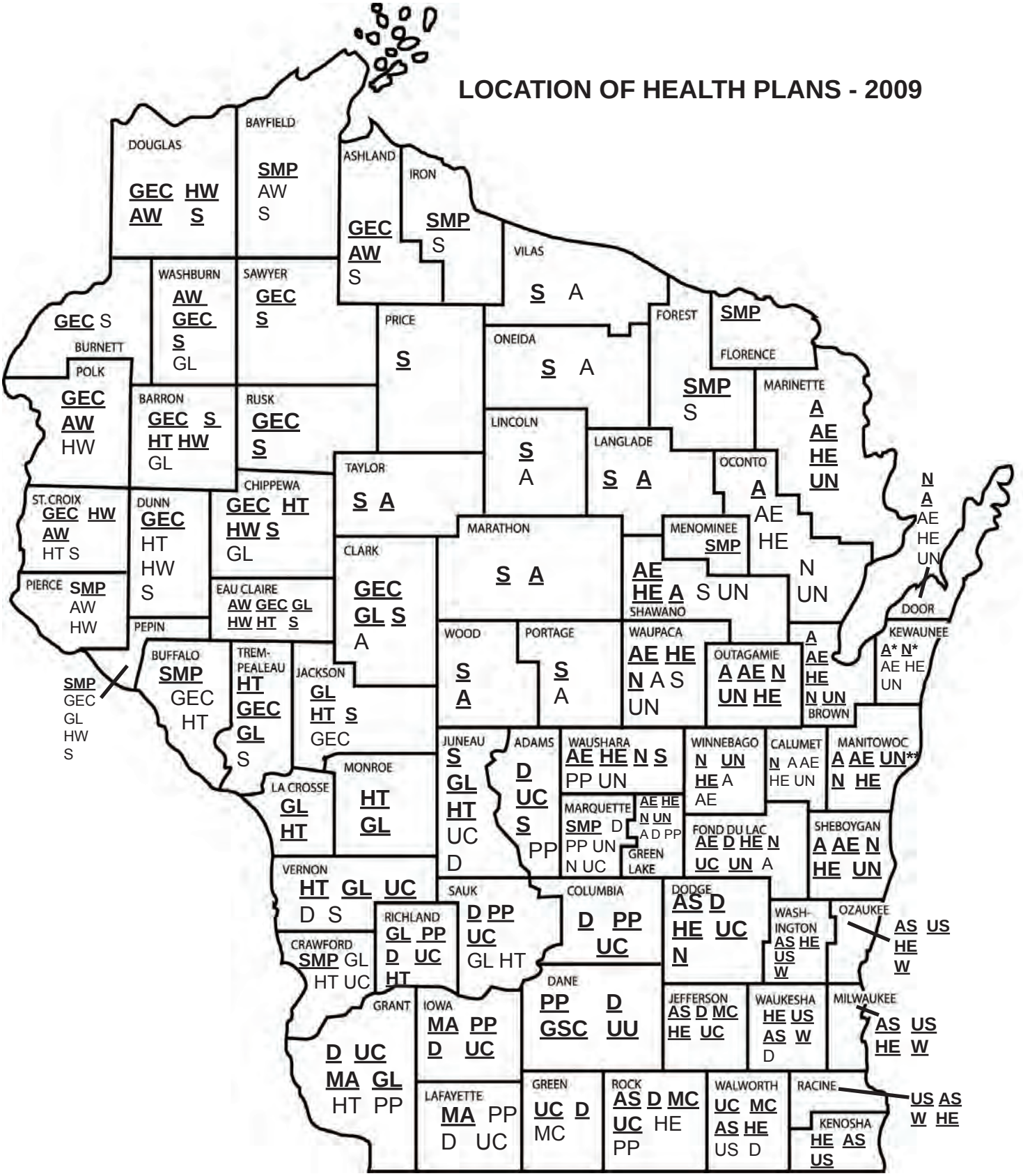
2009 Plans	Plan Code
Anthem BCBS-Northeast	AE
Anthem BCBS-Northwest	AW
Anthem BCBS-Southeast	AS
Arise Health Plan	A
Dean Health Plan	D
Group Health Cooperative of Eau Claire	GEC
Group Health Cooperative of South Central Wisconsin	GSC
Gundersen Lutheran Health Plan	GL
Health Tradition Health Plan	HT
Humana Eastern	HE
Humana Western	HW
Medical Associates Health Plan	MA
MercyCare Health Plan	MC
Network Health Plan	N
Physicians Plus – Meriter & UW Health	PP
Security Health Plan	S
State Maintenance Plan (WPS Health Insurance)	SMP
Standard Plan (WPS Health Insurance)	None
UnitedHealthcare Northeast	UN
UnitedHealthcare Southeast	US
Unity Community	UC
Unity UW Health	UU
WPS Metro Choice (formerly WPS Patient Choice Plan 1 and 2)	W

HOW TO USE THIS MAP

- See the Plan Codes above to determine which plans are in your county.
- If the plan code is <u>underlined</u> 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 is 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 plan. There may also be non-qualified plan 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 AND MEDICARE PLUS $1,000,000 ARE AVAILABLE ANYWHERE. As such, these plans do not appear on the map.

LOCATION OF HEALTH PLANS - 2009



* Qualified in a county with no hospital.
** Hospital 4 miles from major city.

A number of plans have changed their service areas for 2009; some have made significant changes. As a result, you may need to change plans for 2009.

"Qualified plans in each county are underlined and show in **bold** type. "Non-qualified" plans are not underlined or bolded. Non-qualified plans have limited provider availability in the indicated county.

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

MONTHLY ANNUITANT GROUP HEALTH INSURANCE RATES FOR 2009	NON-MEDICARE RATES		MEDICARE RATES		
PLAN NAME	SINGLE	FAMILY	MEDICARE SINGLE	MEDICARE 2**	MEDICARE 1***
STANDARD PLAN*	985.30	2459.40	NA	NA	1311.00
STATE MAINTENANCE PLAN (SMP)*	609.70	1520.80	NA	NA	931.40
MEDICARE + $1,000,000*	NA	NA	319.60	636.60	NA*
ANTHEM BCBS NORTHEAST	609.50	1520.10	423.70	844.90	1030.70
ANTHEM BCBS NORTHWEST	711.80	1775.80	474.80	947.10	1184.10
ANTHEM BCBS SOUTHEAST	654.50	1632.60	446.20	889.90	1098.20
ARISE HEALTH PLAN	609.70	1520.60	423.70	844.90	1030.90
DEAN HEALTH PLAN	524.80	1308.30	373.80	745.10	896.10
GHC OF EAU CLAIRE	692.10	1726.60	464.90	927.30	1154.50
GHC OF SOUTH CENTRAL WISCONSIN	521.90	1301.10	379.90	757.30	899.30
GUNDERSEN LUTHERAN HEALTH PLAN	633.80	1580.80	375.10	747.70	1006.40
HEALTH TRADITION HEALTH PLAN	639.60	1595.30	438.10	873.70	1075.20
HUMANA EASTERN	681.10	1699.10	352.00	701.50	1030.60
HUMANA WESTERN	647.40	1614.80	352.00	701.50	996.90
MEDICAL ASSOCIATES HEALTH PLAN	517.40	1289.80	315.30	628.10	830.20
MERCYCARE HEALTH PLAN	508.50	1267.60	373.20	743.90	879.20
NETWORK HEALTH PLAN	585.00	1458.80	411.40	820.30	993.90
PHYSICIANS PLUS--MERITER & UW HEALTH	532.70	1328.10	385.20	767.90	915.40
SECURITY HEALTH PLAN	671.10	1674.10	401.10	799.70	1069.70
UNITEDHEALTHCARE NE	590.40	1472.30	414.10	825.70	1002.00
UNITEDHEALTHCARE SE	641.80	1600.80	439.80	877.10	1079.10
UNITY COMMUNITY	613.30	1529.60	407.60	812.70	1018.40
UNITY UW HEALTH	531.60	1325.30	384.70	766.90	913.80
WPS METRO CHOICE	661.80	1650.80	440.40	878.30	1099.70

*Additional Information for Persons on Medicare: Participants with Standard Plan or SMP coverage who become enrolled in Medicare Parts A & B will automatically have coverage with the Medicare + $1,000,000 plan. See page G-58 & G-59 for benefit information. For families with 1 or more people on Medicare Parts A & B, coverage for all other non-Medicare family members remains under the Standard Plan or SMP while coverage for the Medicare enrollee(s) is under the Medicare + $1,000,000 Plan. Medicare Part D enrollment is not required.

**Medicare Family 2=Two or more family members enrolled in Medicare Parts A & B.
***Medicare Family 1=One family member enrolled in Medicare Parts A & B.

State and Federal Notif cations/ Patients' Rights and Responsibilities

State and Federal Notifications:

Notice of Privacy Practices B-2

COBRA: Continuation of Coverage Provisions for the Group Health Insurance Program B-5

HIPAA/Privacy, Standards, and Security B-6

HIPAA/Pre-Existing Conditions..... B-6

HIPAA/Special Enrollment Opportunities B-6

Independent Review B-7

National Medical Support Notice.....B-7

Women's Health Cancer Rights Act of 1998 .....B-7

Medicare Prescription Drug Coverage: Notice of Creditable Coverage B-8

Patients' Rights and Responsibilities B-10

NOTICE OF PRIVACY PRACTICES

for the

Standard Plan, State Maintenance Plan, Medicare Plus $1,000,000

(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, State Maintenance Plan, and Medicare Plus $1,000,000. 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.

Privacy Rights Contact Information

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. <u>If you choose COBRA, complete and return the forms to ETF. Do not send a check. Your health plan will bill you.</u>

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.

<u>The employee or a family member has the responsibility to inform the employer of a divorce or a child losing dependent status</u>. 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, Wis. Adm. Code § INS. 18.11 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 $282 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. **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.** Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a **Medicare Part D Prescription Drug Plan (Medicare PDP)** or join a **Medicare Advantage Plan (like an HMO or PPO)** that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
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 and is therefore considered Creditable Coverage.** Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You may have wondered how Medicare's prescription drug coverage (Part D) might affect you. For 2008 prescription drug coverage will be available to everyone with Medicare through various Medicare PDP's. All Medicare PDP's 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 ETF has determined that the existing prescription drug coverage administered by Navitus Health Solutions (Navitus) is "Creditable Coverage", it is not necessary to enroll in a 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, 2008 through December 31, 2008. However, because you have **"Creditable Coverage"** through Navitus, while you can choose to join a Medicare PDP, you are not required to. Each year, you will have the opportunity to enroll in a Medicare PDP from November 15th through December 31st.

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

If you lose your current creditable prescription drug coverage through Navitus, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare PDP.

You should also know that if you drop or lose your coverage with the State and do not enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you might pay more to enroll in Medicare Part D PDP later.

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Certificate of Creditable Coverage for Medicare Part D

KEEP THIS NOTICE – DO NOT DISCARD

If you are Medicare eligible, and go without creditable prescription drug coverage for 63 consecutive days or longer, your monthly Medicare PDP premium may go up by at least 1% of the Medicare base beneficiary premium per month, for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join. For more information about your Medicare premium, please contact Medicare directly.

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. You may also request a copy of this notice from ETF at any time. 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 Care

Phone toll free: 1-866-333-2757 Hours: 24 hours a day, 7 days a week
(Closed Thanksgiving and Christmas Day)

Department of Employee Trust Funds

Phone toll free 1-877-533-5020
Local to Madison 608-266-3285
Web site ..... http:\\etf.wi.gov

Mailing Address:
P.O. Box 7931
Madison, WI 53707-7931

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 PDP providers, you can get more information about Medicare prescription drug coverage from the following sources:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help (see the inside back cover of the "Medicare & You" handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- ***Prescription Drug Helpline:***.....Phone toll free: 1-866-456-8211, Mon. - Fri.
- ***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. You can request additional copies of this notice from ETF.

rev. 8/08

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 and Answers

If you need additional information regarding:

Benef ts Exclusions Limitations Participating Providers	Bene Address	Contact the health plan or Pharmacy f ts Manager (PBM) directly. and telephone numbers are listed on the inside back cover.
Applications Eligibility Enrollment General Information	Contact	Employee Trust Funds.

All changes in your subscriber information, family status, or providers must be made through Employee Trust Funds (ETF). Changes must be submitted on ETF approved forms. Please f ll 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. Also, the Uniform Benefits in Section (D) is the benefits certificate for those enrolled in alternate health plans and SMP (but not the Standard plan or Medicare Plus $1,000,000).
- Currently insured retirees who, during the October Dual-Choice Enrollment period, are changing to a different plan for the following calendar year.
- Currently insured retirees who wish to change from single to family coverage without incurring waiting periods or exclusions for pre-existing conditions. This is generally possible only during the Dual-Choice Enrollment period.
- Former employees and/or dependents who are insured under the health insurance continuation option.
- COBRA continuants. Those individuals who are covered for a maximum of **36 months** following a qualifying event as defined in the Consolidated Omnibus Reconciliation Act of 1986 (COBRA).

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

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

The following former state employees who are not covered under the state's group health insurance may apply for coverage under the State Group Health Insurance program:

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

(See **Questions 7: When can I enroll in health insurance as an annuitant?** and **8: What if I didn't have coverage at retirement or if coverage later lapsed?**)

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 or Medicare Plus $1,000,000).

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.

Dual-Choice Health Fairs

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

4. Privacy of Social Security Number

Social Security numbers (SSN) are a common form of member/patient identification (ID). In instances where a health plan or ETF request and retains SSN, the health plan or ETF uses the utmost care to protect the information and uses it for certain reporting purposes. The SSN does not appear on any documentation that could be public, such as your ID card or correspondence from the plan.

HEALTH INSURANCE COMPLAINT PROCESS

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

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

Depending on the nature of your complaint, you may be given rights to request an independent review through an outside organization approved by the Office of the Commissioner of Insurance. This option becomes available when a plan has denied services as either not medically necessary or experimental. **Note:** 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 the ETF review will not be initiated until you have completed the grievance process available to you through the plan. After your complaint is received, your complaint is acknowledged and information is obtained from the health plan. An ombudsperson in the Quality Assurance Services Bureau will review and investigate your complaint and attempt to resolve your dispute with your plan. If the ombudsperson is unable to resolve your complaint in your favor, you will be notified of additional administrative review rights available through the Department.

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

ENROLLING FOR COVERAGE

ANNUITANT ENROLLMENT

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

When you retire, your health insurance plan will automatically continue if your retirement annuity from the Wisconsin Retirement System (WRS) begins within **30 days** after your employment termination date. If you terminate employment after 20 years of creditable service but are not eligible for an immediate annuity, your completed application, ET-2301, with a *Continuation/Conversion Notice*, form ET-2311, must be received by Employee Trust

Funds within **90 days** of your termination of employment to continue coverage. You may switch coverage to any other available plan during the Dual-Choice Enrollment period.

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

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

Separate enrollment opportunities to re-enroll for coverage apply to those who have escrowed their sick leave. Contact ETF for details on this process. (See **Questions 10: What if I lose other coverage?** and **Question 11: Can I delay or initiate use of sick leave credits after I retire?**)

9. When must I apply for Medicare?

Most people become eligible for Medicare upon reaching age 65. For some, it occurs earlier due to disability or End Stage Renal Disease (ESRD).

- 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 health insurance coverage is provided. For such annuitants, you may want to consider enrolling with Medicare Part A when you first become eligible at age 65. Medicare Part A is free to you, and may cover hospital services if your health plan denies them.
- <u>For subscribers and their dependents with End Stage Renal Disease (ESRD).</u> You will want to contact your Local Security Office, health plan, provider, and Medicare to make sure you to enroll in Medicare Parts A and B at the appropriate times. You will want to decide if it would be beneficial to enroll in Part B during your initial enrollment opportunity to avoid later premium penalities.
- If you have terminated employment**,** or are a surviving spouse or dependent, or a continuant and are eligible for coverage under the federal Medicare program, you must immediately enroll in both Part A and B of Medicare unless you are otherwise employed and have health

insurance coverage through that employment. **If you do not enroll for all available portions of Medicare upon retirement, you may be liable for the portions of your claims that Medicare would have paid beginning on the date Medicare coverage would have become effective.** However, if you or your insured spouse is also insured as an active employee under a non-state group plan, enrollment in Medicare may be deferred until retirement from that job.

Medicare D- Individuals may choose to enroll in Medicare D, however, it is not a recommended or required for your continued coverage under the State group health insurance program. The prescription drug coverage under the State's program is considered creditable coverage. 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 typical Medicare prescription drug plan. Therefore enrollment in a Medicare D plan is voluntary. It you choose to enroll in a Medicare D plan, your health insurance premium for the state plan does not change but your ETF pharmacy coverage will be secondary to Medicare D. (See **Question 70: How does Medicare Part D Affect My Prescription Drug Coverage? Should I enroll?**).

To enroll in Medicare Part A or Part B, or if you have questions about enrollment and eligibility, please contact your local social security office. Once you receive your Medicare card, please send a photocopy to the ETF.

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

If you are enrolled in the Standard Plan, or SMP Plan, your coverage will be changed to the Medicare Plus $1,000,000 plan when you enroll in Medicare Parts A and B.

OTHER ENROLLMENT INFORMATION

10. What if I lose other coverage?

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

1. Your annuity began (or you received a lump sum retirement benefit) within **30 days** after your employment termination date; AND,

2. You have escrowed your sick leave account; AND,
3. You and/or your dependents are not insured under the state health program because of being insured under a comparable group health insurance plan elsewhere; AND either,
4. a. Your eligibility for that other coverage is lost; OR
   b. The employer's premium contribution for the other coverage ceases.

To enroll, submit a Health Insurance Application/Change form and other information documenting the loss of coverage or loss of the employer's premium contribution within **30 days** of the date the other coverage ended. The coverage will be effective on the date the other coverage or the employer's premium contribution ends. If you are currently enrolled and need to change from single to family coverage, at least one family member must have lost the other coverage in order to qualify.

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

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

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

If you are currently enrolled in the State Group Health Insurance program, but with single coverage because of your spouse being insured under a group health insurance plan elsewhere, and she/he loses eligibility or the employer contribution for that coverage ends, this special enrollment opportunity would also allow you to change from single to family coverage to insure her/him.

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

Yes. Under the law, retirees receiving a WRS annuity or surviving insured dependents may elect to delay use (escrow) or initiate use (unescrow) of sick leave credits annually. In order to escrow, you must certify that you have health coverage comparable to the State of Wisconsin's

Standard Plan. You may escrow only once during a calendar year. You may unescrow during Dual-Choice for coverage effective January 1 of the following year or the first of the month in the following year that you select. If you lose eligibility for your comparable coverage (not voluntary cancellation), or the contribution for it (if it is an employer sponsored plan) you may unescrow (re-enroll) by filing an application within **30 days** of the loss. Please contact ETF at 1-877-533-5020 for more information.

12. 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/Change (ET-2301) within **30 days** after the change occurs. Always file an application through Employee Trust Funds to notify your plan of changes. Request applications from Employee Trust Funds. Failure to report changes on time may result in loss of benefits or delay payment of claims. The changes to be reported are (See **Question 20: What family changes need to be reported?**):

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
5. Addition/deletion of a dependent to an existing family plan
6. Changing primary physicians within an HMO network

RE-EMPLOYED ANNUITANTS

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

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

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

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

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

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

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

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

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

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

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

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

SINGLE/FAMILY ELIGIBILITY

SINGLE VS FAMILY COVERAGE

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

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

You may change from single to family coverage during the Dual-Choice Enrollment period with family coverage becoming effective on the following January 1.

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

1. If a Health Insurance Application/Change is received by ETF **within 30 days** of the following events, coverage becomes effective on the date of the event. All eligible dependents will then be covered:
   - Marriage
   - You or any eligible dependents involuntarily lose eligibility for other medical coverage or lose the employer contribution for the other coverage. (See **Question10: What if I lose other coverage?**)

- 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.
- Legal guardianship is granted.

2. If an application is received by ETF **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, the coverage will be effective on the first of the month following receipt of the application.
3. If an application is received by ETF upon order of a Federal Court under a National Medical Support Notice coverage will be effective on either:
   - the first of the month following receipt of the application by ETF, or
   - the date specified on the Medical Support Notice.

   Note: This can occur when a parent has been ordered to insure his/her child(ren) who are not currently covered.

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 not apply to you (the subscriber). The waiting

period does not apply to children born or adopted after the effective date of coverage change.

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

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

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

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

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

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

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

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

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

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

One family policy can be split into two single plans with the same carrier effective on the beginning of the month following receipt of a Health Insurance Application/Change or a later date specified on the 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 who should die first.

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

If, at the time of marriage, the employees and/or annuitants each have family coverage or one has family coverage and the other has single coverage, **coverage must be changed to one of the options listed above within 30 days of the marriage**. 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/Change* form is postmarked within **30 days** of the marriage.

20. What family changes need to be reported?

You need to report the following changes to ETF within **30 days** of the change. Failure to report changes on time may result in loss of benefits or delay payment of claims. To report the following changes, contact Employee Trust Funds Self-Service Line at 1-877-383-1888 to obtain a *Health Insurance Application/Change* form number ET-2301.

- Change of name, address, telephone number, and Social Security number, etc.
- Obtaining or losing other health insurance coverage
- Addition of a dependent
- Loss of a dependent's eligibility for coverage
- Marriage
- Divorce
- Death of subscriber
- Death of dependent. (Contact ETF if dependent is your named survivor.)
- Eligibility for Medicare Contact ETF for the appropriate Medicare package.

21. 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. (See **Question 16: When can I change from single to family coverage without restrictions?**)

If you were enrolled in family coverage before your marriage, you need to complete a *Health Insurance Application/Change* form as soon as possible and within **30 days** to report your change in marital status, add your new spouse (and stepchildren) to the coverage, and if applicable, change your name. In most cases, coverage for the newly added dependent(s) will be effective as of the date of the marriage. (See **Question 19: What if my spouse is also a state or university employee or annuitant? for any exceptions.**)

Birth/Adoption/Dependent Becoming Eligible

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

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

Divorce

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

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

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

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

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

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

Death

Surviving Spouse/Dependents

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

If family coverage was in force at the time of death, any unused sick leave credits in the deceased employee's account are available to the surviving spouse/dependents for premium payments. If the surviving dependents terminate coverage for any reason they may not re-enroll later. If sick leave credits are escrowed, the surviving dependents may continue to escrow the credits or may apply to convert the credits to pay health insurance premiums.

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

Medicare Eligibility

If you and/or your insured dependents are eligible for coverage under the federal Medicare program and you are retired, you must immediately enroll in both Part A and Part B of Medicare. Enrollment in Medicare Part D is optional. ETF does not collect your Medicare Part A, B, or D premium, this is handled by Social Security. The drug coverage provided through the State group health insurance program 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, drug coverage through the State group health insurance program will pay secondary to Part D. (See **Question 9: When must I apply for Medicare?** and **Question 70: How does Medicare Part D affect my prescription drug coverage? Should I enroll?**)

DEPENDENT CHILDREN

22. 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 28: When does health coverage terminate for dependents?**)

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

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

Even though custody of your child may have been transferred to the other parent, you may still insure the child if the other dependency requirements are met. (See **Question 18: What if I am a single mother or a father establishing paternity?)**

24. 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.

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/Change* form with ETF 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.

25. What does full-time student mean and how does a medical leave affect student status?

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 class). 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 break), night schools, and student commitments after the semester ends, such as student teaching. You will be required to verify your dependent's eligibility annually.

Effective January 1, 2009, if a full-time student requires a medically necessary leave of absence and ceases to be a full-time student, they will be required to submit documentation of the medical necessity of the leave of absence from the person's attending physician to the health plan. Upon receipt of the documentation, the health plan will determine if coverage can be continued for up to one year. The member is required to advise the health plan (and coverage will end) if the full-time student:

- Does not intend to return to school full-time, or
- Becomes employed full-time, or
- Marries, or
- Reaches the end of the year in which he/she turns age 25,
- The dependent obtains other health coverage, or
- If the subscriber plans to discontinue their coverage.

26. 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 delete 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/Change* form. Charges for services rendered during the period of termination would then be covered. However, it is required that you to notify Employee Trust Funds if student status terminates. Failure to do so may result in the loss of continuation rights.

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

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

28. 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. (exception: if dependent is over age 19, such as a student, coverage ends at the end of the month in which support and maintenance ceases.)
- The date eligibility for coverage ends for 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 1. 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 granted. See section CONTINUATION OF HEALTH COVERAGE for additional information. (See **Question 20: What family changes need to be reported?**)

SELECTING A HEALTH PLAN

29. How do I select a health plan?

See chart on Page iii.

30. What types of health plans are available?

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

Self-insured plans

Medicare Plus $1,000,000 (administered by WPS Health Insurance (WPS) is a fee-for-service indemnity plan available to those eligible for and enrolled in Medicare Parts A and B. Medicare Plus $1,000,000 permits you and your eligible dependents to receive care from any qualified health care provider anywhere in the world for treatment covered by the plan. You may be responsible for filing claims and for finding the providers who can best meet your needs.

The Standard Plan (administered by 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 Health Maintenance Organization (HMO). It offers Uniform Benefits, such as the HMOs. See Section D of this booklet for benefit information. Please note that SMP has physician, hospital and specialty care networks and referral and prior authorization processes.

The Standard Plan and SMP 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 prepaid fee. Each HMO offers service only in specific areas of the state.

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

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

HMOs generally refer outside their networks only if they are unable to provide needed care within the HMO. **If you go to a non-HMO provider for non-emergency care without an approved referral, you will not be reimbursed by the HMO**. If you have questions regarding the availability of physicians, hospitals, or other medical professionals, you should contact the HMO directly.

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

Medicare Coordinated Plans

Since all state health plans have coverage options which are coordinated with Medicare, you will remain covered by the plan you selected after you are enrolled in Medicare Parts A and B. The one exception is coverage for participants enrolled in the Standard Plan, or the SMP Plan, will be changed to the Medicare Plus $1,000,000

plan on the participant's Medicare effective date. Your health coverage will remain substantially the same as before Medicare coverage became effective, but the state health plans are designed to supplement, not duplicate the benefits you receive under Medicare. Prescription drugs will continue to be covered. Because of this coordination with Medicare, your monthly premiums for state health insurance may be less.

If you are enrolled in Humana in 2009 after you enroll in Medicare Parts A and B through Social Security, Humana will enroll you in their Medicare Advantage Private Fee-For-Service (MA-PFFS). (See the paragraph below for further information on MA-PFFS)

Medicare Advantage Private Fee-For-Service plan (MA-PFFS)

The MA-PFFS plan is governed by a contract with the Centers for Medicare and Medicaid Services (CMS). The MA-PFFS plan allows members to use any healthcare provider that participates with Medicare, accepts Medicare payments, and accepts the health plan's administration. As such, it can offer access to many more providers, even nationwide, than are currently available to an alternate health plan. The MA-PFFS plan offered is modeled on Uniform Benefits. (See **Question 66: If Medicare coverage is in effect how do I file medical, Part B and Pharmacy claims?** and **68: If I have Medicare as my primary coverage, how are my benefits coordinated?**)

Humana will continue offering this type of Medicare plan in 2009.

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. Uniform Benefit PPPs are only available through WPS Metro Choice.

Note: All HMOs and WPS Metro 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)**

31. Which plans are actually available to me?

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

32. Are there differences between alternate health plans?

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

In addition, remember that Uniform Benefits does not mean that all plans will treat all illnesses or injuries in an identical manner. Treatment will vary depending on the needs of the

patient, the methodologies employed by the physicians involved, and the managed care policies and procedures of the plan.

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

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

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

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

While HMOs provide reimbursement for emergency care outside of their service areas, routine care must be received from the HMO's own physicians. Some HMOs also require that follow-up care after an emergency be received from a plan provider. A preferred provider plan such as WPS Metro Choice or the Standard Plan, and Medicare Plus $1,000,000 allow you the flexibility to seek routine 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, Section D., VI, item I for information on submitting claims for non-plan providers,** and **Question 27: Will an HMO cover dependent children who are living away from home?**)

35. Does an HMO cover 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 network unless there is an authorized referral. For emergency or urgent care, plans are required to pay for care outside of the network, but it may be subject to usually and customary charges. This means the plan may not pay the entire bill and try to negotiate lower fees. However, ultimately the plan must hold you harmless for collection efforts by the provider.

PROVIDER QUALITY INFORMATION

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

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

37. What is Leapfrog?

The ETF has endorsed a nationwide effort taking aim at improving the quality, safety and efficiency 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 hospitals for voluntarily reporting their progress in fully adopting the standards. The three key standards the State has asked urban hospitals to adopt are: Computerized Prescription Order Entry (CPOE); Intensive Care Unit Physician Staffing (ICU); and Evidence-Based Hospital Referral. Urban and rural hospitals have also been asked to complete a survey based on their efforts in adopting 13 of the National Quality Forum safety practices called the Safe Practices Score. These practices, if used universally in applicable clinical settings, would reduce risk of harm to patients. Provider progress on these measures are updated monthly with information available at **http://www.leapfroggroup.org/for_consumers.**

38. 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. The measures are designed to help consumers understand how effective a hospital is at providing quality of care for specific diagnoses or procedures, or progress towards the use of safe practices.

CheckPoint currently provides data on interventions that research indicates should occur when treating heart attacks, heart failure, pneumonia, and for the prevention of surgical infection and medical errors. Visit their web site for the most up-to-date information at **www.wicheckpoint.org**.

39. Where can I get a comparison of Hospital Health Care Quality and Safety information for Wisconsin hospitals?

A grid that illustrates which Wisconsin hospitals have submitted data to Leapfrog and/or CheckPoint and if they have attained certain levels of safety and quality appears in section G of this book, beginning on page G-6. This grid is provided to recognize Wisconsin hospitals on their attainment, or work toward improvements in patient safety and quality.

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

1) The Wisconsin Collaborative for Healthcare Quality web site gives consumers access to an extensive public report that compares the performance of Wisconsin health care organizations. The report includes important information on medical groups, hospitals, and health plans.

   By visiting the web site at **www.wchg.org**, consumers will find information on such things as:

   - How long it takes to get an appointment at a specific clinic
   - How well patients with diabetes, high blood pressure, or coronary artery disease receive the care that has been proven to make a difference in their health and well-being
   - How often physician groups perform essential screenings for colorectal, cervical or breast cancer and provide certain vaccinations

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 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 found at: **www.medlineplus.gov.**

3) The Wisconsin Health Reports web site simplifies your search for information on the quality, safety, and price of services provided by Wisconsin medical clinics and hospitals. The web site serves as portal or entry point for a variety of health care reporting initiatives in Wisconsin, including the Performance & Progress Report from the Wisconsin Collaborative for Healthcare Quality as well as CheckPoint and PricePoint from the Wisconsin Hospital Association. The Wisconsin Health Reports web site is available at **www.wisconsinhealthreports.org**.

PROVIDER INFORMATION

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

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

42. 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.

43. How do I choose a primary physician or pharmacy who's right for me?

If you're not sure a provider holds the same beliefs as you do, call the clinic or pharmacy and ask about your concerns. For example, you may want to ask the provider's opinion about dispensing a prescription for oral contraceptives.

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

Alternate plans (HMOs and WPS Metro 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/Change* form available from Employee Trust Funds indicating the effective date of your change as specified by the plan.

45. 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.

46. 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.

47. 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.

PREMIUM CONTRIBUTION

48. How will my health premiums be paid?

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

- **From your Accumulated Sick Leave Conversion Credits until those credits are exhausted.** If you have accumulated sick leave at the time of your retirement or death (and your applicable compensation plan or collective bargaining agreement provides for sick leave conversion), the credits can be converted to a dollar amount to pay your health premiums for the State Group Health Insurance Program. (Sick leave credits can only be converted for payment of State Group Health Insurance program premiums; they cannot be used for

other insurances; they have no cash value and accrue no interest.) If you choose to escrow your sick leave, this can be done at the time of retirement or a later date. Contact ETF for the escrow form.

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

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

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

  WARNING: Your coverage will be cancelled if you fail to pay your premium in a timely manner. If you re-enroll, coverage will be effective the first of the seventh month following the application receive date. If you are a surviving spouse or dependent, you are not eligible for re-enrollment.
- **From your converted life insurance.** If you are retired and have life insurance coverage through the State of Wisconsin, are at least 66, and **have used up all your sick leave credits**, you may elect to convert your life insurance to pay health insurance premiums. If you make this election, your life insurance coverage will cease and you will receive credits in a conversion account equal to the present value of your life insurance. The present value ranges from about 44% to 80% of the face amount, depending on your age. The life insurance company, Minnesota Life, will pay health insurance premiums on your behalf from your conversion account until the account is exhausted. You will NOT receive any direct cash payment. You may file the election at any time, and it will be effective no earlier than 61 days after ETF receives it. For more information, contact ETF.

49. Does a health plan with a higher premium offer more benefits?

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

The Standard Plan and Medicare Plus $1,000,000 will continue to offer benefits that differ from Uniform Benefits.

50. 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.

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

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

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

OR

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

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

CHANGING HEALTH PLANS

DUAL-CHOICE ENROLLMENT

During the Dual-Choice Enrollment period all subscribers currently continuants, and retirees insured by the State Group Health Insurance program are allowed to change from one plan to another, or from single to family coverage, for the following calendar year without a waiting period or

exclusions for pre-existing medical conditions. You will receive a new *It's Your Choice* booklet prior to the enrollment period. You do not need to submit a completed application to continue coverage in your current plan for next year provided the plan is still offered.

52. What does Dual-Choice mean?

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

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

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

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

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

55. 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 **Question 16: When can I change from single to family coverage without restrictions?**)

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

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

You do not need to return an application if you are not making any changes.

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

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

CHANGING HEALTH PLANS

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

Yes, but only if you, the subscriber file an application within **30 days** of the following events with coverage effective on the first day of the month on or following receipt of the application:

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 . You may again change plans when you return for **3 months** by submitting another application within **30 days** after your return. (See **Question 61: What if I have a temporary or permanent move from the service area?**)
2. If you are an employee or continuant or his/her dependent that 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. (If you learn that you are nearing your health plan's lifetime maximum, you should consider changing health plans during the next Dual-Choice enrollment period to avoid out-of-pocket costs.)
3. You involuntarily lose other coverage or lose the employer contribution for it.
4. If you are an employee or continuant who adds one or more dependants due to marriage, birth, adoption, or placement for adoption.

OR

5. You may change to the Standard Plan/Medicare Plus $1,000,000 at any time by canceling your existing coverage and submitting an application for the Standard Plan/Medicare Plus $1,000,000. 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 the Dual-Choice Enrollment period.

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

When you change plans for any reason (for example, Dual-Choice or a move from a plan's service area), any annual health insurance benefit maximum under Uniform Benefits will start over at $0 with your new plan, even if you change plans mid-year. Examples are the 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.

60. 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.

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

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

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

62. 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, a skilled nursing facility, or in some cases an Alcohol and Other Drug Abuse (AODA) residential center) or require 24 hour home care on the effective date of the coverage with the new plan, you will begin to receive benefits from your new plan unless the facility you are confined in is not in your new plan's network. If you are confined in such a facility, your claims will continue to be processed by your prior plan as provided by contract until that confinement ends and you are discharged from the non-network hospital or other facility, **12 months** have passed, or the contract maximums 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

63. 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.

64. How do I file claims?

Most of the services provided by an HMO do not require filing of claim forms. However, you may be required to file

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

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

When you are covered under two or more group health insurance policies (other than Medicare) at the same time, and both contain coordination of benefit provisions, insurance regulations require the primary carrier be determined by an established sequence. This means that the primary carrier will pay its full benefits first; then the secondary carrier would consider the remaining expenses. (See **the Coordination of Benefits Provision found in the Uniform Benefits in Section D**.) It should be noted that with coordination of benefits the secondary carrier may not always cover all of your expenses that were not covered by the primary carrier.

66. If Medicare coverage is in effect, how do I file Medical, Part B and Pharmacy claims?

If Medicare is the primary insurance (and you are not enrolled in a Medicare Advantage Private Fee-for-Service plan, or MA-PFFS plan), your provider must submit claims to Medicare first. Once Medicare processes the claim(s) Medicare will send you a quarterly Medicare Summary Notice (MSN).

Alternate Plans (WPS Metro Choice's PPP and HMO's, except for MA-PFFS plans): Many of the health plans have an automated procedure after Medicare processes the claim, where the provider then submits it to the health plan for processing. However, some health plans require members to submit a copy of the MSN and, in certain circumstances, a copy of the provider's bill. You should discuss with your provider if they will bill Medicare and your health plan on your behalf. **Contact your health plan for additional information.**

An alternate health plan may offer Medicare Coordinated Coverage through a Medicare Advantage Private Fee-For-Service plan (MA-PFFS). When you visit your provider you must show your health plan MA-PFFS card. Your provider will submit your claims directly to the MA-PFFS plan. To request reimbursement for a covered service charge that you paid, send your receipt (noting on it your name and your MA-PFFS member ID) and a copy of your MA-PFFS card to the address on the back of that card.

You must be enrolled in Medicare Parts A and B to be eligible for a health plan's MA-PFFS. You should keep your

Medicare card in a safe place, but you should not show it when you receive health care services as the MA-PFFS plan will be primary for your service. (See **Question 68: If I have Medicare as my primary coverage, how are my benefits coordinated?**)

Humana will continue offering this type of Medicare plan in 2009.

Medicare Plus $1,000,000: Your responsibilities in the claims process will depend on the policies and practices of the medical facility from which you receive care. You may be required to submit the claims to Medicare and then submit the proper forms to WPS Health Insurance for supplemental payments. Refer to the "Medicare Plus $1,000,000" (ET-4113) benefit booklet available from WPS or ETF for more information, and contact your health care provider or facility regarding their particular Medicare claims procedures.

Pharmacy Benefit Manager: For specific information on utilizing Medicare Part B prescription coverage (See **Section G: The Plan Description Page** for **Navitus™ Health Solutions**.)

67. What is the Medicare Cross-over Option?

A claims processing system for services received under Medicare Parts A and B is available to you at no additional cost. It is designed to eliminate some of the paperwork involved in filing claims. As an example, WPS Health Insurance (WPS) has an agreement with Medicare to cross-over claims for any services that Medicare processed as primary. Medicare will automatically forward your Explanation of Medicare Benefits (EOMB) to WPS for services you receive throughout the United States. Claim forwarding is automatic for each person covered under Medicare. You do not need to complete a form or contact WPS to take advantage of cross-over. Other health plans may also have a similar feature. Please contact your health plan for further information.

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

Since all state health plans have coverage options that are coordinated with Medicare, you will remain covered by the plan you selected after you are enrolled in Medicare, even though Medicare is the primary payor of your claims.

Exception: if you are enrolled in the Standard Plan or SMP, your coverage will be changed to the Medicare Plus $1,000,000 plan. There are some differences in benefits between these plans. Medicare Plus $1,000,000 is designed to supplement, not duplicate the benefits you receive under Medicare.

If you are enrolled in an alternate plan (HMO or WPS Metro Choice), your health coverage will remain the same as before Medicare coverage became effective. This type of coverage is called a carve-out plan. Your alternate plan supplements, not duplicates, the benefits you receive under Medicare. Because of this coordination with Medicare, your monthly premiums for state health insurance will be less. **Note:** For some benefits under Uniform Benefits, such as durable medical equipment, Medicare Part B and the health plan both have a 20% coinsurance that you are responsible to pay.

In 2009, Humana will continue to offer its Medicare Coordination Coverage through a Medicare Advantage Private Fee-For-Service plan (MA-PFFS). As Medicare has contracted financial responsibility for medical benefit administration to this MA-PFFS plan, all claims should be submitted to the MA-PFFS plan. You must keep Medicare Part A & B coverage, but you should put away your Medicare card as you will not need to show it to your providers with this health plan. Members who are direct billed by Humana will receive two bills, that when combined, will add up to the total amount due. Both bills must be paid monthly for coverage to continue.

This MA-PFFS plan offers greater flexibility in provider selection than a traditional HMO for retirees over age 65 and on Medicare. For members under age 65 and not on Medicare, you must comply with the health plan's network requirements.

If you are enrolled in MA-PFFS plan, have Medicare Part A and B, and are no longer an active employee, your benefits will be modeled on Uniform Benefits, and include those of original Medicare. You have the freedom to choose providers however, prior to seeking services we recommend you ask your provider if he/she

1) Participates with Medicare
2) Accepts Medicare's payments
3) And accepts the health plan's MA-PFFS plan administration (not an HMO)

If your provider does not, contact the MA-PFFS plan for further assistance and you may be subject to out-of-pocket costs.

MEDICARE PART D INFORMATION

69. What is Medicare Part D?

Medicare Part D is a voluntary prescription drug benefit program administered by the federal government

70. How does Medicare Part D affect my prescription drug coverage? Should I enroll?

Keep in mind you are already paying for and receiving comprehensive prescription drug coverage through the state's group health insurance program. **Participation in Medicare Part D is voluntary and requires a premium payment if you enroll in a Medicare Part D prescription drug plan (PDP).** Your current drug coverage, administered through Navitus Health Solutions, is considered creditable coverage in comparison to the Medicare PDP prescription drug benefit, therefore we do not recommend enrolling in a Medicare PDP. This coverage will allow you to defer enrollment in Part D without penalty. If you would like to maintain your current level of prescription drug benefits under our program, **it is not necessary to enroll in a Medicare PDP at this time.** (See **page B-8 Certificate of Creditable Coverage**).

71. Will my health insurance premium go down if I enroll in a Medicare Part D prescription drug plan?

No. Your health insurance premium includes both medical and prescription drug coverage and is already reduced to account for the Medicare Retiree Drug Subsidy (RDS). Under the RDS program the Employee Trust Funds is eligible for a reimbursement of a portion of the pharmacy claims paid for retirees who are not enrolled in Medicare Part D. If you enroll in a Medicare prescription drug plan, you will continue to pay the same premium in addition to paying the Medicare PDP premium (approximately $38/month) to Medicare. Navitus will coordinate coverage with Medicare and pay after Medicare processes your prescription claims, minus the applicable copayments and coinsurance that are your responsibility.

STANDARD PLAN

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

This plan, often called a Preferred Provider Plan (PPP), offers participants under 65 the choice to see any provider, but there are differences in reimbursements depending on whether you go to an in-network or an out-of-network provider. If you receive services from an in-network provider you will have lower out-of-pocket costs. 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 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: 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 and annuitants or other dependent(s) under 65 have the option to enroll in this plan.

73. 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)

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

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

75. 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 that are determined to be medically-effective, efficient 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. New drugs, as well as existing, are reviewed on a continuous basis to make sure the formulary is kept up-to-date.

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.

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

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

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

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

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

TERMINATION/LEAVING YOUR HEALTH PLAN

CANCELLATION / TERMINATION OF COVERAGE

78. How do I cancel coverage?

Voluntary cancellation (or switching from family to single coverage which is deemed voluntary cancellation for all insured dependents) requires written notification to Employee Trust Funds. 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 Employee Trust Funds receives your written request on or before the last day of the month preceding the month for which you request the refund. Under no circumstances are partial month's premiums refunded. Once coverage terminates, you will be responsible for any claims inadvertently paid beyond your coverage effective dates.

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

Your coverage can only be terminated because:

1. Premiums are not paid by due date.
2. Coverage is voluntarily cancelled.
3. Failure to apply for both Medicare Part A and B when first eligible. The Medicare enrollment requirement is deferred while you or your spouse are employed and covered under a group health insurance plan from that employment. (See **Question 9: When must I apply for Medicare?**)
4. Ineligible for coverage as an annuitant because of becoming an active WRS employee. (See **Question 14: How are my health benefits affected by my return to work (for an employer who is under the WRS)?**)
5. 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.
6. Death of subscriber.

Contact Employee Trust Funds for the date coverage will terminate.

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

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

1. A retired employee of the state who is receiving a retirement annuity or has received a lump sum payment under Wis. Stat. § 40.25 (1);

   OR
2. An employee of the state who terminates creditable service after attaining 20 years of creditable service, remains a WRS participant and is not eligible for an immediate annuity.

If so, you may submit an application to enroll and may select any offered health plan. Coverage will be effective on the first day of the *seventh* month following the Department's receipt of the application. Surviving dependents are not eligible to re-enroll. (See **Question 2: Which annuitants are eligible for State of Wisconsin group health insurance?)**

CONTINUATION OF HEALTH COVERAGE

81. Who is eligible for continuation?

See **COBRA: Continuation of Coverage Provisions for the Group Health Insurance Program** in Section B of this booklet. Both you and your spouse should take the time to read this section carefully.

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

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

83. 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.

If you or your covered dependent becomes eligible for Medicare, you may need to enroll in Medicare as soon as you are eligible. (See **Question 9: When Must I Apply for Medicare?**)

84. Will my premium change under continuation?

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

85. How do I cancel continuation coverage?

To cancel continuation coverage, notify ETF in writing. Include your name, Social Security number, date of birth and address. ETF will forward your request to the plan. Your coverage will be cancelled at the end of the month in which Employee Trust Funds receives the request to cancel coverage.

86. 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.

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

If you move out of the service area (either permanently, or temporarily for three months or more) you are eligible to change plans. (See **Question 61: What if I have a temporary or permanent move from the service area?**)

Your application to change plans must be postmarked within **30 days** after your move. Because you are on continuation coverage, call the ETF Employer Communication Center at (608) 264-7900 to obtain a *Health Insurance Application/ Change* (ET-2301). Complete and submit the application to the Department of Employee Trust Funds, P. O. Box 7931, Madison, WI 53707-7931.

Uniform Benef ts
Certif cate of Coverage

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

The Group Insurance Board adopted a uniform medical insurance benef ts 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 Benef ts is to help contain the rising cost of health insurance and simplify the selection of a health plan for employees. Employees and annuitants 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 specif c physicians or other health care providers
4. Plan referral policies

Uniform Benef ts 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. See Section G for health plan specif c information

The following pages describe the benef ts which will be offered by all alternate plans in 2009. Your plan is not required to provide a separate description of benef ts. **It is very important that you keep this brochure for your reference throughout 2009.** If you have questions, please contact the plans directly.

The Uniform Benef ts will cover some oral surgery, but alternate plans also have the option of offering other dental benef ts. **Plans offering dental benefits are listed in Section G starting on page G-2**.

Uniform Benefits do not apply to the Standard Plan or Medicare Plus $1,000,000 except that their prescription drug coverage is through the Pharmacy Benefit Manager (PBM).

NOTABLE CHANGE TO UNIFORM BENEFITS
EFFECTIVE JANUARY 1, 2009

Topic	*Page*	*Section*	*Year 2009 Benefit*	*Year 2008 Benefit*
Annual Prescription Drug Out-of-Pocket Maximum	D-7	Schedule of Benefits	For all participants, except those enrolled in the Standard Plan: $385 per individual $770 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: $350 per individual $700 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 2009. 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 Metro 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 available when 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 Related 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.

- 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 <u>mental health only</u> 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. (Contact lens fittings are not part of the routine exam and are not covered.)

- 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 except as specifically listed in Benefits and Services section. 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):
$385 per individual or $770 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: Payable at 80%, 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 child.
  - Legal ward who becomes a legal ward of the Subscriber prior to age 19, but not a temporary ward.
  - Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896.
  - Stepchild.
  - Grandchild 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.

  A Dependent child must be dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed.

  A child born outside of marriage becomes a Dependent 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 equivalent if the birth was outside of Wisconsin. The Effective Date of coverage will be the date of birth if a statement of paternity or a court order is filed within 60 days of the birth.

  A spouse and a stepchild 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. A child age 19 or over who is a full-time student, if otherwise eligible (that is, continues to be a Dependent for support and maintenance and is not married), cease to be a Dependent:
     - At the end of the calendar year in which the child ceases to be a full-time student or in which the child turns age 25, whichever occurs first.
     - At the end of the month in which the child marries.

     Student status includes any intervening vacation period if the child continues to be a full-time student. As defined in Wis. Adm. Code § ETF 10.01 (5), 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 Code, 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. As required by Wis. Stat. §632.895 (15), eligibility will continue up to one year when the Dependent ceases to be a full-time student due to a medically necessary leave of absence.

2. A dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age, so long as the child remains so disabled if he or she is otherwise eligible (that is, the child meets the support tests as a Dependent for federal income tax purposes and is not married). The Health Plan will monitor mental or physical disability at least annually, terminating coverage prospectively upon determining the Dependent is no longer so 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. 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. Emergency services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **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.

- **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 Provider.

- **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.

- **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. Urgent services from a Non-Plan Provider may be subject to Usual and Customary Charges. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **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. However, the Health Plan must hold the member harmless from any effort(s) by third parties to collect from the member the amount above the Usual and Customary Charges for medical/hospital services.

- **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. Prior Authorizations for the follow-up care are at the sole discretion of the Health

Plan. 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. Prior Authorizations for the follow-up care are at the sole discretion of the Health Plan.

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:

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, 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.

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
- 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 Diabetic Equipment and Related 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 directly related to 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 maximum payment applies to all services directly related to the

hearing aid, for example, an ear mold. 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). Services will be covered subject to 20% Coinsurance as outlined in the Schedule of Benefits. Except for services related to cochlear implants and hearing aids, the out-of-pocket costs will apply to the annual out-of-pocket maximum for Durable Medical Equipment.

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. Coverage of Newborn Infants with 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.

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.

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 discharge, which can reasonably be purchased on an outpatient basis.

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 Prior Authorized as required 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 (for example, electronic keyboard for an hearing impairment); 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. This includes the upgrade of equipment, models or devices to better or newer technology when the existing equipment, models or devices are sufficient and there is no change in the Participant's condition nor is the existing equipment, models or devices in need of repair or replacement.

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.

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.

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, not withstanding 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.

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

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, 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.

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.

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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 2008

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

Health Plans included in the Report Cards . . . . . **page E-4**

2009 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**

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Details for Selected Health Plan Results (CAHPS) . . . . . **page E-17**

Health Care Rating Summary (CAHPS) . . . . . **page E-24**

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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.

- **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 actual clinical performance.**

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 recommended care for HEDIS measures is based on medical evidence.

The 2009 Health Plan Quality Comparison (found on page E-6) provides summary quality scores that evaluate health plans based on the following four areas of care: Wellness and Prevention, Behavioral Health, 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 four 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 2007. 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 that are proven to reduce medical errors and save lives:

- Computer Physician Order Entry (CPOE)—medication orders are entered electronically to prevent prescribing errors. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50 percent. 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. Research indicates that if patients were referred to the hospital with the best success rate for their procedure, then a patient would have a 40 percent less chance of dying. Applies to urban hospitals only.
- ICU Physician Staffing (IPS)— staffing intensive care units with doctors who have special training in critical care medicine called "intensivists" has been shown to reduce the risk of death by 40 percent. Applies to urban hospitals only.
- Leapfrog Safe Practices Score--The National Quality Forum's Safe Practices data include the three described above as well as safety practices that are designed to reduce the harm in certain processes, systems, or environments of care. These safety practices apply to rural and urban hospitals.

For more information on Leapfrog, visit their web site at www.leapfroggroup.org. This web site provides consumers with the ability to select hospitals and compare their performance on patient safety ratings.

Checkpoint is a program sponsored by the Wisconsin Hospital Association that currently provides reliable data on interventions that medical experts agree should be taken to treat: heart attacks, congestive heart failure, and pneumonia. There are indexes for each of these disease areas as well as for the surgical infection prevention measures. 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 web site at www.wicheckpoint.org.

Please see the notable changes on page (iii) for information on how ETF is involved with these quality efforts. Information on Leapfrog and Checkpoint participation and data reporting is displayed in a separate listing of hospitals 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. Web site: 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 and experiences. 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 availability of a smoking cessation program, whether or not the health plan uses a diabetes registry, whether or not a health plan offers a 24-hour nurse line, whether or not members have online access to their medical information and what dental benefits are covered. 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 2009 Health Plan Quality Comparison, all HMO health plans that were available in 2008 were included in the calculation of the composite scores. The results are only published for health plans that are available in 2009.

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 2009. CAHPS data is collected from State employees, including the university and graduate assistants and State retirees. No data was collected for Anthem BCBS Northeast.

Note that health plan, health care, and provider ratings could be influenced by the model of care provided. The Standard Plan and WPS Metro Choice (formerly known as WPS Patient 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.

Significant shifts in provider networks can also affect health plan ratings. Beginning January 1, 2008 the composition of Humana Western's network of providers changed from the previous year. As a result, the average core ratings for Humana Western dropped significantly in comparison to prior years. This drop in ratings was not experienced for the Medicare population which was not affected by change in the Humana Western provider network.

The ETF Grievance and Complaints tables on pages E-31 and E-32 report grievance and complaints for all health plans received in 2007. Results are only displayed for health plans available to members in 2009.

The HEDIS report card includes all HMOs that are available to ETF members in 2009, for which there is available data. No HEDIS data is available for WPS Metro Choice, 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.

2009 Health Plan Quality Comparison

HEALTH PLAN	Overall Quality Score	Wellness and Prevention Score	Behavioral Health 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	★★★	★★★	★★★★	★★★★	★★★
UnitedHealthcare NE	★	★★	★★	★	★
UnitedHealthcare SE	★★	★★	★★	★	★★
Unity Community	★★★	★★★★	★★★	★★★	★★★
Unity UW Health	★★★	★★★★	★★★★	★★★	★★★

★★★★	**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**

2009 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 four areas of focus described below are included in the overall quality score. The performance of each health plan is compared to the average performance of all health plans available in 2008, except for WPS Metro Choice, 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, than 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 immunizations, well child visits, prenatal and postpartum care, and appropriate use of antibiotics for children and adults, and breast, cervical and colorectal cancer screenings. 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, their exercise habits and diet habits.

Behavioral Health

This composite includes HEDIS® measures for the treatment of depression and follow up after a hospitalization for mental illness. This composite also includes a survey question on whether or not members could obtain needed treatment or counseling for a personal or family problem.

Disease Management Score

This composite includes HEDIS® measures that address treatment and screenings for members with acute cardiovascular conditions, hypertension, diabetes, chronic obstructive pulmonary disease, and asthma. This composite also includes a measure that address monitoring of members who are on persistent medications of interest.

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, 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?

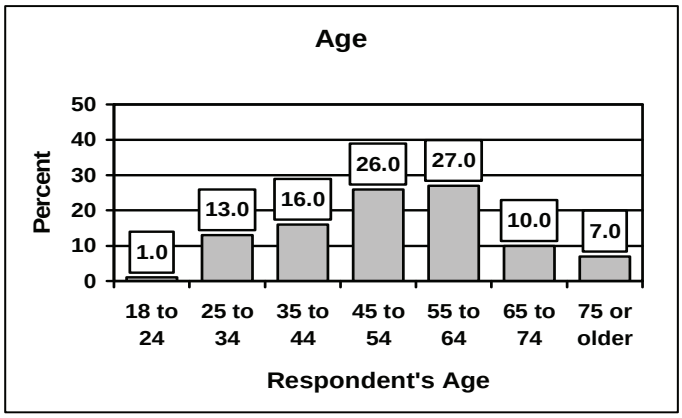
Answers to these and other questions are in this section to help you evaluate your health plan choices. The survey results are the opinions and judgments of the people who were surveyed. Your experience with a health plan could be different from those of the people surveyed. However, it can be helpful 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.

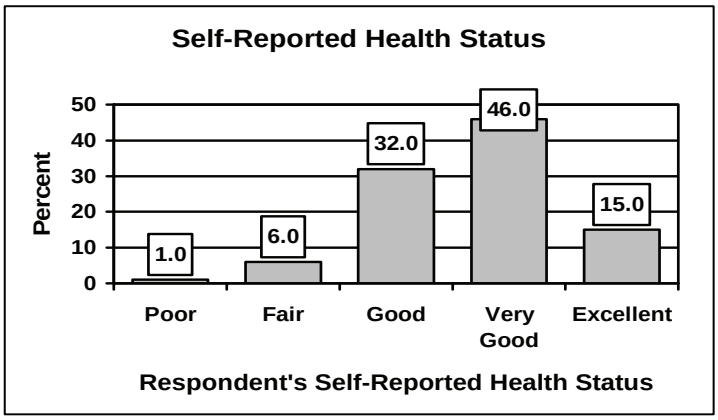
Background on the Survey and Demographics Profile of Study Participants

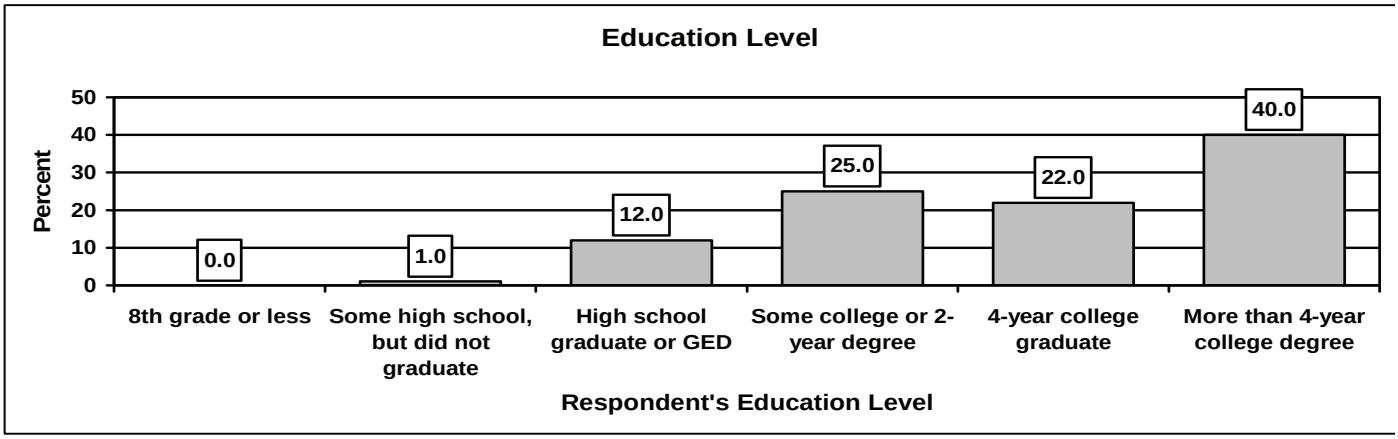
2008 ETF PARTICIPANT SURVEY. The health plan report card section includes results of a random sample of active health plan members from 21 health plans. The survey was conducted from February to June of 2008, and a total of 6,275 members responded to the survey via the Internet or mail. Health plan members 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 44 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 web site 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 ±5% at a 95% confidence interval for each participating health plan. This level of precision was largely achieved.

Length of Time in Health Plan

Question: "How many years in a row have you been in this 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."

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.

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	**6%**	**14%**	**30%**	**50%**
Anthem BCBS Northwest	**31%**	**18%**	**29%**	**21%**
Anthem BCBS Southeast	**29%**	**14%**	**31%**	**26%**
Arise Health Plan	**2%**	**11%**	**37%**	**50%**
Dean Health Plan	**3%**	**3%**	**14%**	**80%**
GHC Eau Claire	**3%**	**21%**	**55%**	**21%**
GHC-SCW	**10%**	**11%**	**22%**	**57%**
Gundersen Lutheran	**4%**	**6%**	**15%**	**75%**
Health Tradition	**1%**	**10%**	**39%**	**50%**
Humana Eastern	**7%**	**10%**	**39%**	**44%**
Humana Western	**15%**	**7%**	**18%**	**61%**
Medical Associates	**2%**	**4%**	**12%**	**83%**
MercyCare Health Plan	**3%**	**5%**	**22%**	**70%**
Network Health Plan	**1%**	**5%**	**20%**	**74%**
Physicians Plus	**3%**	**5%**	**15%**	**78%**
Security Health Plan	**5%**	**52%**	**41%**	**2%**
Standard Plan	**2%**	**8%**	**21%**	**68%**
State Maintenance Plan	**10%**	**23%**	**37%**	**30%**
UnitedHealthcare NE	**1%**	**7%**	**48%**	**44%**
UnitedHealthcare SE	**13%**	**43%**	**43%**	**1%**
Unity Community	**4%**	**16%**	**42%**	**37%**
Unity UW Health	**5%**	**10%**	**31%**	**54%**
WPS Metro Choice	**7%**	**44%**	**46%**	**3%**

HOW THE SURVEY WAS DONE. From February to June of 2008, 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 members for whom e-mail addresses were available, were emailed an invitation to participate in the survey.

The e-mail invitation included information about the survey along with a link that, when clicked on, took survey participants directly to the questionnaire. Members who did not have an e-mail address were sent an invitation in the U.S. Postal mail. The invitation encouraged their participation via the Internet and included the Interent site, 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.

WPS Metro Choice was formerly known as WPS Patient Choice.

	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	4697	75%	1578	25%	6275	100%
Anthem BCBS Northwest	58	42%	80	58%	138	100%
Anthem BCBS Southeast	263	83%	54	17%	317	100%
Arise Health Plan	200	65%	109	35%	309	100%
Dean Health Plan	288	74%	99	26%	387	100%
GHC Eau Claire	297	82%	63	18%	360	100%
GHC-SCW	316	87%	45	13%	361	100%
Gundersen Lutheran	228	74%	80	26%	308	100%
Health Tradition	251	84%	49	16%	300	100%
Humana Eastern	296	82%	65	18%	361	100%
Humana Western	240	85%	41	15%	281	100%
Medical Associates	118	69%	54	31%	172	100%
MercyCare Health Plan	167	75%	55	25%	222	100%
Network Health Plan	253	73%	95	27%	348	100%
Physicians Plus	275	73%	103	27%	378	100%
Security Health Plan	297	85%	53	15%	350	100%
Standard Plan	154	41%	220	59%	374	100%
State Maintenance Plan	23	74%	8	26%	31	100%
UnitedHealthcare NE	258	74%	93	26%	351	100%
UnitedHealthcare SE	150	71%	61	29%	211	100%
Unity Community	146	69%	65	31%	211	100%
Unity UW Health	315	85%	54	15%	369	100%
WPS Metro Choice	104	76%	32	24%	136	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.

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 $p<0.05$ 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 Trending 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 2008 to the average scores from 2007 and also compares the average scores from 2007 to the average scores from 2006. A two-tailed t-test was used to determine statistical differences between years at 95% confidence level. ↑/↓ indicates average scores are significantly higher/ lower than previous year scores.

Humana Western significantly changed the composition of it's provider network as of January 1, 2008. This change may have adversary affected respondent ratings of the health plan. Please see pages E-4 and E-5 for more detail.

WPS Metro Choice was formerly known as WPS Patient Choice.

Health Plan	How people rated their HEALTH PLAN			How people rated their HEALTH CARE			How people rated their PRIMARY DOCTOR			How people rated their SPECIALISTS		
Year	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**
Average—All Health Plans	8.06	8.03	8.06	8.47	**8.30↓**	8.34	8.36	**8.64↑**	8.66	8.34	**8.42↑**	8.48
Anthem BCBS Northwest	NA	7.35	7.08	NA	8.26	8.40	NA	8.70	8.86	NA	8.44	8.70
Anthem BCBS Southeast	7.58	7.49	7.63	8.33	**7.83↓**	7.95	8.20	8.30	8.28	8.27	8.09	8.24
Arise Health Plan	8.27	8.07	**8.42↑**	8.65	**8.43↓**	**8.62↑**	8.42	8.61	8.76	8.40	8.56	8.55
Dean Health Plan	8.34	8.21	**8.35↓**	8.50	**8.21↓**	**8.45↑**	8.39	**8.69↑**	8.79	8.37	8.35	8.50
GHC Eau Claire	8.51	8.43	8.48	8.60	8.52	8.43	8.55	**8.85↑**	8.84	8.27	8.57	8.70
GHC-SCW	8.22	8.28	8.23	8.30	8.29	8.32	8.16	8.33	8.50	8.18	8.12	8.31
Gundersen Lutheran	8.48	8.51	8.58	8.77	**8.55↓**	**8.75↑**	8.69	**8.93↑**	9.08	8.62	8.45	8.67
Health Tradition	8.35	8.26	8.38	8.51	8.41	8.51	8.52	8.71	**8.92↑**	8.22	8.13	8.41
Humana Eastern	7.64	7.60	7.66	8.32	**8.08↓**	8.21	8.25	8.49	**8.69↑**	8.18	**8.51↑**	8.25
Humana Western	7.76	7.59	**5.75↓**	8.61	8.51	**7.54↓**	8.58	**8.80↑**	**8.50↓**	8.52	8.78	**8.31↓**
Medical Associates	8.60	8.45	8.49	8.77	8.58	8.73	8.72	**9.05↑**	9.20	8.59	8.48	**8.92↑**
MercyCare Health Plan	7.85	7.89	8.05	8.24	8.09	8.19	8.26	8.47	8.49	8.01	8.26	8.35
Network Health Plan	8.32	8.30	8.32	8.39	8.20	8.19	8.13	**8.42↑**	8.41	8.37	8.45	8.58
Physicians Plus	8.44	8.32	8.33	8.54	8.33	8.45	8.34	8.57	8.60	8.55	8.43	8.56
Security Health Plan	NA	NA	8.22	NA	NA	8.31	NA	NA	8.57	NA	NA	8.51
Standard Plan	8.45	8.39	8.58	8.76	**8.56↓**	8.65	8.59	**8.90↑**	8.91	8.63	8.85	8.83
State Maintenance Plan	6.98	6.98	6.35	8.07	7.94	7.63	8.14	**8.63↑**	8.17	8.00	8.23	**7.29↓**
UnitedHealthcare NE	7.46	7.69	7.85	8.39	8.23	8.27	8.25	**8.62↑**	8.54	8.33	8.20	8.37
UnitedHealthcare SE	NA	7.78	7.78	NA	8.31	8.19	NA	8.79	8.59	NA	8.30	8.54
Unity Community	7.97	8.24	8.27	8.31	8.34	8.29	8.22	**8.68↑**	8.44	7.82	**8.45↑**	**7.99↓**
Unity UW Health	8.37	8.19	8.20	8.58	**8.31↓**	8.31	8.34	8.47	8.54	8.45	8.40	8.32
WPS Metro Choice	NA	7.23	7.58	NA	8.07	8.28	NA	8.69	8.8	NA	8.08	8.29

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							
	How people rated their **HEALTH PLAN**		How people rated their **HEALTH CARE**		How people rated their **PRIMARY DOCTOR**		How people rated their **SPECIALISTS**	
Health Plan	Overall	3 or more visits	Overall	3 or more visits	Overall	3 or more visits	Overall	3 or more visits
Average—All Health Plans	**8.06**	**8.13**	**8.34**	**8.34**	**8. 66**	**8.71**	**8.48**	**8.47**
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	★★★	★★★	★★	★★	★★	★★	★★	★★
Standard Plan	★★★	★★★	★★	★★	★★	★★	★★	★★
State Maintenance Plan	★	★	★	★	★	★★	★	★
UnitedHealthcare NE	★★	★★	★★	★★	★★	★★	★★	★★
UnitedHealthcare SE	★★	★★	★★	★★	★★	★★	★★	★★★
Unity Community	★★★	★★★	★★	★★	★★	★★	★	★★
Unity UW Health	★★★	★★★	★★	★★	★★	★★	★★	★★
WPS Metro Choice	★★	★★	★★	★★	★★	★★	★★	★★

Health Plan Rating 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**

**Rating repeated from page E-14 for convenience of side-by-side comparison.*
WPS Metro Choice was formerly known as WPS Patient Choice.

Health Plan	Overall Health Plan Rating			% Definitely/ Probably would recommend health plan to family and friends
	Total Sample*	Among those with 3 or more medical visits in last 12 months*	% Who rated health plan 7 or above	
Average—All Health Plans	**8.06**	**8.13**	**86**	**91**
Anthem BCBS Northwest	★	★	**68**	**73**
Anthem BCBS Southeast	★★	★★	**76**	**89**
Arise Health Plan	★★★	★★★	**93**	**94**
Dean Health Plan	★★★	★★★	**92**	**97**
GHC Eau Claire	★★★	★★★	**93**	**96**
GHC-SCW	★★★	★★★	**89**	**96**
Gundersen Lutheran	★★★	★★★	**93**	**96**
Health Tradition	★★★	★★★	**92**	**98**
Humana Eastern	★★	★★	**82**	**90**
Humana Western	★	★	**44**	**49**
Medical Associates	★★★	★★★	**91**	**96**
MercyCare Health Plan	★★	★★	**83**	**90**
Network Health Plan	★★★	★★★	**90**	**94**
Physicians Plus	★★★	★★★	**91**	**97**
Security Health Plan	★★★	★★★	**89**	**94**
Standard Plan	★★★	★★★	**91**	**93**
State Maintenance Plan	★	★	**55**	**68**
UnitedHealthcare NE	★★	★★	**86**	**91**
UnitedHealthcare SE	★★	★★	**83**	**91**
Unity Community	★★★	★★★	**91**	**96**
Unity UW Health	★★★	★★★	**89**	**96**
WPS Metro Choice	★★	★★	**82**	**87**

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:
- **Getting information or help from customer service**
- **Courteous and respectful customer service staff**

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	★★	★★★
Security Health Plan	★★★	★★★
Standard Plan	★★★	★★
State Maintenance Plan	★★	★
UnitedHealthcare NE	★	★
UnitedHealthcare SE	★★	★★
Unity Community	★★★	★★★
Unity UW Health	★★★	★★★
WPS Metro Choice	★★	★

Overall Health Plan Ratings Detail

How people rated their HEALTH PLAN

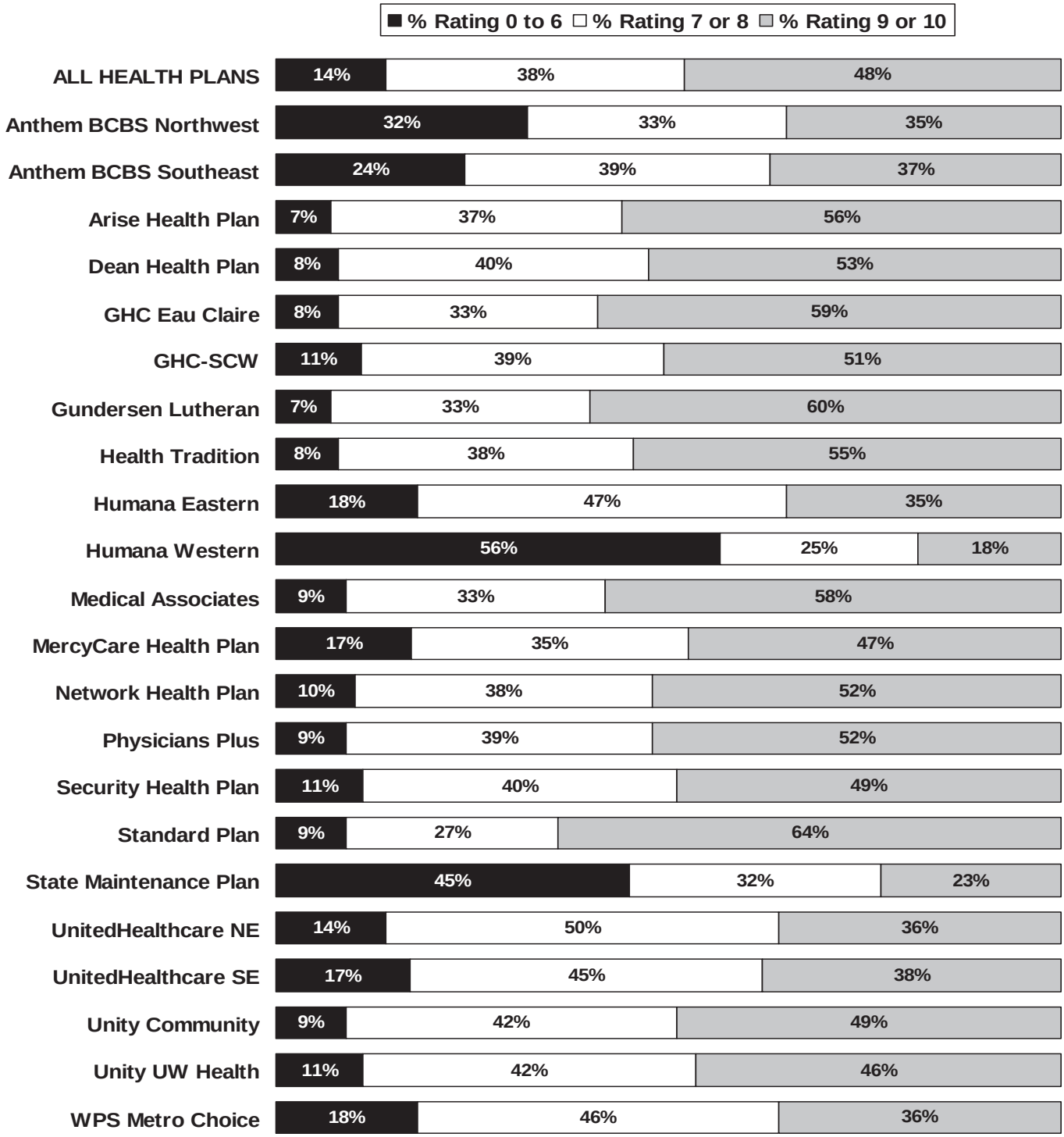
This graph shows:

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.

WPS Metro Choice was formerly known as WPS Patient Choice.

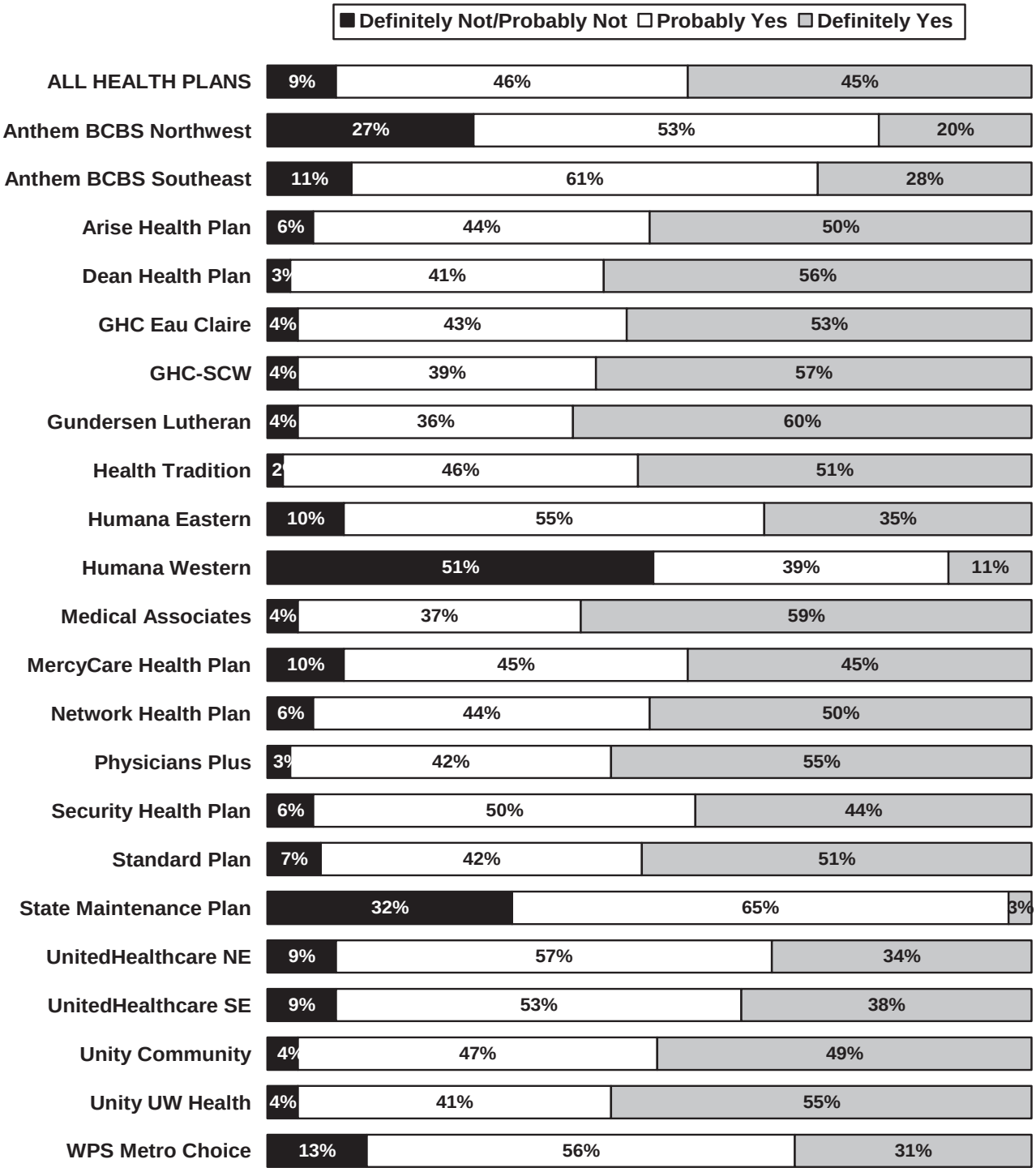


Health Plan Recommendation Detail

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

Question: "Would you recommend your health plan to your family or friends?"
This graph shows:
The percentage of people who said "definitely not"/ "probably not," "probably yes," or "definitely yes."

Due to rounding, the bars may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Health Plan Performance Detail

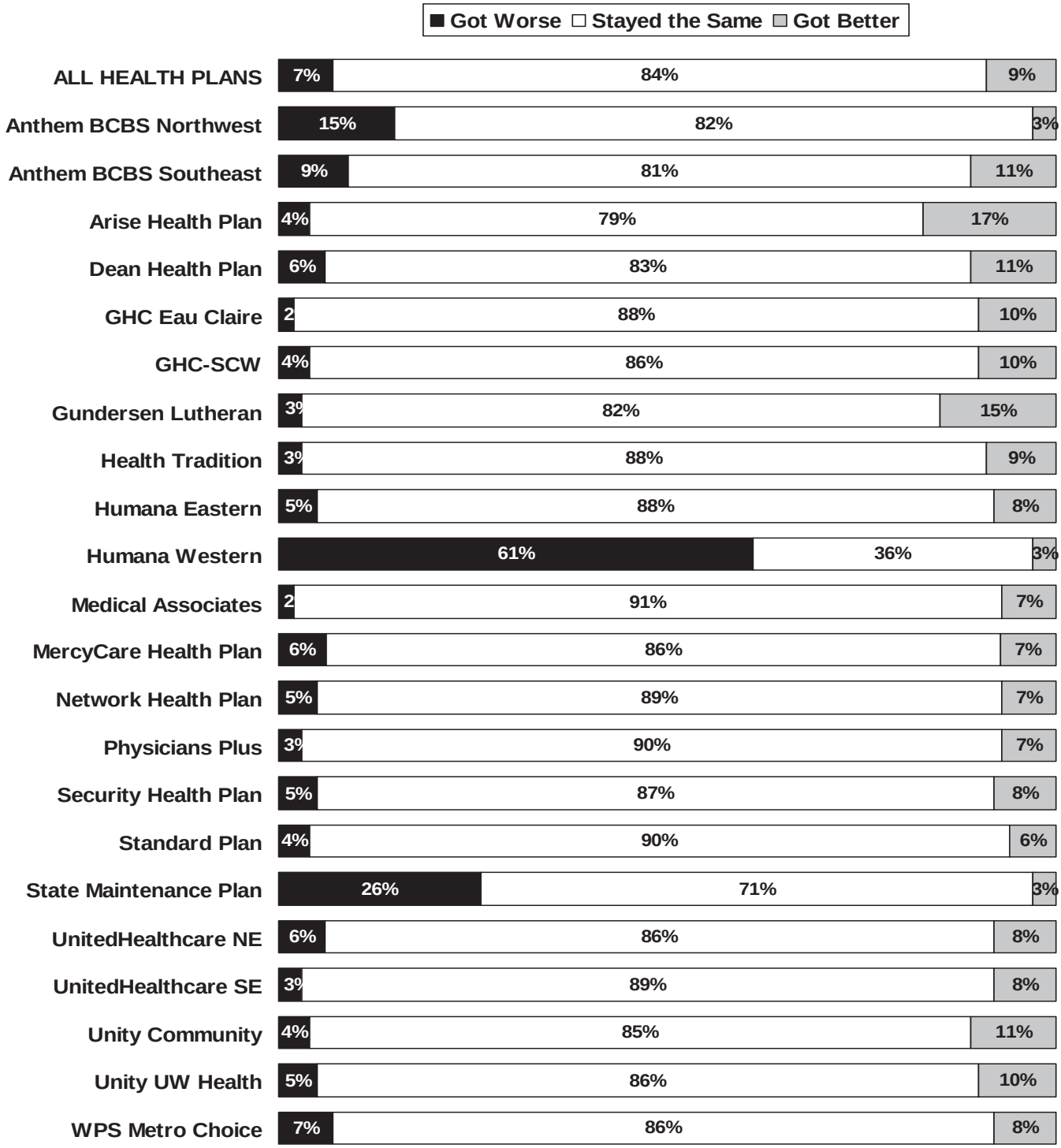
Over the past 12 months, did your plan's overall performance get better, stay the same, or get worse?

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

This graph shows:

The percentage of people who said it "got worse," "stayed the same," or "got better."

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

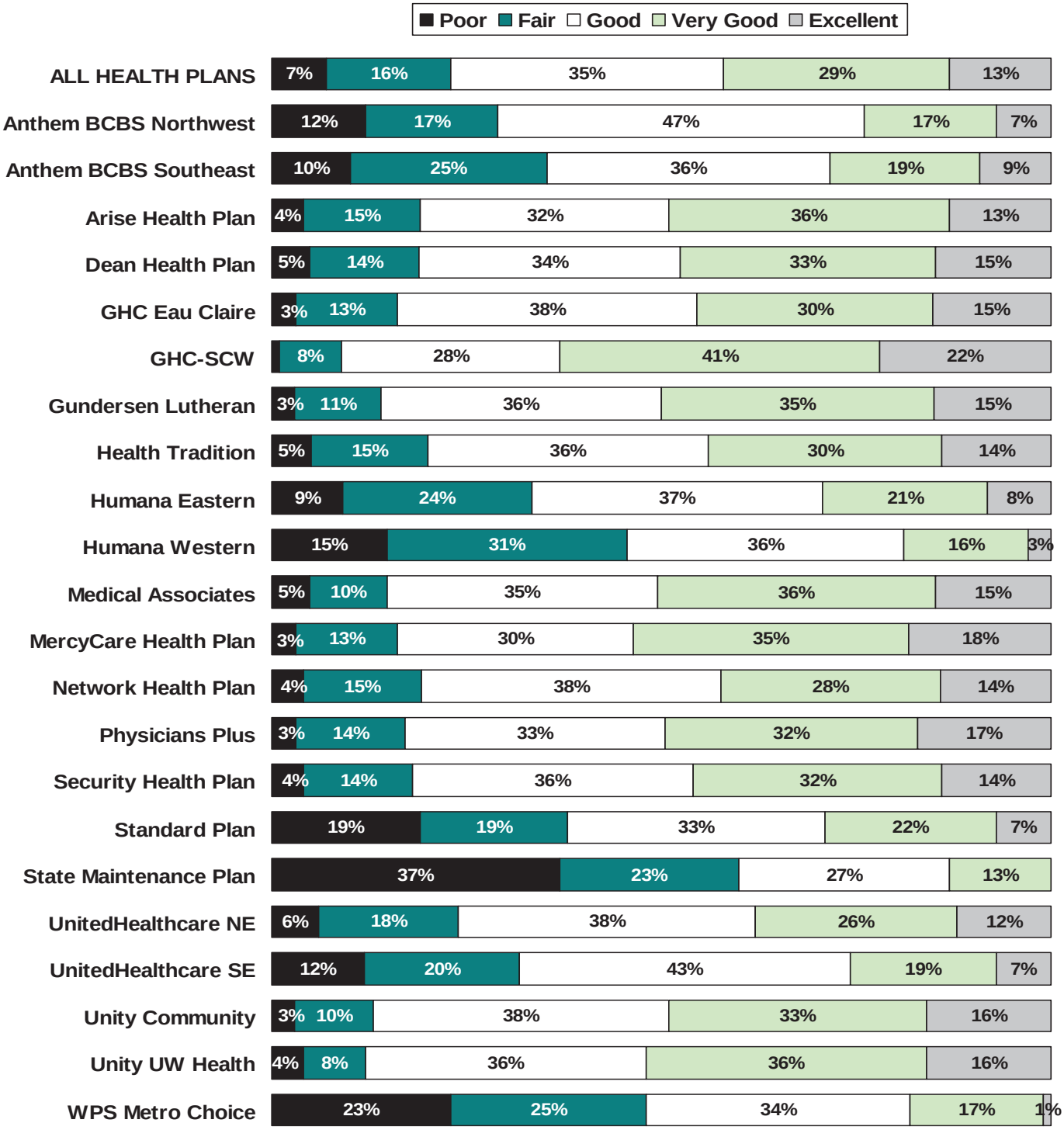


Health and Wellness Education Detail

Health Plan efforts to provide educational materials on health and wellness

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.?"
This graph shows:
The percentage of people who responded "excellent," "very good," "good," "fair," or "poor."

Due to rounding, the bars may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Customer Service Detail

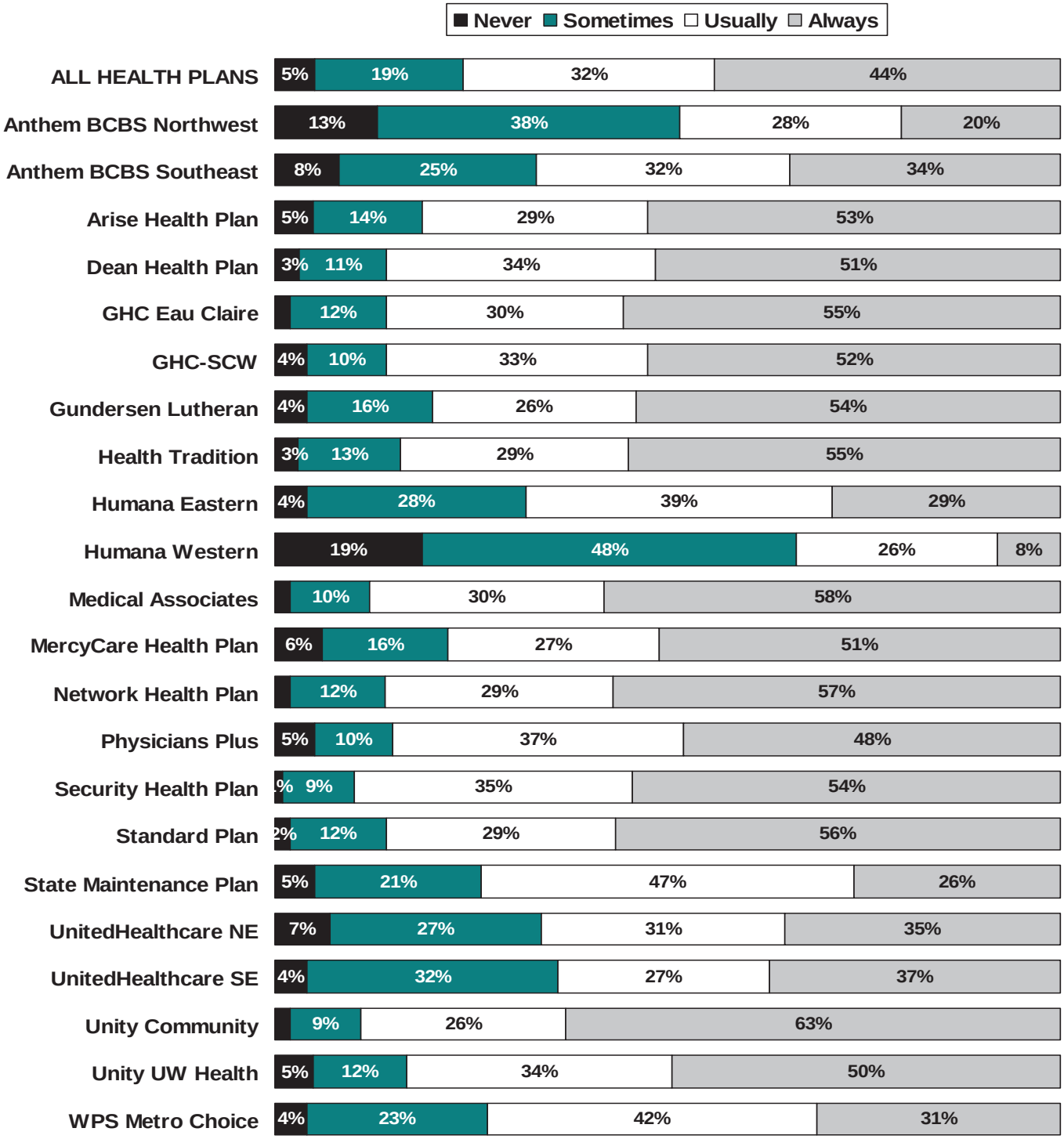
How often did your health plan's customer service give you information or help you needed?

Question: "In the last 12 months, 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."

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

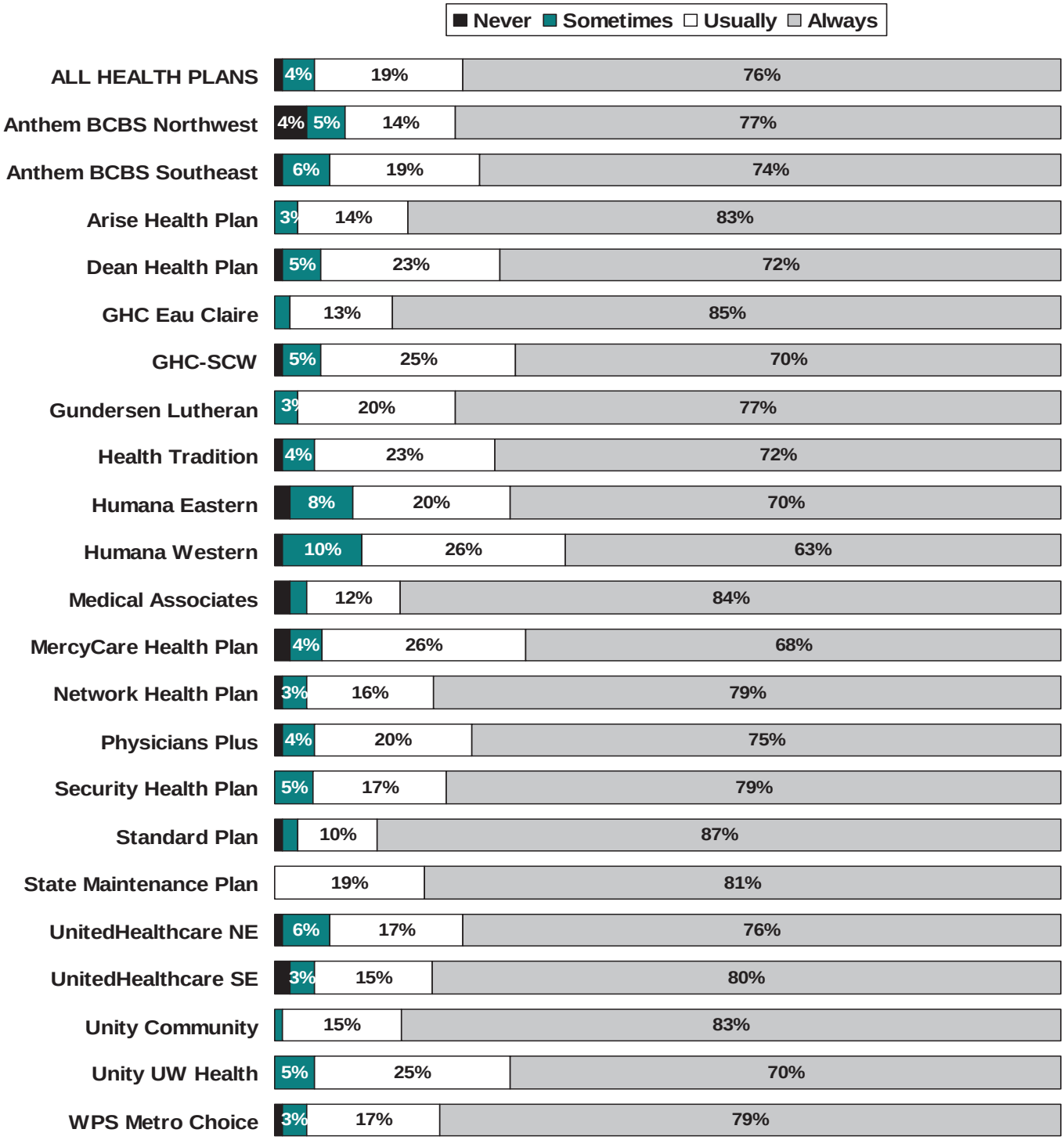


Customer Service Detail

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

Question: "In the last 12 months, 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."

Due to rounding, the bars may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Customer Service Detail

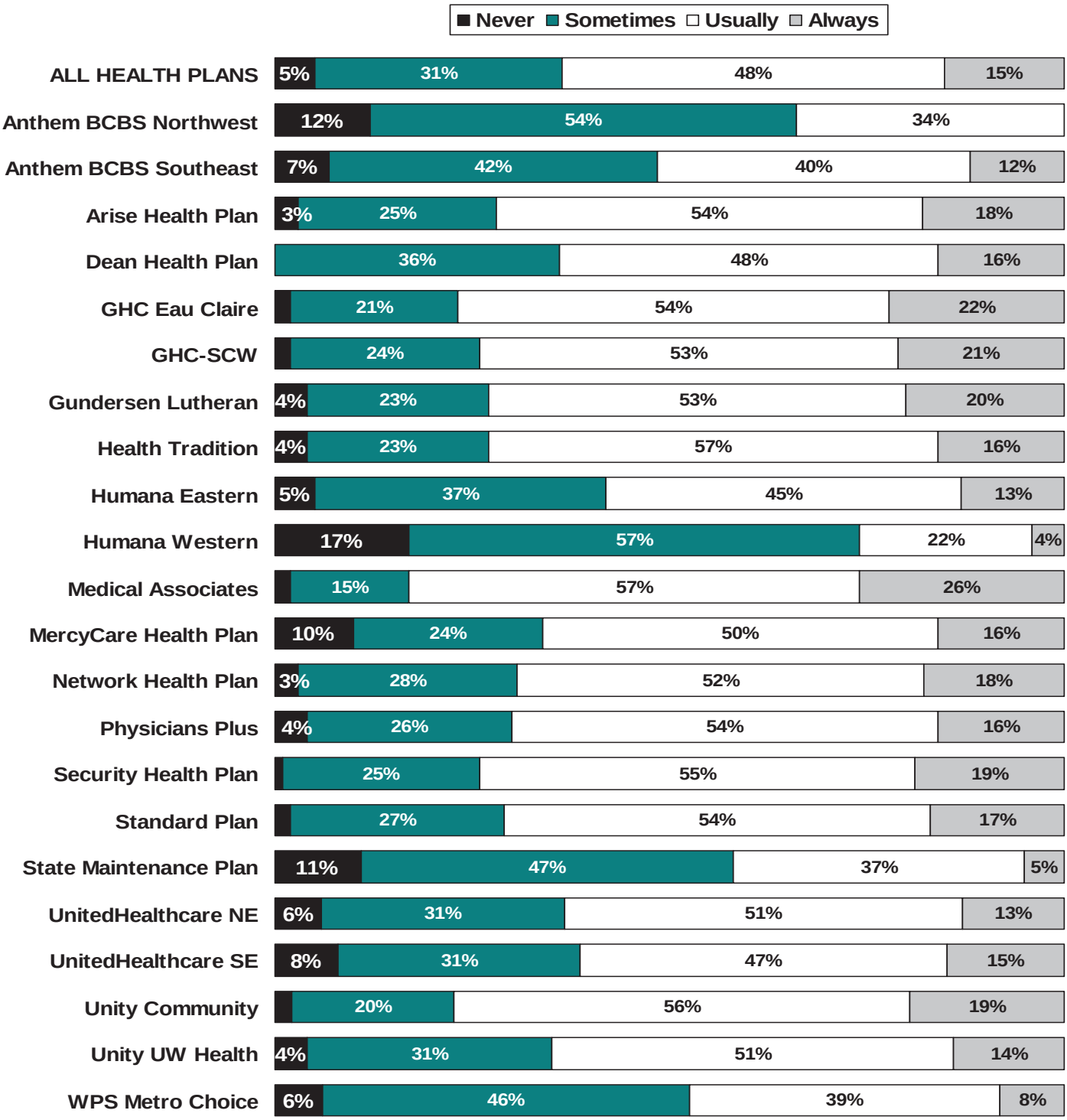
How often did the written materials or the Internet provide the information you needed about how your health plan works?

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 graph shows:

The percentage of people who said "always," "usually," "sometimes," or "never."

Due to rounding, the bars may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



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 Primary Doctor (star ratings are shown on page E-14)**
- **Rating of Specialists (star ratings are shown on page E-14)**

**Rating repeated from page E-14 for convenience of side-by-side comparison.*
WPS Metro Choice was formerly known as WPS Patient Choice.

	Overall Health Care Rating				
Health Plan	Total Sample*	Among those with 3 or more medical visits in last 12 months*	% 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	**8.34**	**8.34**	**91**	**92**	**89**
Anthem BCBS Northwest	★★	★★	91	95	94
Anthem BCBS Southeast	★	★★	83	87	85
Arise Health Plan	★★★	★★	95	95	92
Dean Health Plan	★★	★★	93	94	90
GHC Eau Claire	★★	★★	91	95	91
GHC-SCW	★★★	★★	90	92	86
Gundersen Lutheran	★★★	★★★	94	97	89
Health Tradition	★★★	★★★	93	95	88
Humana Eastern	★★	★★	90	93	88
Humana Western	★	★	78	93	89
Medical Associates	★★★	★★★	94	98	94
MercyCare Health Plan	★★	★★	88	88	86
Network Health Plan	★★	★★	86	88	90
Physicians Plus	★★	★★	93	90	90
Security Health Plan	★★	★★	92	93	90
Standard Plan	★★	★★	92	95	92
State Maintenance Plan	★	★	83	83	71
UnitedHealthcare NE	★★	★★	91	91	88
UnitedHealthcare SE	★★	★★	92	92	91
Unity Community	★★	★★	91	89	84
Unity UW Health	★★	★★	92	91	92
WPS Metro Choice	★★	★★	94	94	90

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**
- **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**

WPS Metro Choice was formerly known as WPS Patient Choice.

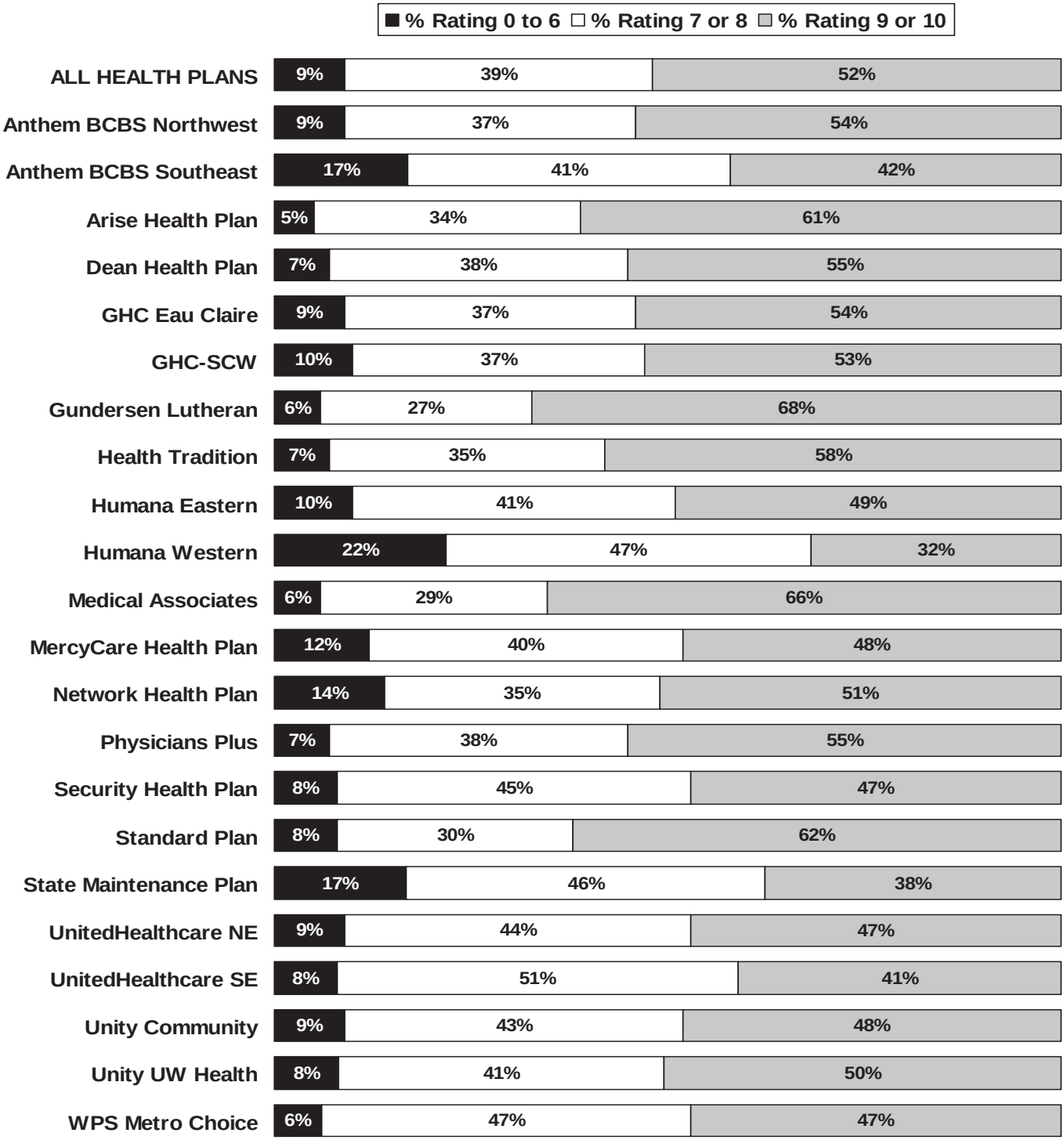
	Getting the care you need, when you need it		Doctors	
Health Plan	Getting needed care	Getting care quickly	How well doctors communicate	Shared Decision Making
Anthem BCBS Northwest	★★	★★	★★	★★
Anthem BCBS Southeast	★★	★★	★	★★
Arise Health Plan	★★★	★★	★★	★★
Dean Health Plan	★★	★★	★★	★★
GHC Eau Claire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

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.

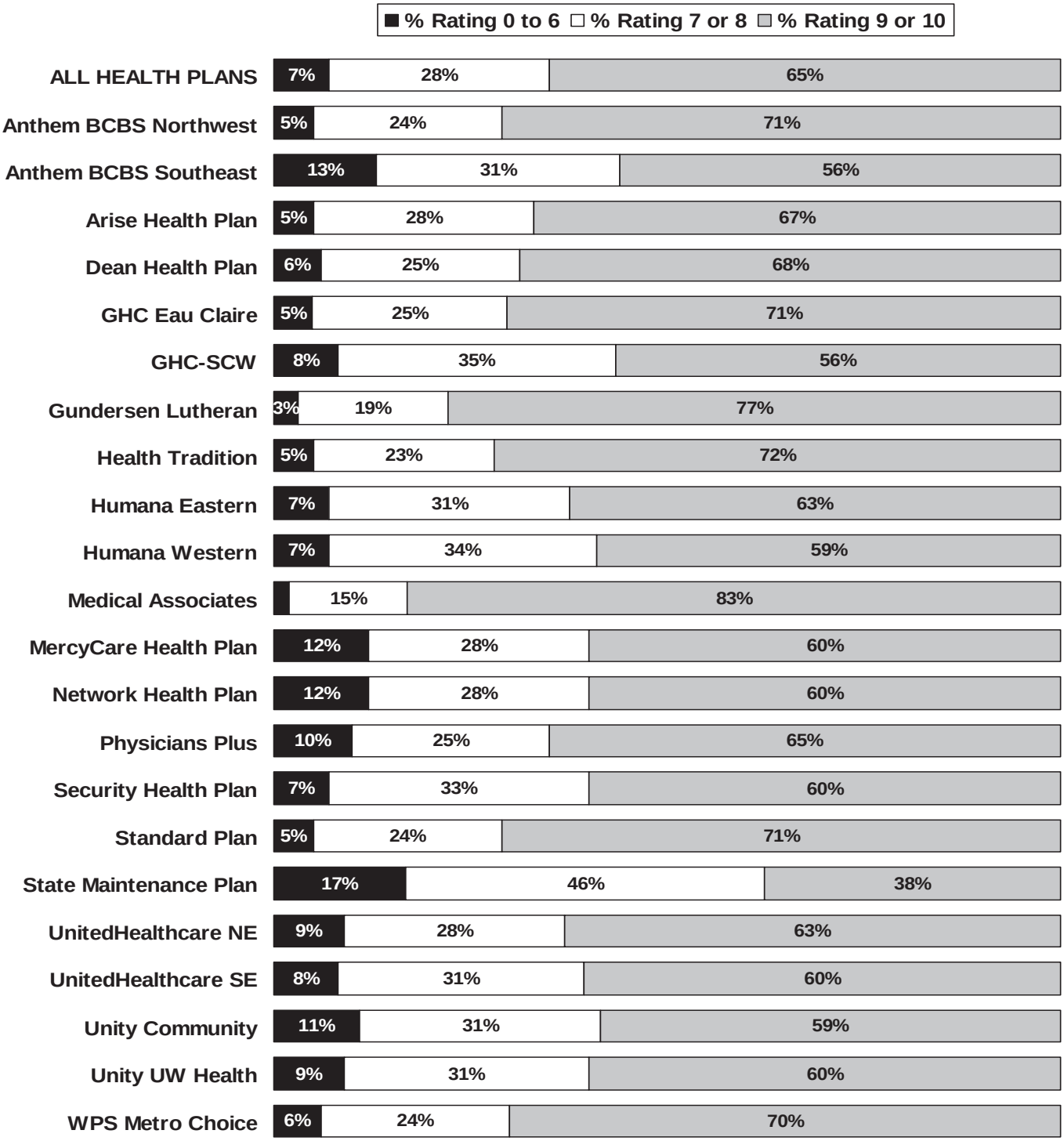


Overall Ratings Detail

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.
WPS Metro Choice was formerly known as WPS Patient Choice.

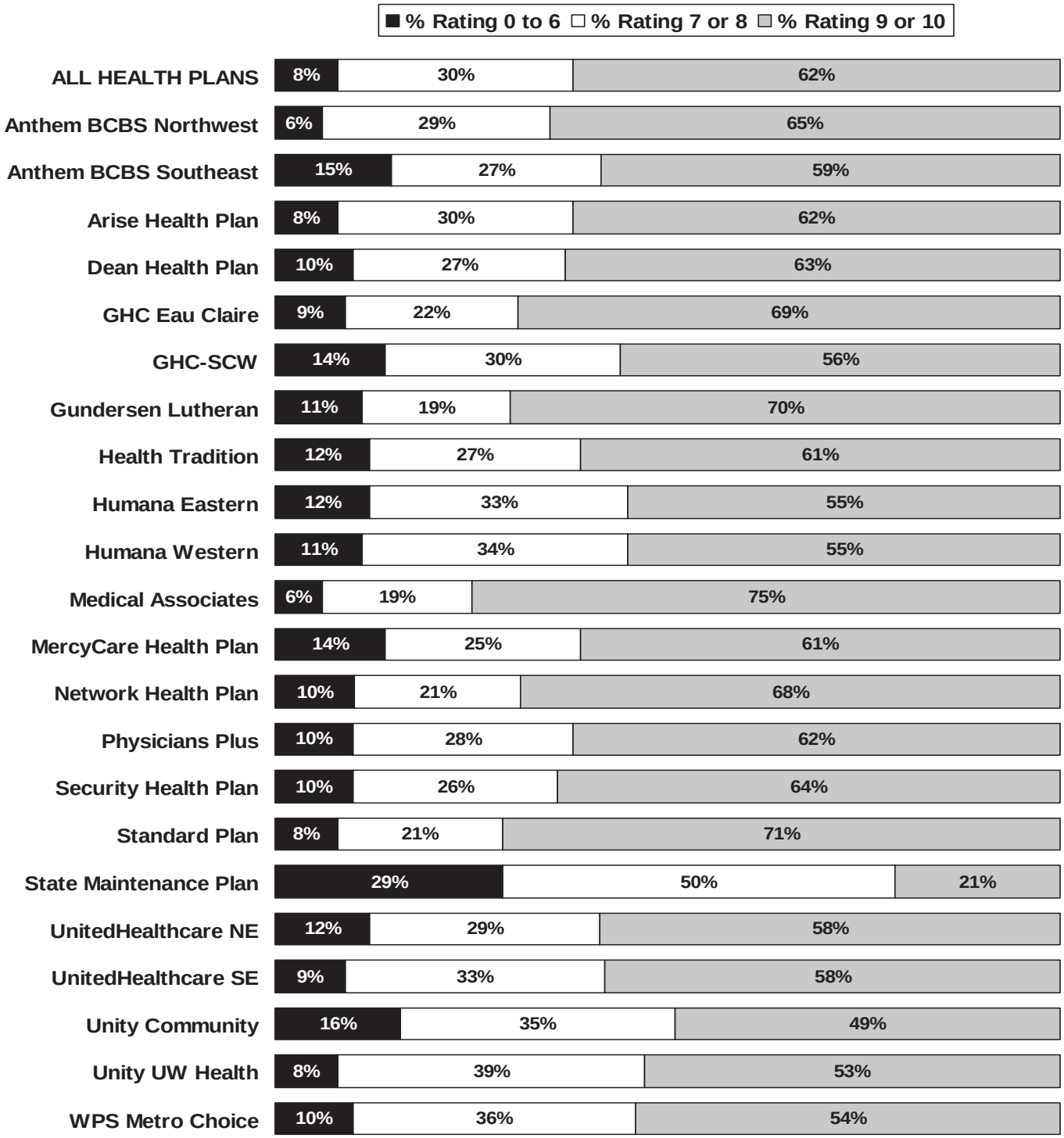


Overall Ratings Detail

Specialist

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.
WPS Metro Choice was formerly known as WPS Patient Choice.



Health Care Detail

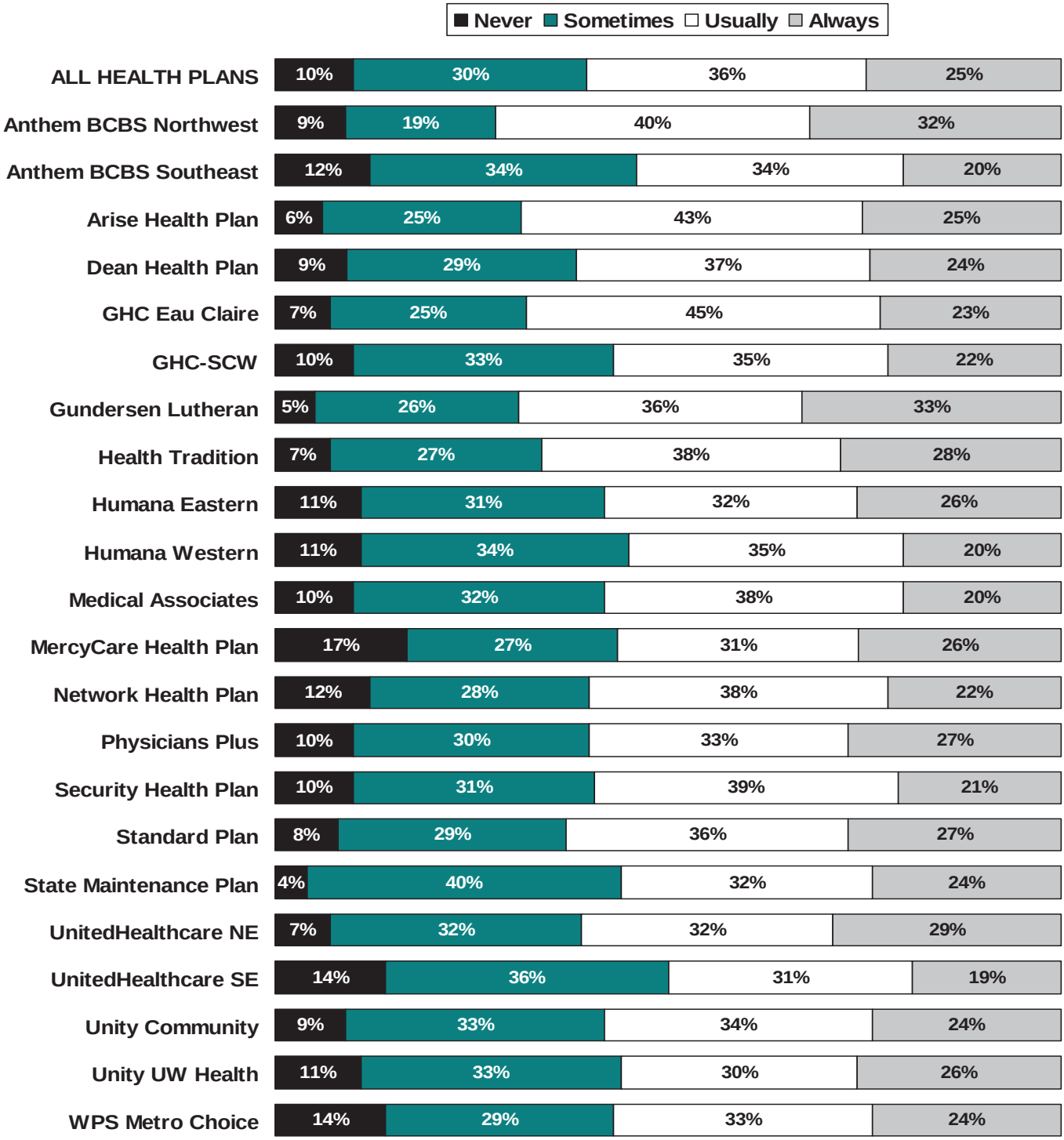
How often did you and a doctor/health provider talk about specific things you could do to prevent illness?

Question: "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".

Due to rounding, the bars may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Health Care Detail

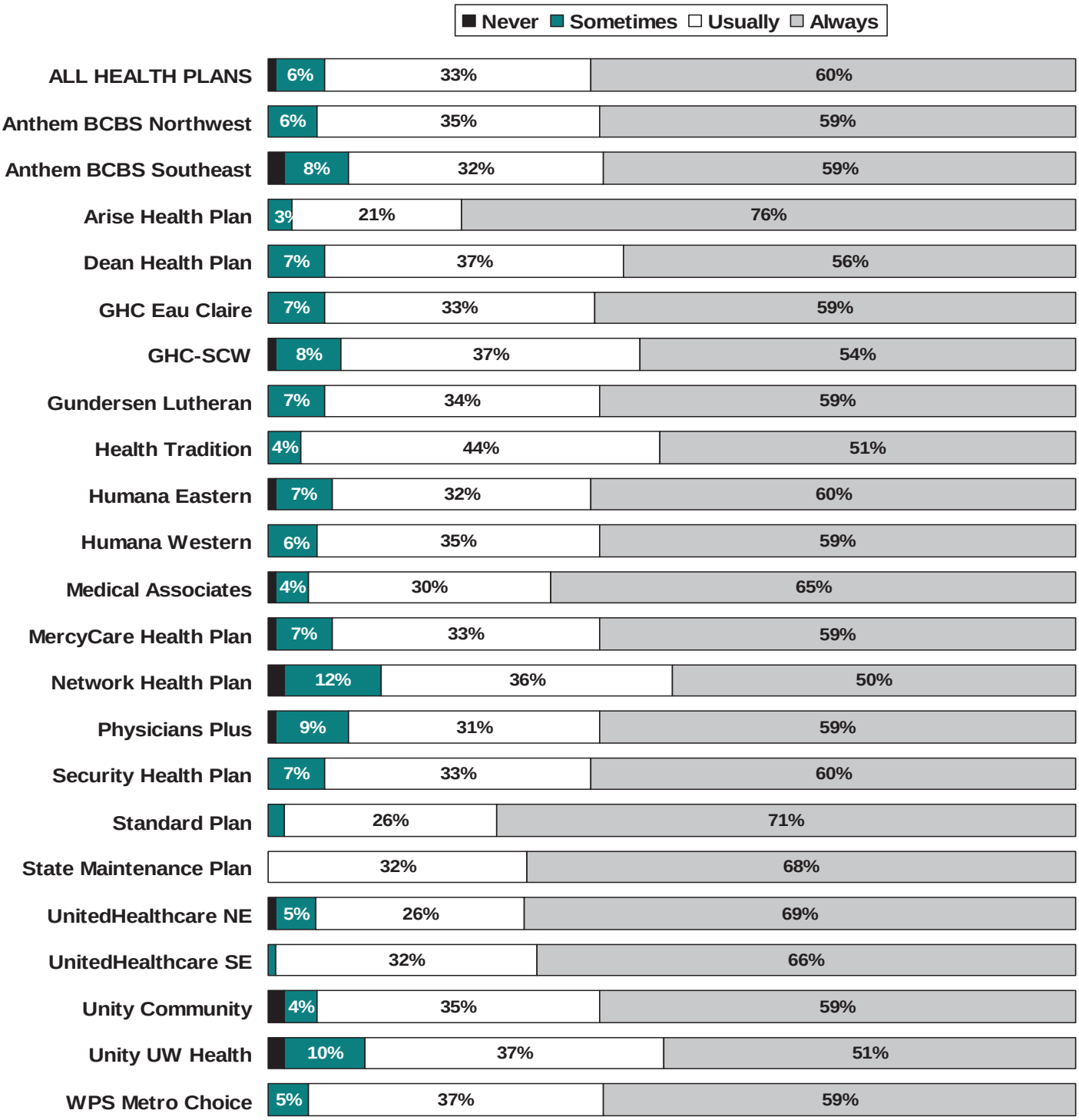
Received Care in Timely Manner

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 graph shows:

The percentage of people who said "always," "usually," "sometimes," or "never."

Due to rounding, the bars may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Grievance and Complaint Tables for Health Plans Available in 2009

2007 HEALTH PLAN GRIEVANCE REPORT[1]

(SELF-REPORTED BY EACH PLAN)

Plan Name	Total Number of Grievances	Number Over-turned Members Favor	Number Health Plan Compromise	% Partly/Fully Overturned	% of Total Contracts	% of Total Grievances
Anthem BCBS Northwest	12	6	1	58.3	0.44	1.04
Anthem BCBS Southeast	35	18	3	60.0	2.38	3.03
Arise Health Plan	8	3	0	37.5	0.74	0.69
Dean Health Plan	141	68	4	51.1	22.08	12.22
GHC Eau Claire	17	1	0	5.9	4.02	1.47
GHC-SCW	21	8	0	38.1	8.20	1.82
Gundersen Lutheran	11	5	1	54.5	2.11	0.95
Health Tradition	39	21	1	56.1	2.01	3.38
Humana Eastern	251	211	4	85.7	6.79	21.75
Humana Western	63	46	1	74.6	2.21	5.46
Medical Associates Health Plan	1	0	0	0	0.47	0.09
MercyCare Health Plan	12	7	0	58.3	0.83	1.04
Network Health Plan	31	19	0	61.3	4.35	2.69
Physicians Plus	25	4	5	36.0	10.61	2.17
Security Health Plan	40	14	3	42.5	3.22	3.47
Self-funded Plans[2]	127	51	4	43.3	9.54	11.01
UnitedHealthcare NE	132	64	0	48.5	4.25	11.44
UnitedHealthcare SE	66	38	0	57.6	1.88	5.72
Unity Community	18	11	1	66.7	1.52	1.56
Unity UW Health	89	30	2	36.0	11.98	7.71
WPS Patient Choice 1[3]	14	4	2	42.9	0.30	1.21
WPS Patient Choice 2[3]	1	1	0	100	0.07	0.09

[1]This information is collected by ETF and is not part of the CAHPS® survey.
[2]Includes the Standard Plan, State Maintenance Plan, Medicare Plus $1,000,000 (administered by WPS Health Insurance).
[3]The WPS Patient Choice health plans are available in 2009 as a single health plan called WPS Metro Choice.

Most Common Health Plan Grievance Types Reported:

- Excluded or Non-covered Benefit (25 percent of all grievances reported)
- Prior Authorizations (15 percent of all grievances reported)

HEALTH PLAN COMPLAINTS
RECEIVED BY EMPLOYEE TRUST FUNDS OMBUDSPERSONS IN 2007[1]

Plan Name	Number of Complaints	% of Total Contracts	% of Total ETF Health Insurance Complaints
Anthem BCBS Northwest	14	0.44	2.59
Anthem BCBS Southeast	19	2.38	3.52
Arise Health Plan	7	0.74	1.29
Dean Health Plan	56	22.08	10.4
GHC Eau Claire	12	4.02	2.22
GHC-SCW	6	8.20	1.11
Gundersen Lutheran	6	2.11	1.11
Health Tradition	5	2.01	0.92
Humana Eastern	54	6.79	10.0
Humana Western	25	2.21	4.63
Medical Associates Health Plan	2	0.47	0.37
MercyCare Health Plan	3	0.83	0.55
Network Health Plan	7	4.35	1.29
Physicians Plus	15	10.61	2.78
Security Health Plan	14	3.22	2.59
Self-funded Plans[2]	158	9.54	29.3
UnitedHealthcare NE	93	4.25	17.2
UnitedHealthcare SE	12	1.88	2.22
Unity Community	4	1.52	0.74
Unity UW Health	18	11.98	3.33
WPS Patient Choice 1[3]	9	0.30	1.66
WPS Patient Choice 2[3]	1	0.07	0.18

[1] This information is collected by ETF and is not part of the CAHPS® survey.
[2] Includes the Standard Plan, State Maintenance Plan, Medicare Plus $1,000,000 (administered by WPS Health Insurance).
[3] The WPS Patient Choice health plans are available in 2009 as a single health plan called WPS Metro Choice.

Most Common Health Plan Complaint Types Received:

- Billing/Claim Processing (35 percent of all complaints received)
- Enrollment and Eligibility (28 percent of all complaints received)

HEDIS® SUMMARY

What is HEDIS? The 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 they have since been adapted for use by public purchasers, regulators, and consumers. HEDIS measures address health care issues that are meaningful to consumers and purchasers. They address dimensions of care where improvement can make a meaningful difference in patients' lives, and they measure areas that health care systems can take action to improve. 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 during the open enrollment period to compare the performance of their health care options. When evaluating an HMO's performance, consumers should take the performance on several measures into account. 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 what providers are available, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction and experience data, 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 better at data collection and reporting. Audited data is more reliable than unaudited data; the auditing process ensures that accuracy.

Different member populations. HEDIS scores may differ across HMOs for a number of reasons, such as true differences in performance, lack of reliable data, or differences in the 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 employers in a specific industry, benefit 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.

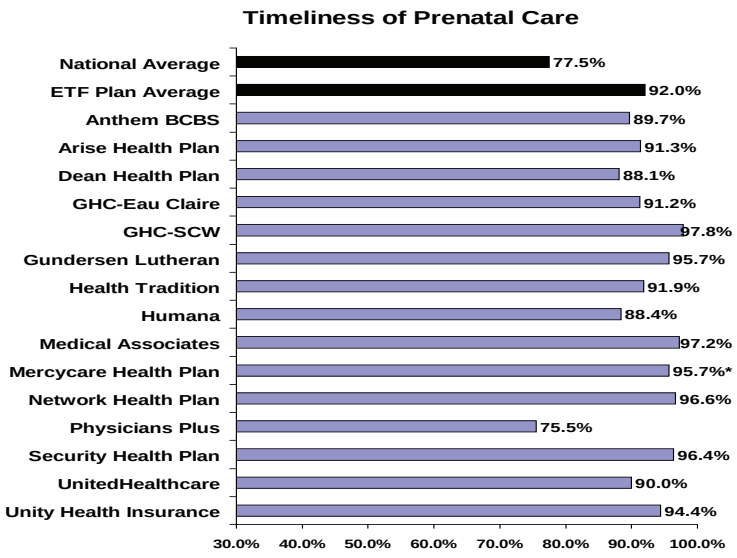
Items to consider when comparing the HMOs included in this report card:

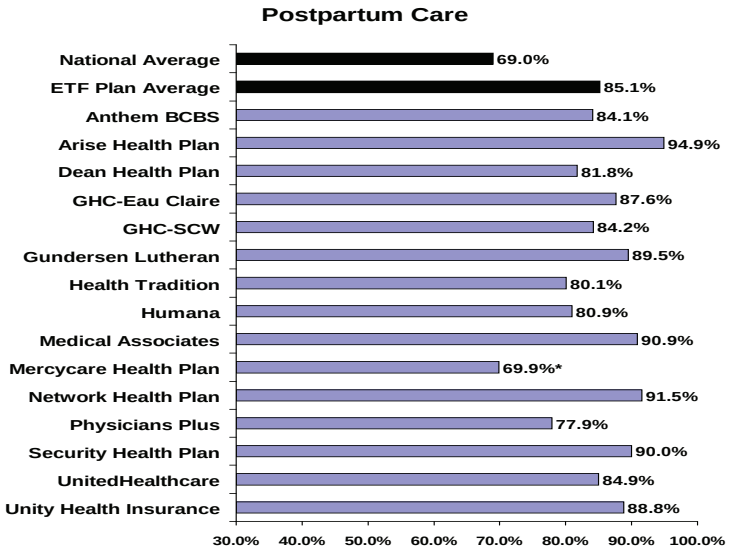
- HEDIS data is not available for the Standard Plan, the State Maintenance Plan, or WPS Metro choice because PPOs do not emphasize the quality improvement and reporting functions of managed care organizations.

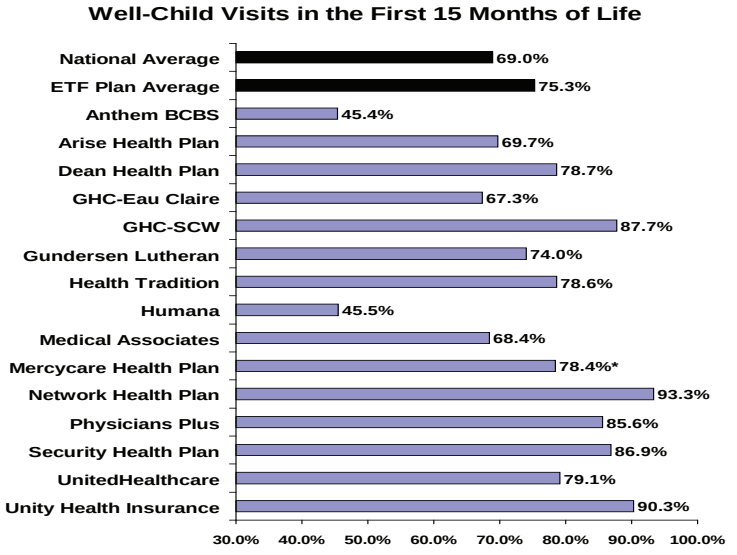
- The Wisconsin averages included in this report card include only HMOs that participate in the State program.

- 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 an 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 web site: http://www.ncqa.org and clicking on the Report Cards link.







Women and Children's Health

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.

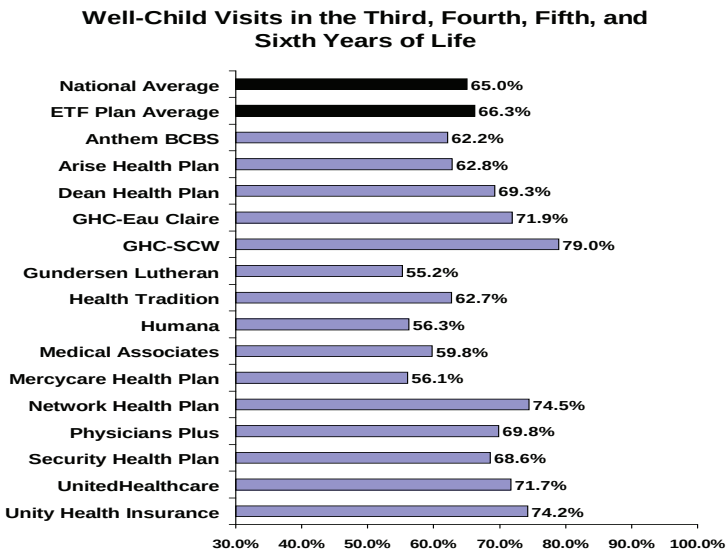
What percentage of women who had live births had a postpartum visit between 21 and 56 days after delivery?

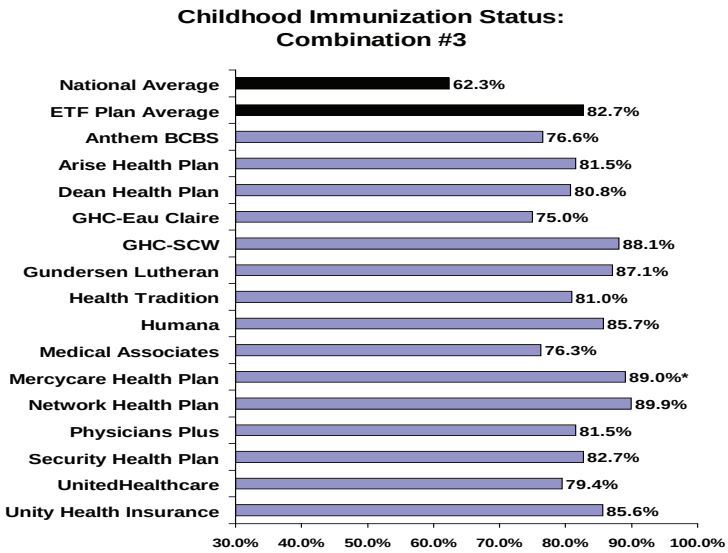
The 8 weeks after giving birth are a period of physical, emotional and social changes for the mother during a time when she is also adjusting to caring for her new baby. To give practitioners a chance to offer advice and assistance, the American College of Obstetricians and Gynecologists recommends that 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 health guidance and counseling on nutrition.

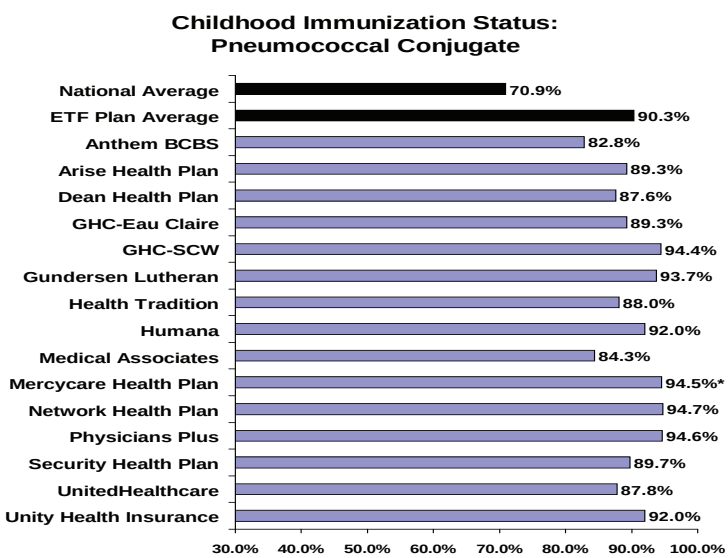
What percentage of children had six or more well-child visits by the time they turned 15 months of age?

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 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

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:

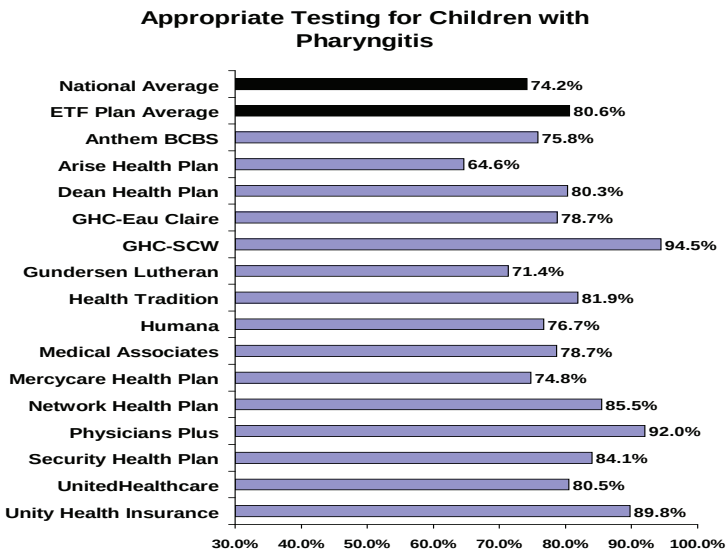
http://dhs.wisconsin.gov/immunization/vfc.htm

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

Appropriate Use of Antibiotics

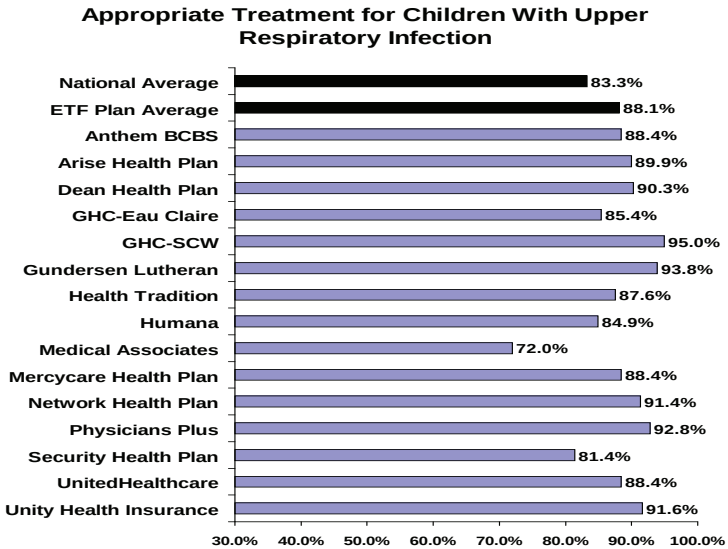
Did children between ages 2 and 18 who were diagnosed with pharyngitis get prescribed an antibiotic at an outpatient visit and receive a group A streptococcus test?

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.



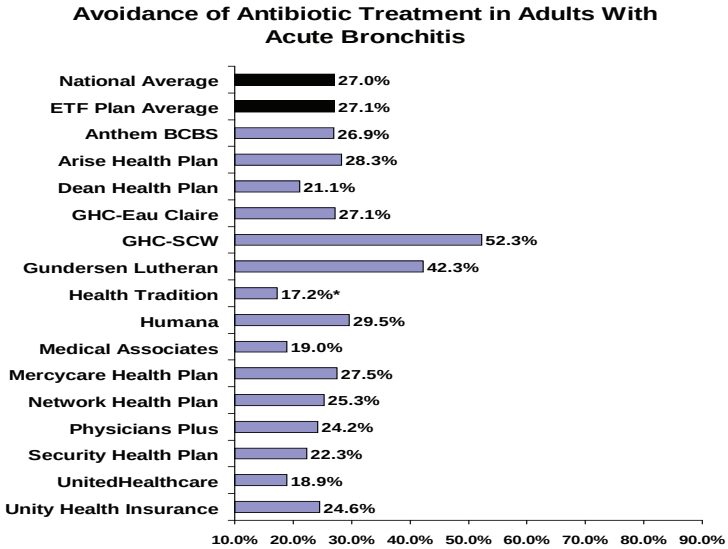
Did children between 3 months and 18 years of age who were given a single diagnosis of an upper respiratory infection at an outpatient visit not receive an antibiotic prescription for that episode of care within three days of the visit?

The common cold (upper respiratory infection) 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 colds.

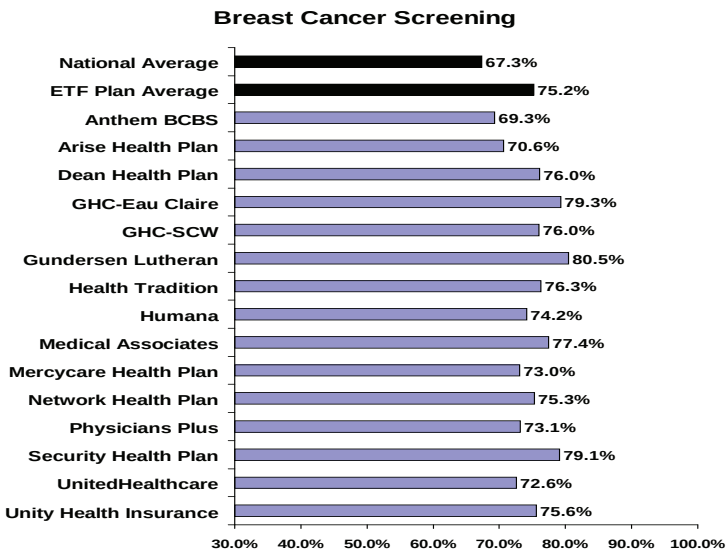


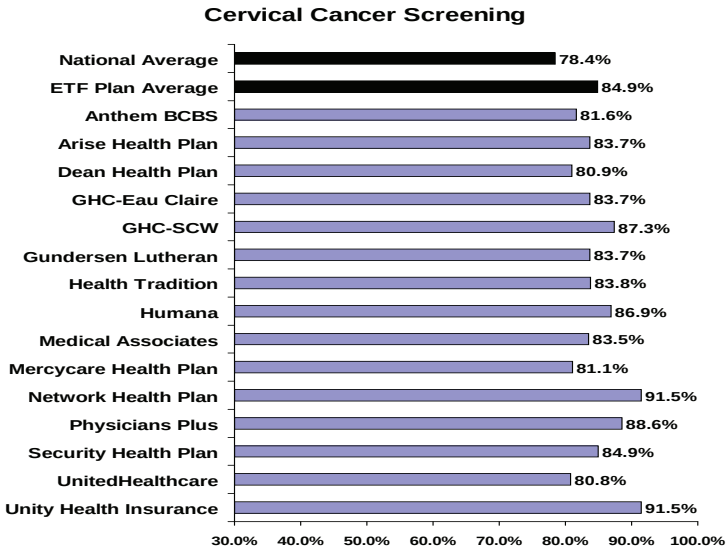
Did adults between 18 and 64 years of age who were diagnosed with acute bronchitis receive an antibiotic prescription for that episode of care within three days?

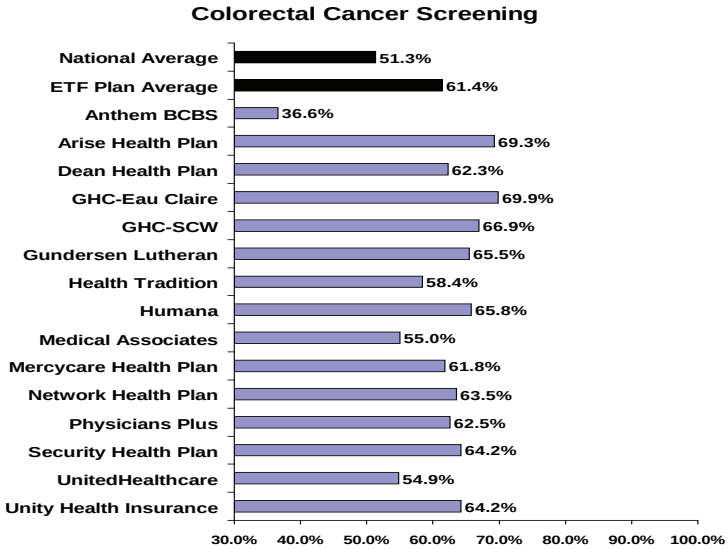
Avoiding antibiotic treatment of adults with acute bronchitis is an important objective, especially since misuse and overuse of antibiotics lead to antibiotic drug resistance. Acute bronchitis consistently ranks among the 10 conditions that account for most ambulatory office visits to U.S. physicians;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



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







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 178,200 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 40 and older. The American Cancer Society recommends that women age 40 and older receive an annual mammogram and that younger women receive one if they have had cancer before or have a family history or genetic predisposition to cancer.

What percentage of women ages 21 to 64 had at least one Pap test during the past three years?

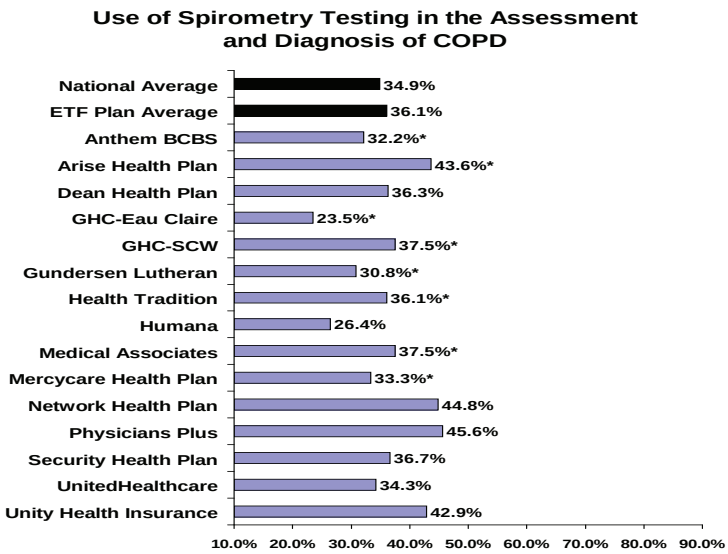
A number of organizations, including the American College of Obstetricians and Gynecologists, the American Medical Association, and the American Cancer Society, recommend Pap testing every one to three years for all women who have been sexually active or who are over 21 years old. Cervical cancer can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

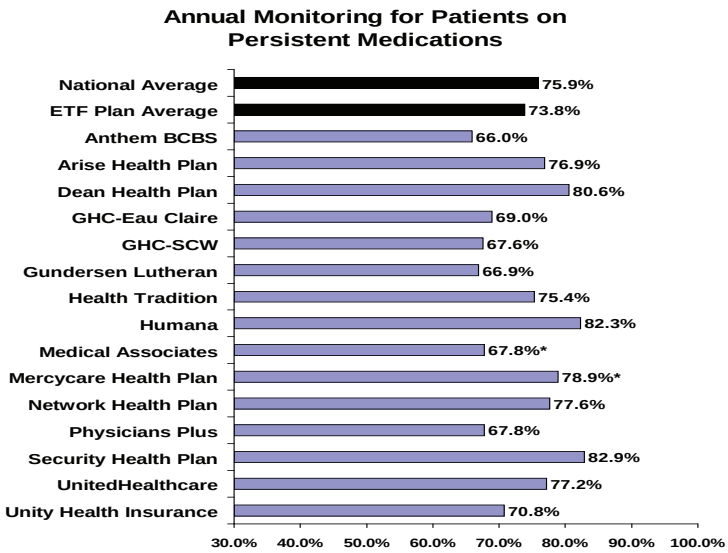
Did adults age 50 to 80 receive an appropriate screening for colorectal cancer? "Appropriate screening" is defined by meeting any one of the four criteria below:

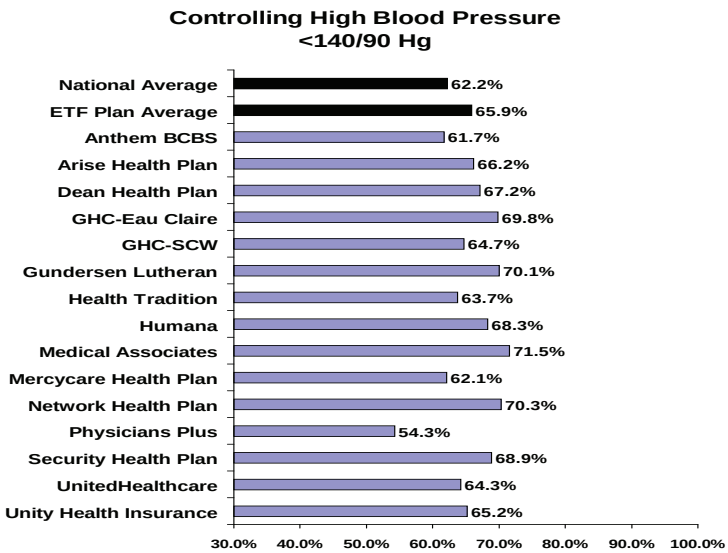
- Fecal occult blood test (FOBT) during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- Double contrast barium enema (DCBE) during the measurement year or the four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

Colorectal cancer 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 screening can detect pre-malignant polyps and guide their removal, which in theory can prevent development of cancer.

For more information on cancer statistics, please go to: http://www.cancer.org







Living with Illness

What percentage of members 40 years of age with a new diagnosis of chronic obstructive pulmonary disease (COPD) received spirometry testing to confirm the diagnosis within a reasonable period of time?

In the United States. COPD afflicts nearly 16 million adults in the United States. COPD defines a group of diseases characterized by airflow obstruction, and includes chronic bronchitis and emphysema. COPD is the fourth leading cause of death in the United States, and is projected to move to third place by 2020. The spirometry test, a simple test that measures the amount of air a person can breathe out and the amount of time it takes to do so, is largely under utilized. This type of testing not only confirms the COPD diagnosis, but it also is used to measure the severity of airflow limitation.

What percentage of members 18 years and older on persistent medications received annual monitoring for one of the following drugs of interest:

- Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Digoxins
- Diuretics
- Anticonvulsants

The total costs of drug-related problems due to misuse of drugs in the ambulatory setting has been estimated to exceed $76 billion annually

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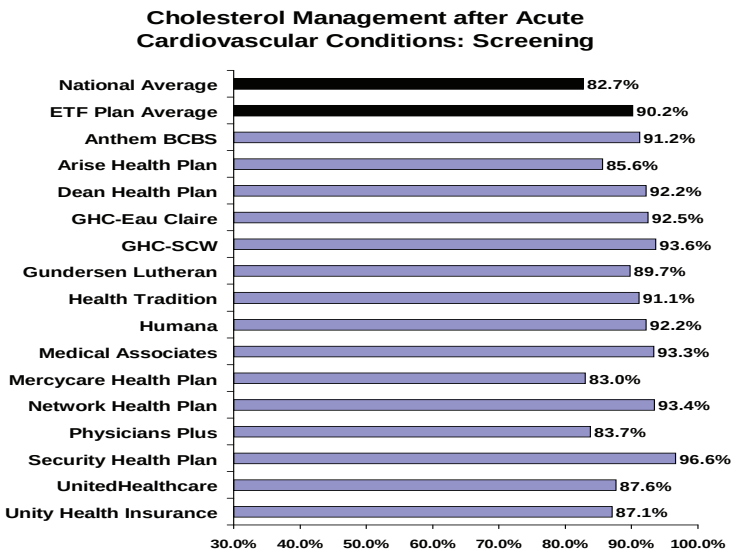
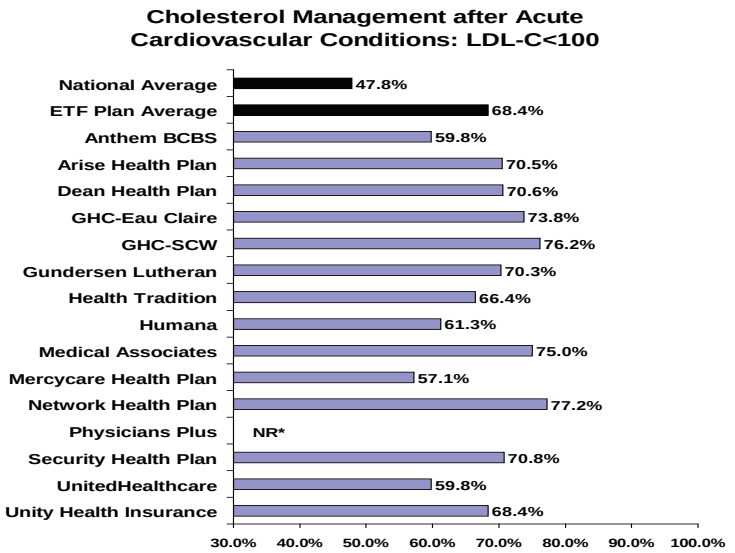
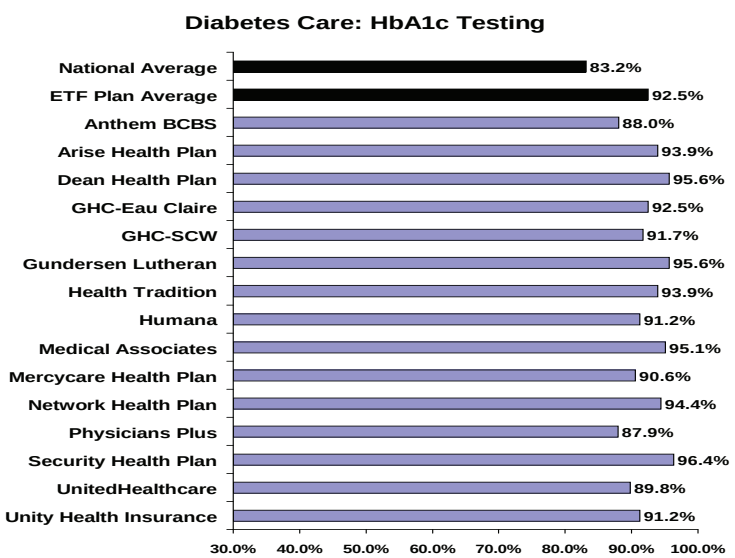
What percentage of adults age 18 to 85 years old that were diagnosed with hypertension had their blood pressure controlled to <140 mm Hg systolic and <90 mm Hg diastolic?

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.

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







*This HEDIS score is not available for Physicians Plus because sample was not collected following NCQA specifications.

Living with Illness

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.

Cholesterol screening and control depends on the combined efforts of the patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

For information on heart disease in Wisconsin, visit the Wisconsin Cardiovascular Health Program at: http://dhs.wisconsin.gov/health/cardiovascular/index.htm

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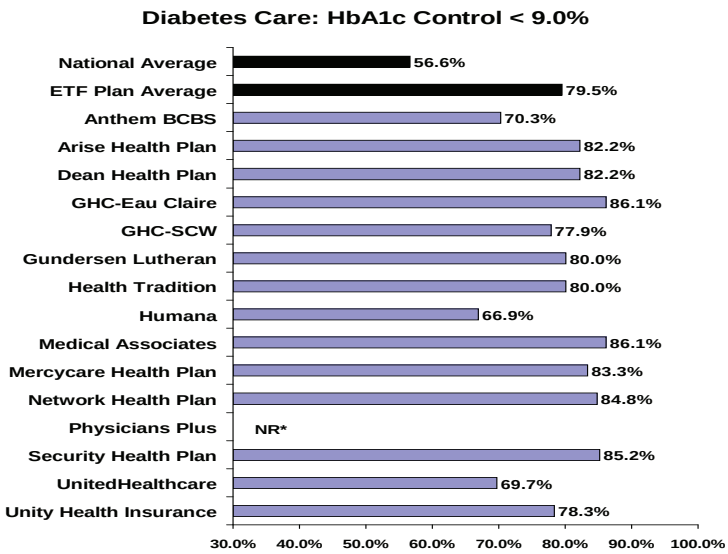
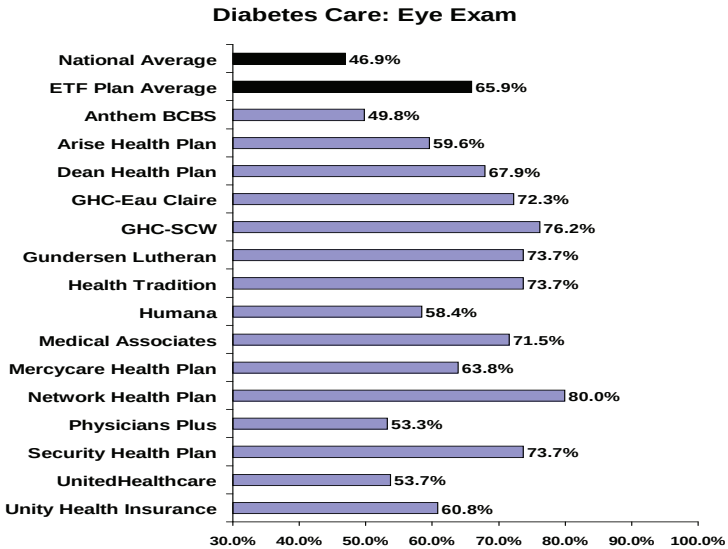
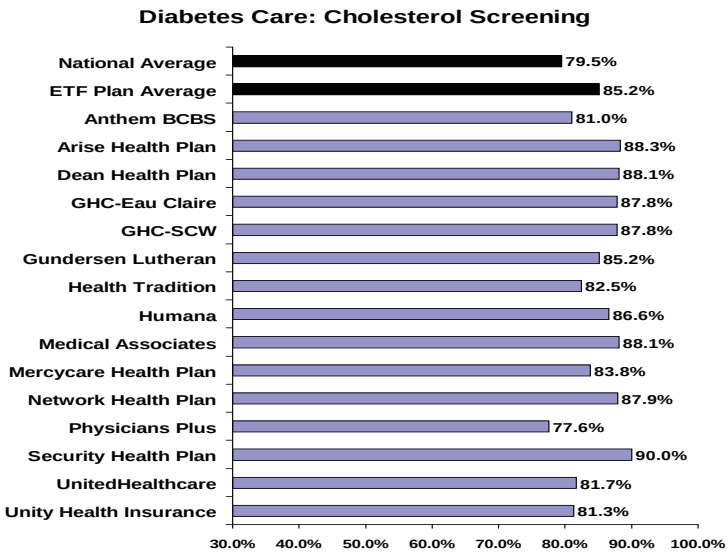
What percent of members with diabetes age 18 to 75 years old:

- Received a hemoglobin (HbAlc) screening (long term glucose blood test)
- Had HbA1c levels controlled at less than 9%)
- 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
- Have blood pressure <130/80

Diabetes continued on next page







*This HEDIS score is not available for Physicians Plus because sample was not collected following NCQA specifications..

Living with Illness

Diabetes continued

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed.

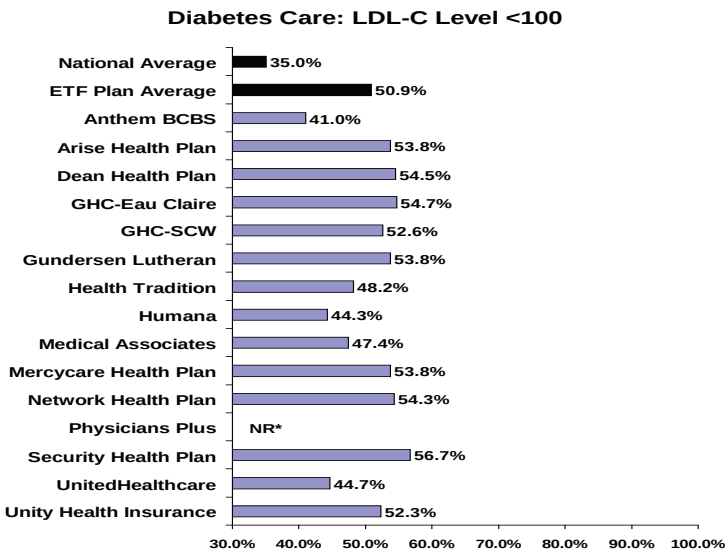
Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in persons over age 25. Many complications, such as amputations, blindness and kidney failure, can be prevented if diabetes is detected and addressed in the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

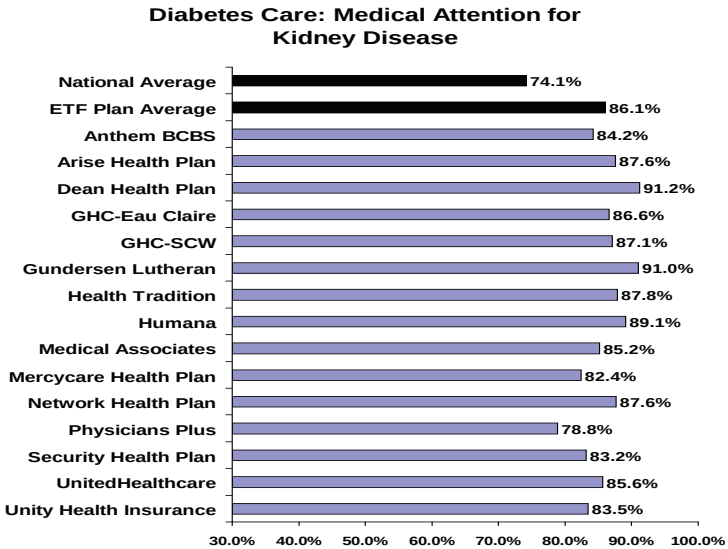
Diabetes is a multi-faceted disease, affecting multiple organs and requiring the involvement of a multidisciplinary health care team. It is difficult to assess comprehensive diabetic care without examining several factors. This measure contains a variety of indicators that provide a comprehensive view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

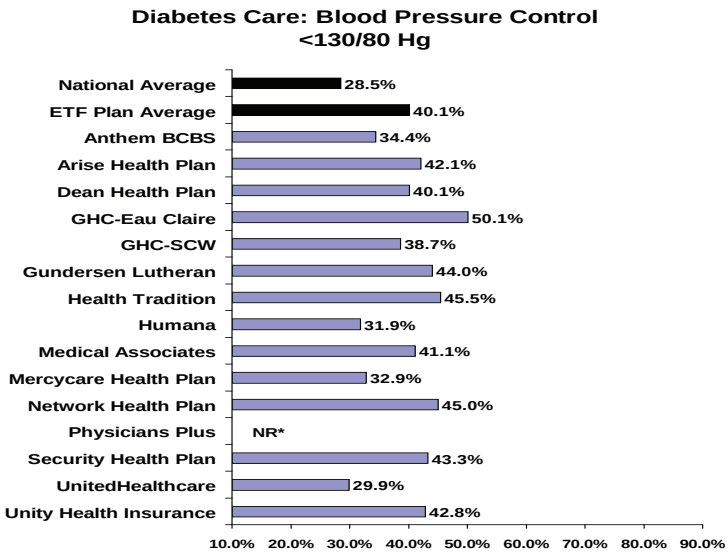
Many organizations have developed comprehensive diabetes management programs that help members with diabetes maintain control over their blood sugar and minimize the risk of complications. These programs can be beneficial to quality of life and cost-effective in the long run. The challenge faced by organizations is to bring more members with diabetes into these programs and help them incorporate healthy behaviors and monitoring practices into their lifestyle. Organizations can learn from higher-performing organizations and develop more integrated approaches to treating members with diabetes.

In addition to the screenings included in this HEDIS measure, the Center for Disease Control (CDC) recommends that people with diabetes visit their doctor, get an annual foot exam with their provider, examine their own feet, monitor their blood-glucose levels, get vaccinations for influenza and pneumococcal disease, and attend diabetes self-management classes.

Diabetes continued on next page







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Living with Illness

Diabetes continued

Diabetes self-care guidelines and a Diabetes Personal Care Record are available at the Wisconsin Department of Health Services Web site at http://dhs.wisconsin.gov/health/diabetes/guidelines.htm

The guidelines and care record can be downloaded in English, Spanish, and Hmong.

According the Wisconsin Diabetes Prevention and Control Program:

- Diabetes is the seventh leading cause of death in Wisconsin with over 1,200 Wisconsin residents dying of the disease each year and many more suffering with disabling complications.
- An estimated 419,870 adults (9.6%) have diabetes.
- An estimated 6,000 children and adolescents have diabetes.
- About 19% of Wisconsin residents 65 and older have diabetes.
- An estimated 1.06 million adults 20 years and above in Wisconsin have pre-diabetes.
- The total societal cost of diabetes in Wisconsin is estimated to be 5.19 billion.

For information on efforts to control diabetes in Wisconsin, visit the Wisconsin Diabetes Prevention and Control Program web site at: http://dhs.wisconsin.gov/health/diabetes

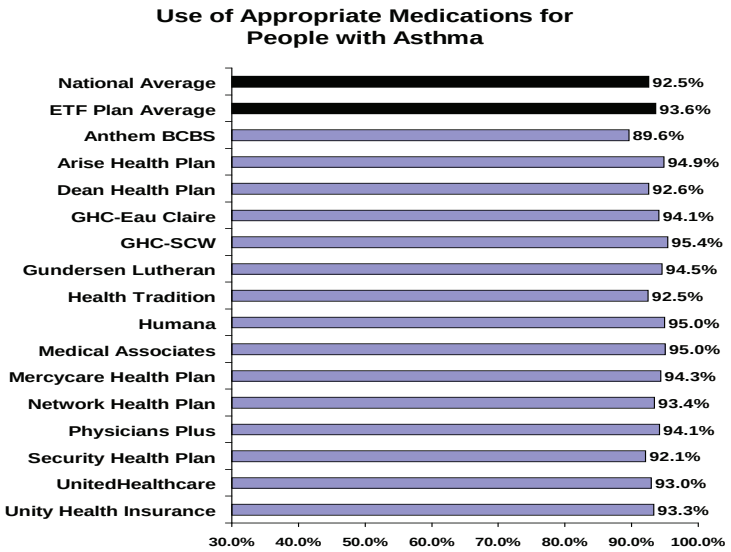
Many resources are available for employers and people with diabetes or at risk of developing diabetes at the Alliance web site at:

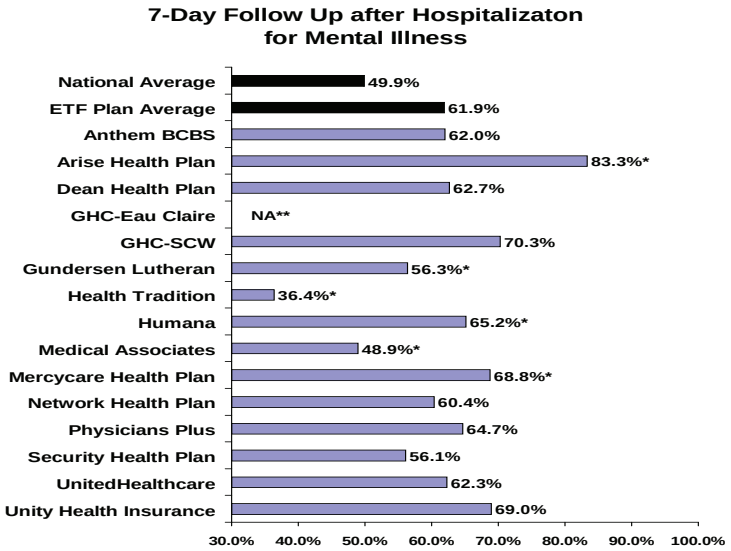
http://www.alliancehealthcoop.com/diabetes/index.htm

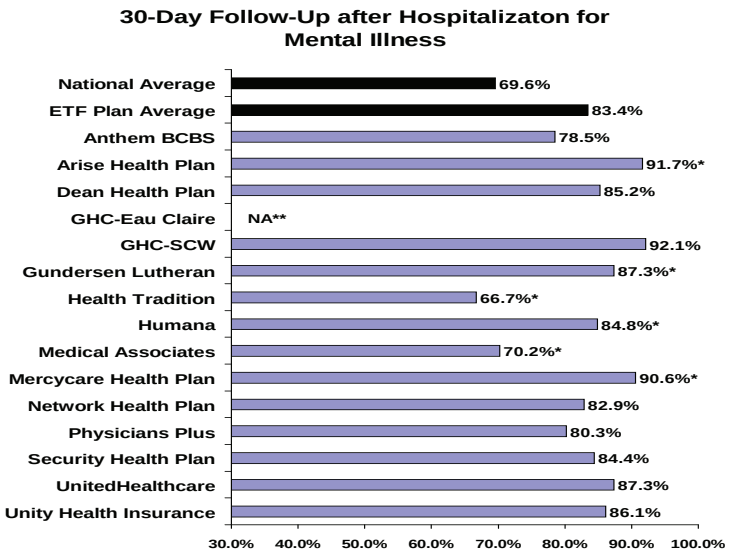
Although geared towards Wisconsin employers, this web site includes many tools and guides for people affected by diabetes including personal care tools and information about managing diabetes in the work place.

Another comprehensive web site for employers and employees on managing diabetes is the diabetes at work web site: http://www.diabetesatwork.org/

Living with Illness/ Behavioral Health







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 people with asthma 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 derived from a denominator <100. Only differences of 20 percentage points or more from this score should be interpreted as meaningful.
**HEDIS scores are not reported because the sample size is too small to be meaningful. N<30.

Behavioral Health

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

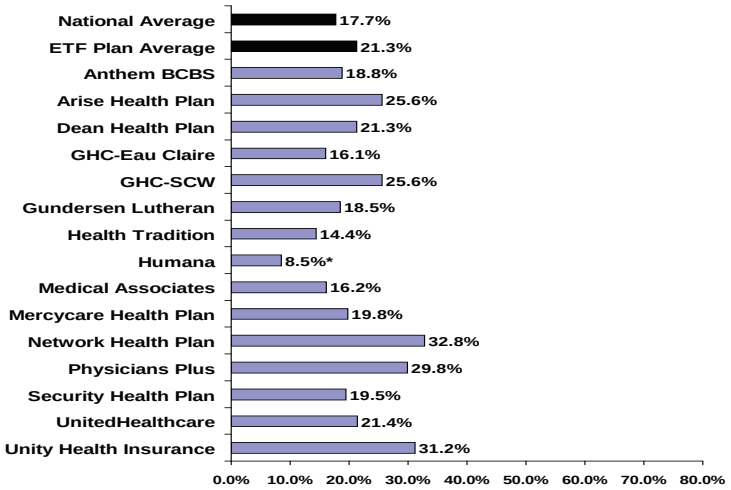
- Adequate clinical management of new treatment episodes (at least three follow-up office visits during the first 12 weeks after diagnosis and start of medications)
- Adequate acute phase trial medications (stayed on medication for 12 weeks)
- Completion of a period of continuous treatment for major 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 20.9 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.

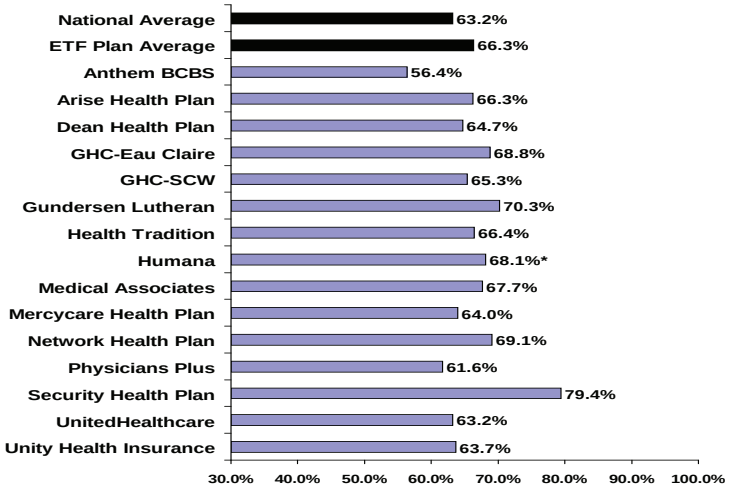
Patients who have a moderate to severe case of major depression are generally good candidates for treatment with antidepressant medication. If pharmacological therapy is initiated, the AHRQ Depression in Primary Care guideline defines three phases of treatment: acute, continuation and maintenance.

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.

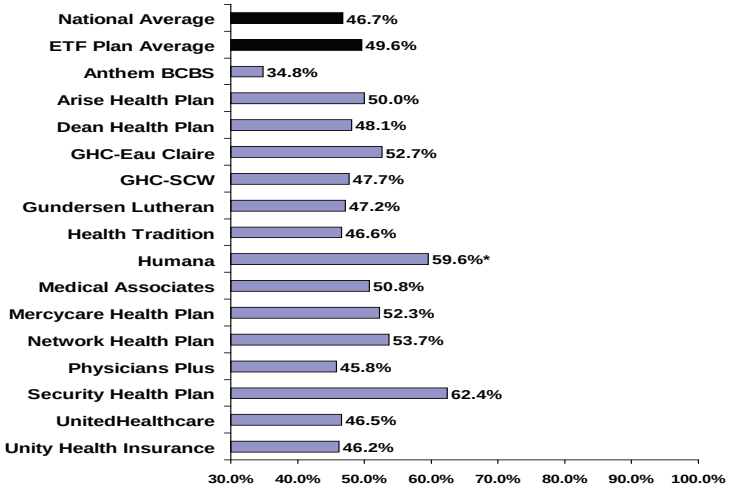
Optimal Practitioner Contacts for Antidepressant Medication Management



Effective Acute Phase Treatment for Antidepressant Medication Management



Effective Continuation Phase Treatment for Antidepressant Medication Management



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Health Care Quality Information
From the Consumer Perspective

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Health Care Quality Information
Based on Health Plan Performance

It's Your Choice 2009

Health Plan Report Card

Supplemental Information

Please refer to **Section E** (health plan report card) in the *It's Your Choice 2009* 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.

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Respondent's Age

Question: "What is your 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."

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.

Health Plan Name	18 to 24 Years	25 to 34 Years	35 to 44 Years	45 to 64 Years	55 to 64 Years	65 to 74 Years	75 Years or older
Average—All Health Plans	1%	13%	16%	26%	27%	10%	7%
Anthem BCBS Northwest	1%	3%	8%	15%	30%	26%	17%
Anthem BCBS Southeast	1%	19%	19%	27%	25%	6%	3%
Arise Health Plan	0%	6%	13%	19%	33%	18%	12%
Dean Health Plan	2%	12%	14%	27%	28%	9%	8%
GHC Eau Claire	2%	11%	18%	29%	31%	7%	2%
GHC-SCW	5%	41%	14%	20%	14%	5%	2%
Gundersen Lutheran	2%	6%	15%	27%	30%	15%	6%
Health Tradition	1%	15%	23%	32%	20%	7%	3%
Humana Eastern	2%	18%	19%	28%	27%	5%	2%
Humana Western	0%	10%	16%	30%	24%	14%	6%
Medical Associates	0%	11%	18%	28%	31%	10%	3%
MercyCare Health Plan	0%	13%	22%	31%	26%	6%	2%
Network Health Plan	1%	8%	22%	32%	29%	8%	2%
Physicians Plus	1%	13%	11%	28%	28%	10%	10%
Security Health Plan	0%	7%	17%	33%	34%	7%	2%
Standard Plan	0%	2%	3%	2%	14%	30%	49%
State Maintenance Plan	0%	3%	17%	30%	43%	7%	0%
UnitedHealthcare NE	0%	9%	18%	28%	31%	11%	3%
UnitedHealthcare SE	2%	21%	17%	24%	32%	2%	1%
Unity Community	2%	13%	18%	33%	24%	6%	4%
Unity UW Health	4%	22%	19%	22%	24%	6%	4%
WPS Metro Choice	3%	10%	18%	29%	37%	2%	1%

Self-Reported Health Status

Question: "In general, how would you rate your overall health now?"
This chart shows:
The percentage of people who responded "poor," "fair," "good," "very good," or "excellent."

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.

Health Plan Name	Poor	Fair	Good	Very Good	Excellent
Average—All Health Plans	**1%**	**7%**	**32%**	**46%**	**15%**
Anthem BCBS Northwest	**2%**	**8%**	**38%**	**44%**	**9%**
Anthem BCBS Southeast	**1%**	**10%**	**33%**	**45%**	**11%**
Arise Health Plan	**1%**	**8%**	**30%**	**47%**	**14%**
Dean Health Plan	**2%**	**8%**	**31%**	**46%**	**13%**
GHC Eau Claire	**1%**	**4%**	**32%**	**48%**	**15%**
GHC-SCW	**1%**	**3%**	**22%**	**50%**	**24%**
Gundersen Lutheran	**0%**	**6%**	**36%**	**45%**	**13%**
Health Tradition	**0%**	**5%**	**36%**	**43%**	**15%**
Humana Eastern	**1%**	**8%**	**33%**	**43%**	**16%**
Humana Western	**0%**	**3%**	**30%**	**49%**	**18%**
Medical Associates	**1%**	**6%**	**34%**	**47%**	**13%**
MercyCare Health Plan	**1%**	**5%**	**31%**	**47%**	**17%**
Network Health Plan	**1%**	**6%**	**38%**	**45%**	**10%**
Physicians Plus	**0%**	**7%**	**32%**	**47%**	**15%**
Security Health Plan	**0%**	**7%**	**30%**	**46%**	**17%**
Standard Plan	**3%**	**14%**	**36%**	**37%**	**11%**
State Maintenance Plan	**3%**	**3%**	**26%**	**48%**	**19%**
UnitedHealthcare NE	**2%**	**5%**	**36%**	**46%**	**12%**
UnitedHealthcare SE	**2%**	**7%**	**31%**	**47%**	**13%**
Unity Community	**1%**	**8%**	**28%**	**50%**	**13%**
Unity UW Health	**1%**	**5%**	**24%**	**46%**	**24%**
WPS Metro Choice	**1%**	**8%**	**32%**	**49%**	**11%**

Respondent's Education Level

Question: "What is the highest grade or level of school that you have completed?"
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," or "4-year college degree," "more than 4-year college degree."

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.

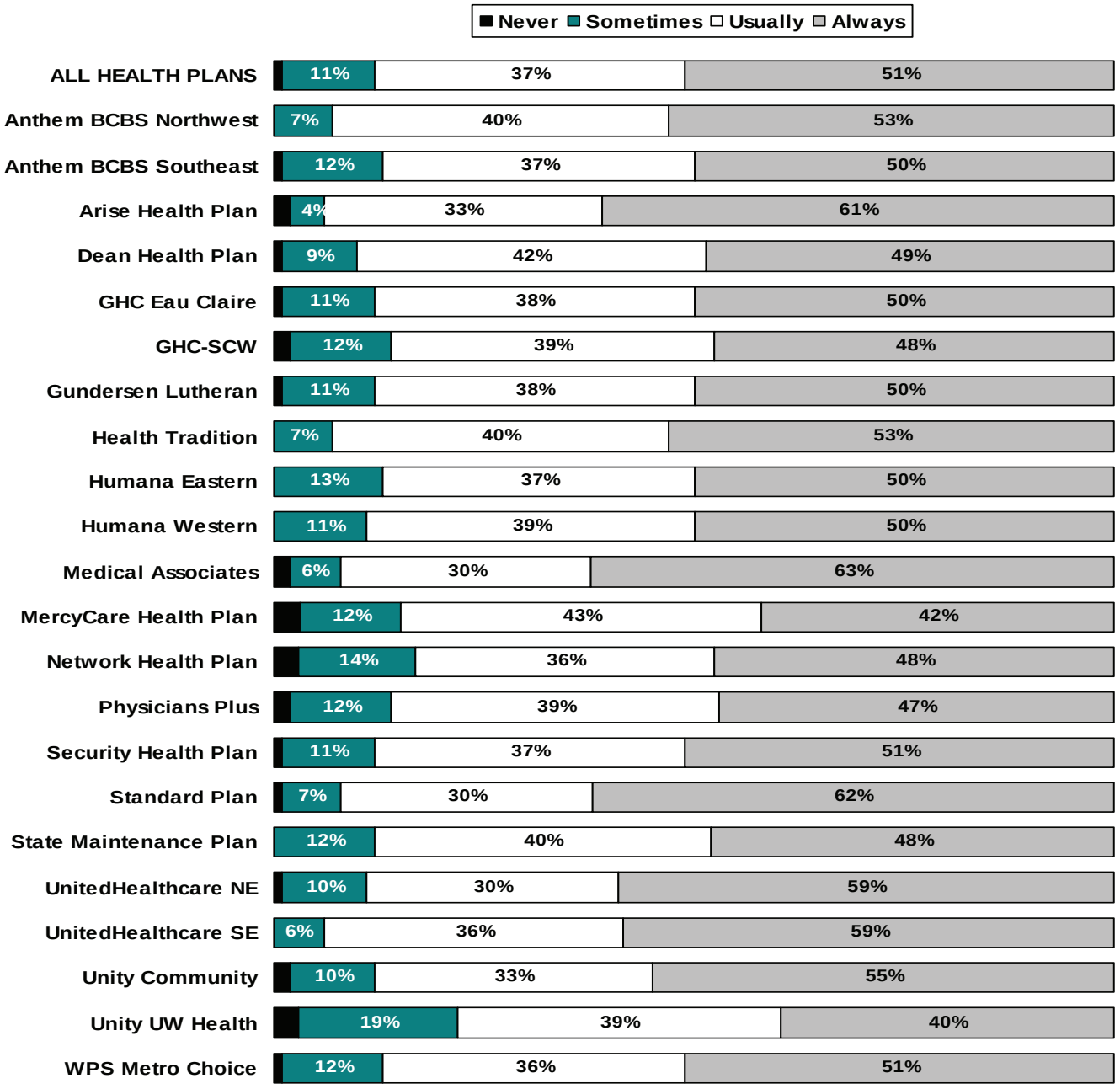
Health Plan Name	8th grade or less	Some high school	High school graduate or GED	Some college or 2-year degree	4-year college graduate	More than 4-year college degree
Average—All Health Plans	**0%**	**1%**	**12%**	**25%**	**22%**	**40%**
Anthem BCBS Northwest	**0%**	**1%**	**22%**	**19%**	**17%**	**42%**
Anthem BCBS Southeast	**0%**	**0%**	**7%**	**26%**	**25%**	**43%**
Arise Health Plan	**0%**	**0%**	**14%**	**23%**	**25%**	**38%**
Dean Health Plan	**1%**	**1%**	**16%**	**31%**	**22%**	**31%**
GHC Eau Claire	**0%**	**1%**	**16%**	**28%**	**23%**	**32%**
GHC-SCW	**0%**	**0%**	**6%**	**11%**	**21%**	**62%**
Gundersen Lutheran	**0%**	**0%**	**15%**	**25%**	**20%**	**40%**
Health Tradition	**0%**	**1%**	**15%**	**32%**	**23%**	**29%**
Humana Eastern	**0%**	**0%**	**9%**	**18%**	**29%**	**45%**
Humana Western	**0%**	**1%**	**9%**	**16%**	**21%**	**53%**
Medical Associates	**1%**	**0%**	**20%**	**26%**	**15%**	**38%**
MercyCare Health Plan	**0%**	**0%**	**9%**	**37%**	**24%**	**30%**
Network Health Plan	**0%**	**1%**	**18%**	**31%**	**21%**	**29%**
Physicians Plus	**0%**	**0%**	**14%**	**24%**	**22%**	**40%**
Security Health Plan	**0%**	**0%**	**10%**	**28%**	**25%**	**37%**
Standard Plan	**1%**	**2%**	**15%**	**14%**	**12%**	**56%**
State Maintenance Plan	**0%**	**0%**	**10%**	**26%**	**32%**	**32%**
UnitedHealthcare NE	**0%**	**1%**	**16%**	**32%**	**21%**	**30%**
UnitedHealthcare SE	**0%**	**0%**	**9%**	**25%**	**26%**	**41%**
Unity Community	**50%**	**50%**	**12%**	**40%**	**21%**	**27%**
Unity UW Health	**0%**	**30%**	**6%**	**19%**	**25%**	**49%**
WPS Metro Choice	**0%**	**0%**	**3%**	**16%**	**21%**	**60%**

Health Care Detail

Getting Care As Soon As You Needed

Question: "In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?"
This chart shows:
The percentage of people who responded "never, " "sometimes," "usually," or "always"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Health Care Detail

Doctor Discussed Pro & Cons of Treatment

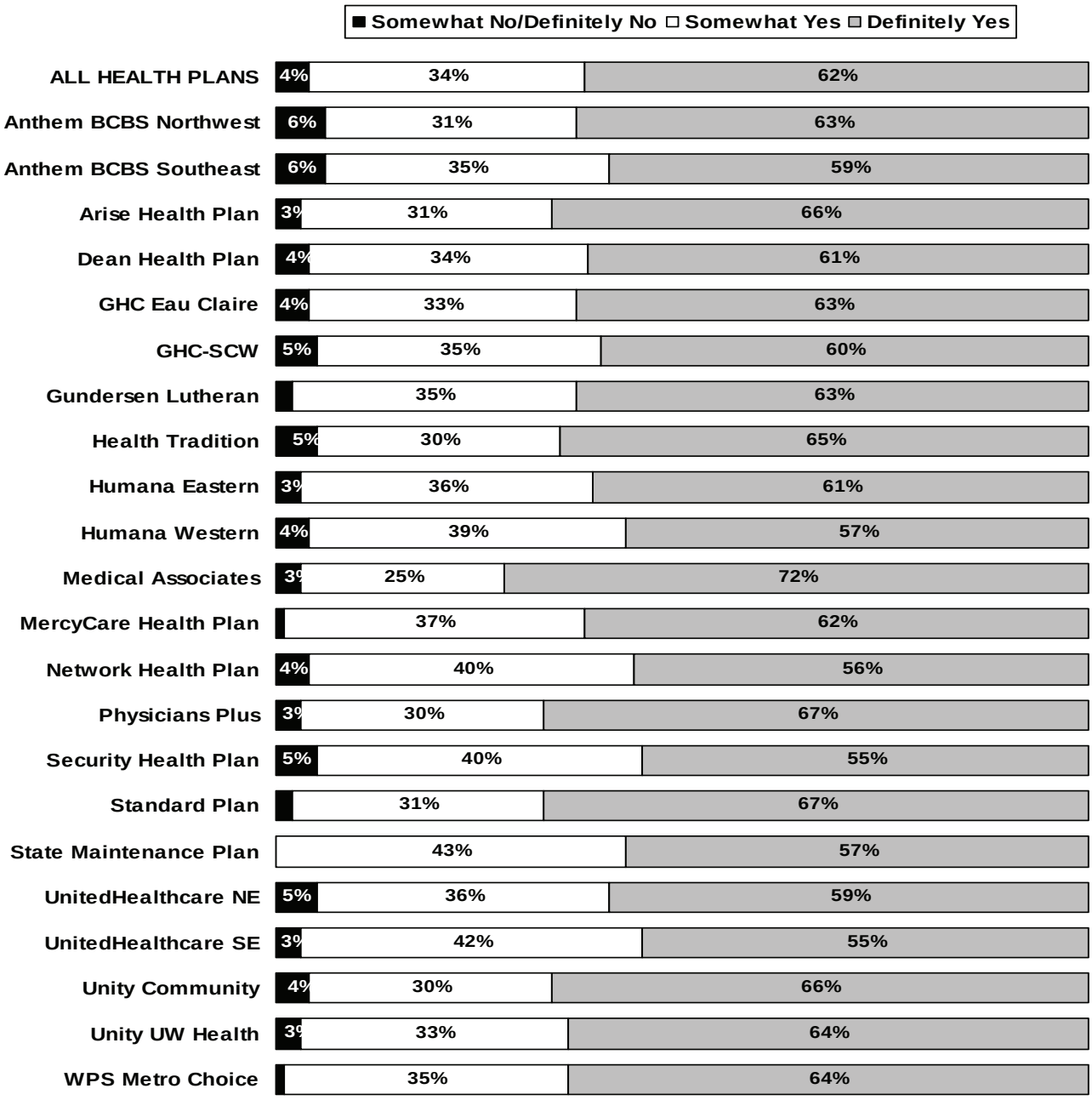
Question: "In the last 12 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?"

This chart shows:

The percentage of people who responded "definitely yes," somewhat yes, " "somewhat no," or "definitely no"

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

WPS Metro Choice was formerly known as WPS Patient Choice.

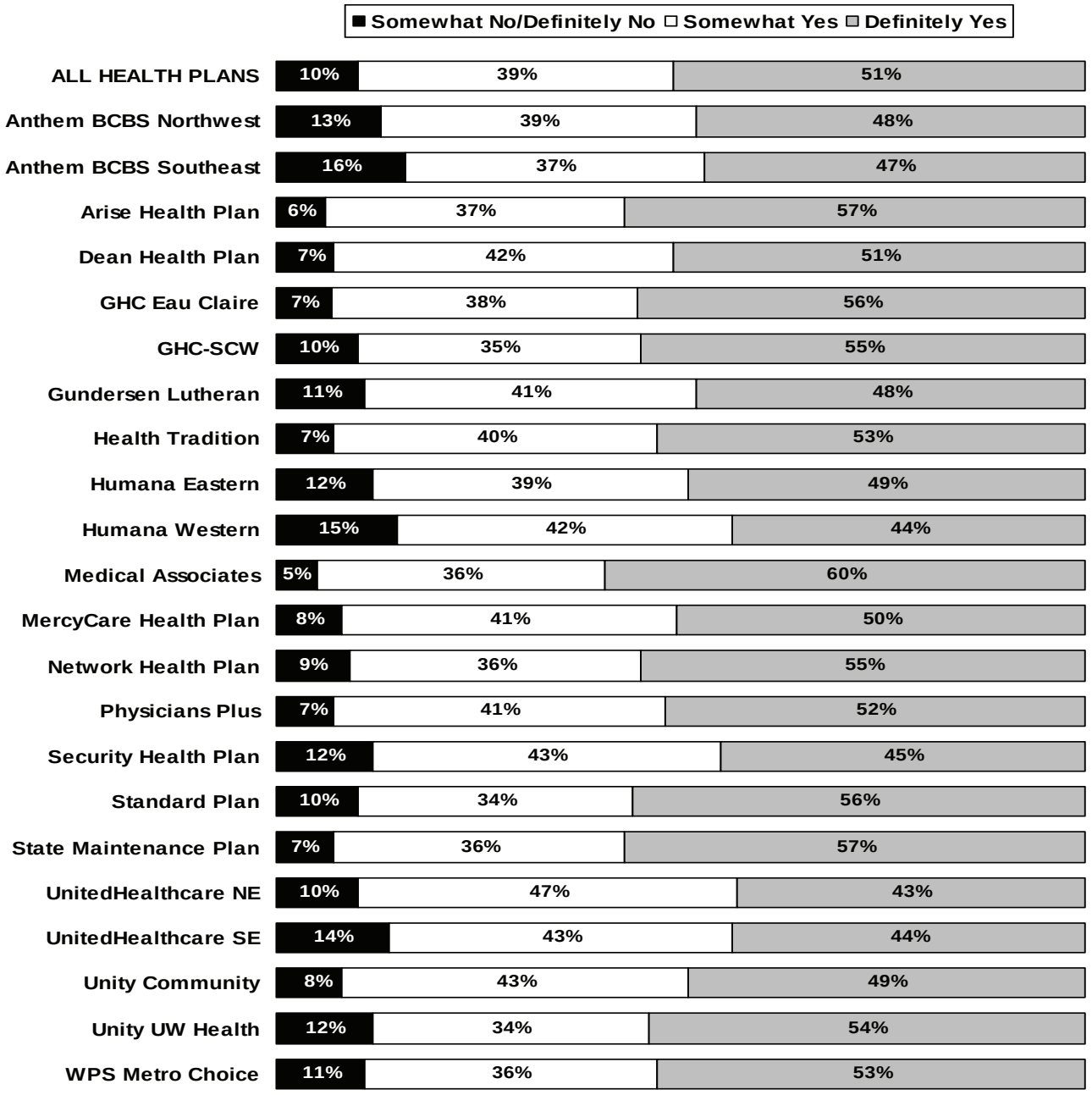


Health Care Detail

Doctor Asked Which Treatment Choice Was Best For You

Question: "In the last 12 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice was best for you?"
This chart shows:
The percentage of people who responded "definitely yes," somewhat yes, " "somewhat no," or "definitely no"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Health Care Detail

Getting the Treatment or Counseling You Needed

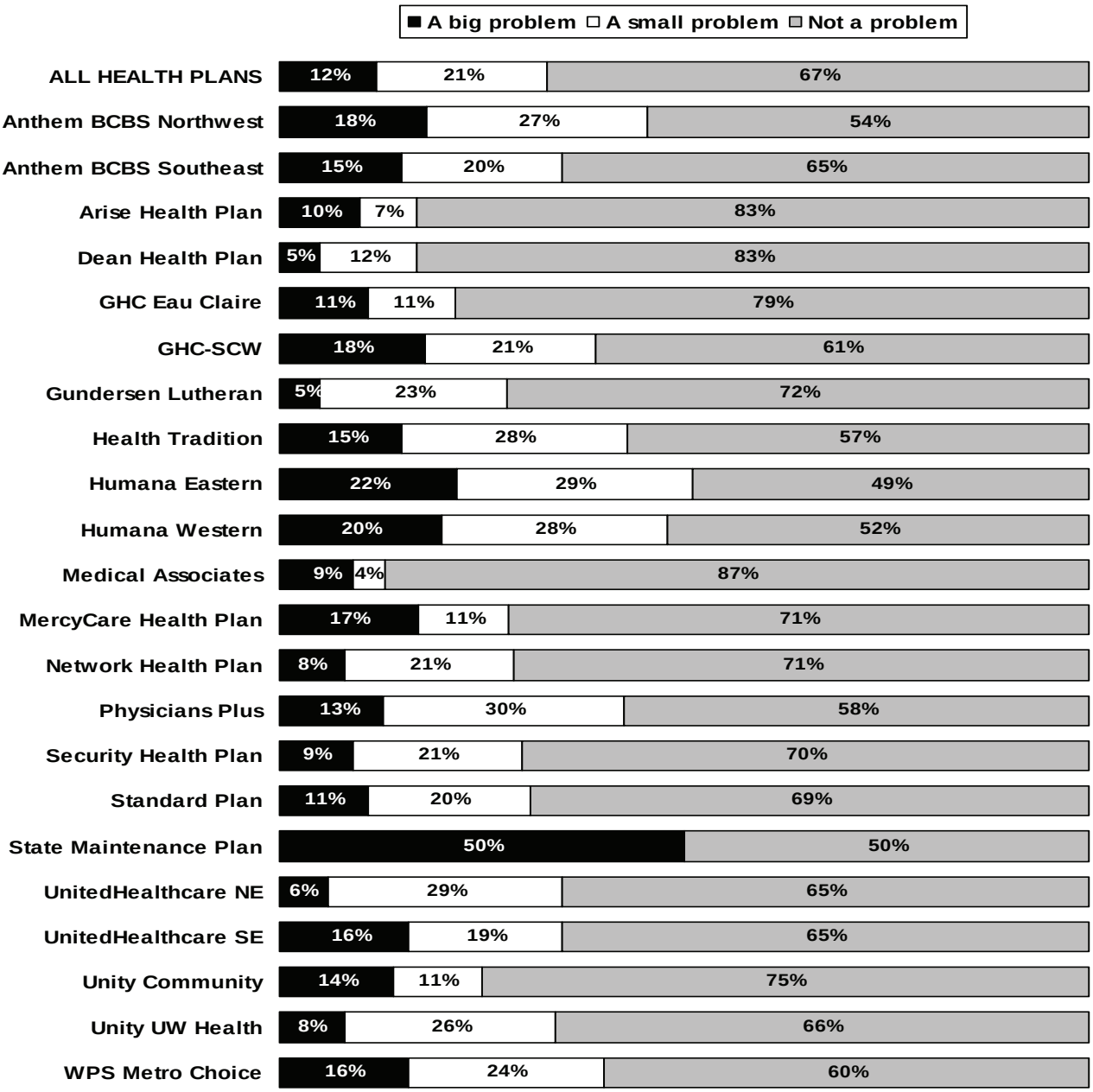
Question: "In the last 12 months, how much of a problem, if any, was it to get the treatment or counseling you needed through your health plan?"

This chart shows:

The percentage of people who responded "a big problem," a small problem, " or "not a problem"

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

WPS Metro Choice was formerly known as WPS Patient Choice.



Health Care Detail

Recieved Care and/or Medical Tests in a Timely Manner

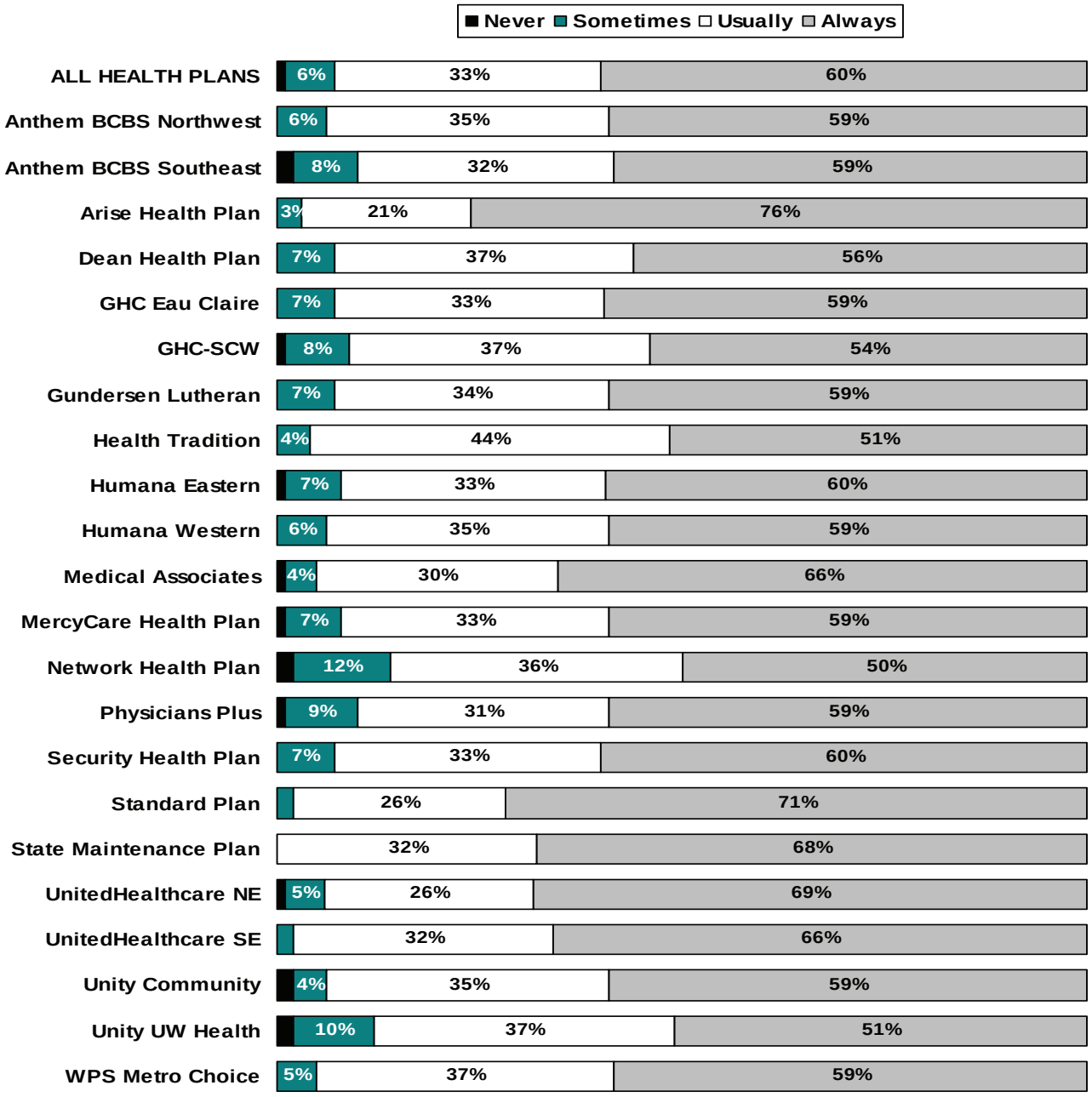
Question: "In the last 12 months, when you visited your doctor's office or clinic, how often were you able to see your provider and receive care and/or medical tests in a timely manner?"

This chart shows:

The percentage of people who responded "never," "sometimes," " usually," or "always"

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

WPS Metro Choice was formerly known as WPS Patient Choice.



Health Care Detail

Doctor's Explanation Was Easy to Understand

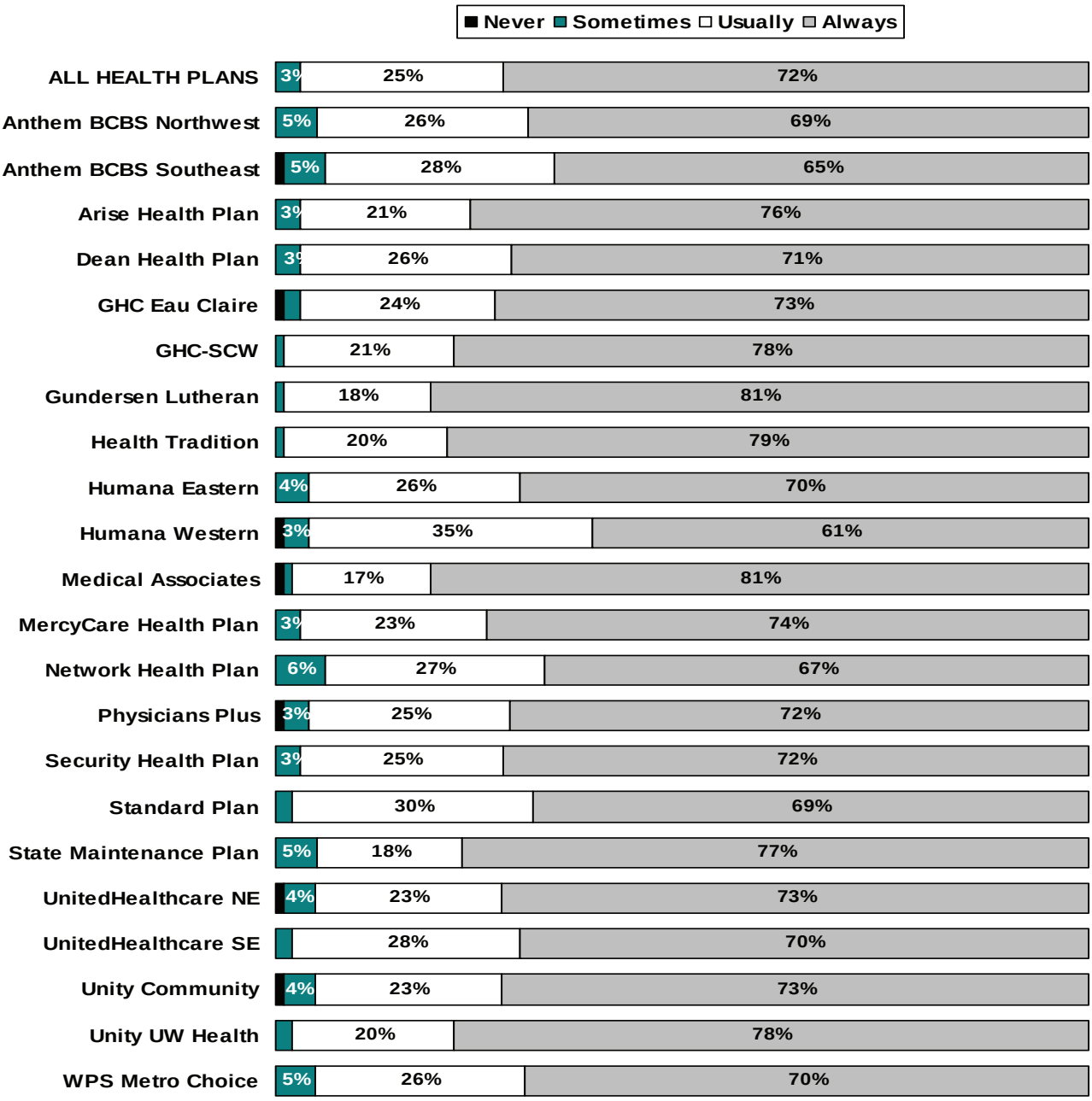
Question: "In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?"

This chart shows:

The percentage of people who responded "never," "sometimes," " usually," or "always"

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

WPS Metro Choice was formerly known as WPS Patient Choice.

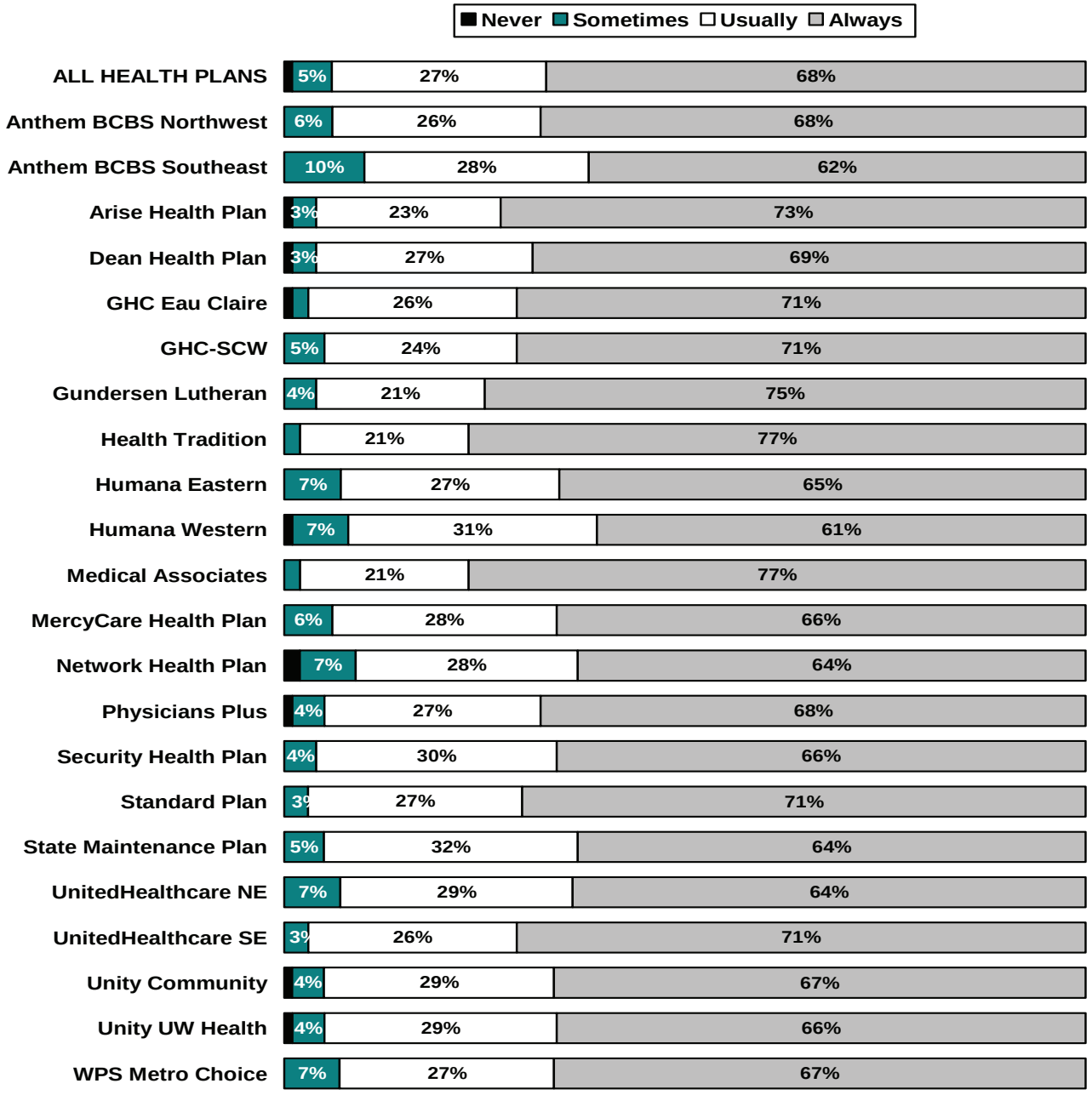


Health Care Detail

Doctor Listened Carefully to You

Question: "In the last 12 months, how often did your personal doctor listen carefully to you?"
This chart shows:
The percentage of people who responded "never," "sometimes," " usually," or "always"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Health Care Detail

Doctor Showed Respect for What You Had to Say

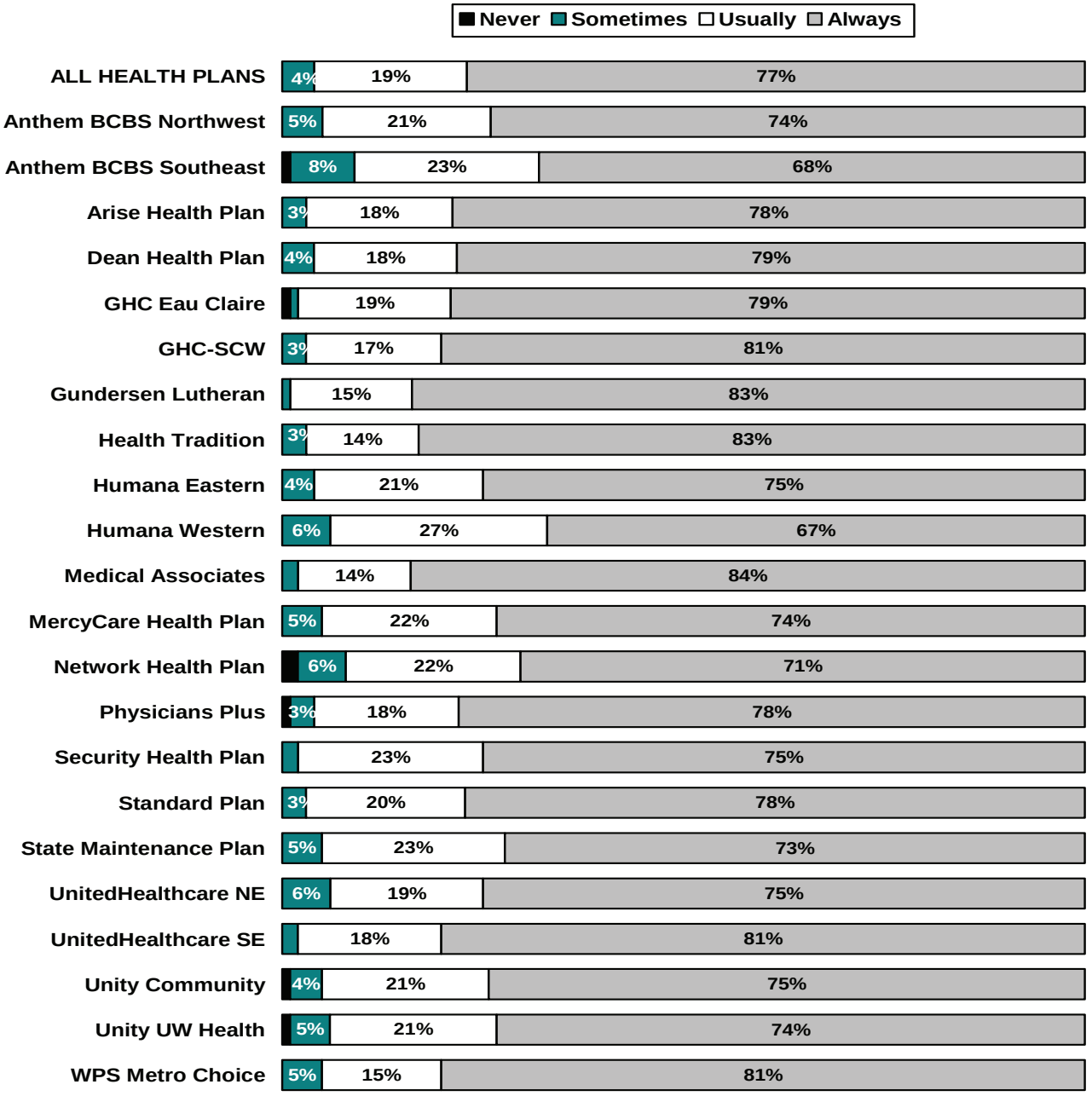
Question: "In the last 12 months, how often did your personal doctor show respect for what you had to say?"

This chart shows:

The percentage of people who responded "never," "sometimes," " usually," or "always"

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

WPS Metro Choice was formerly known as WPS Patient Choice.

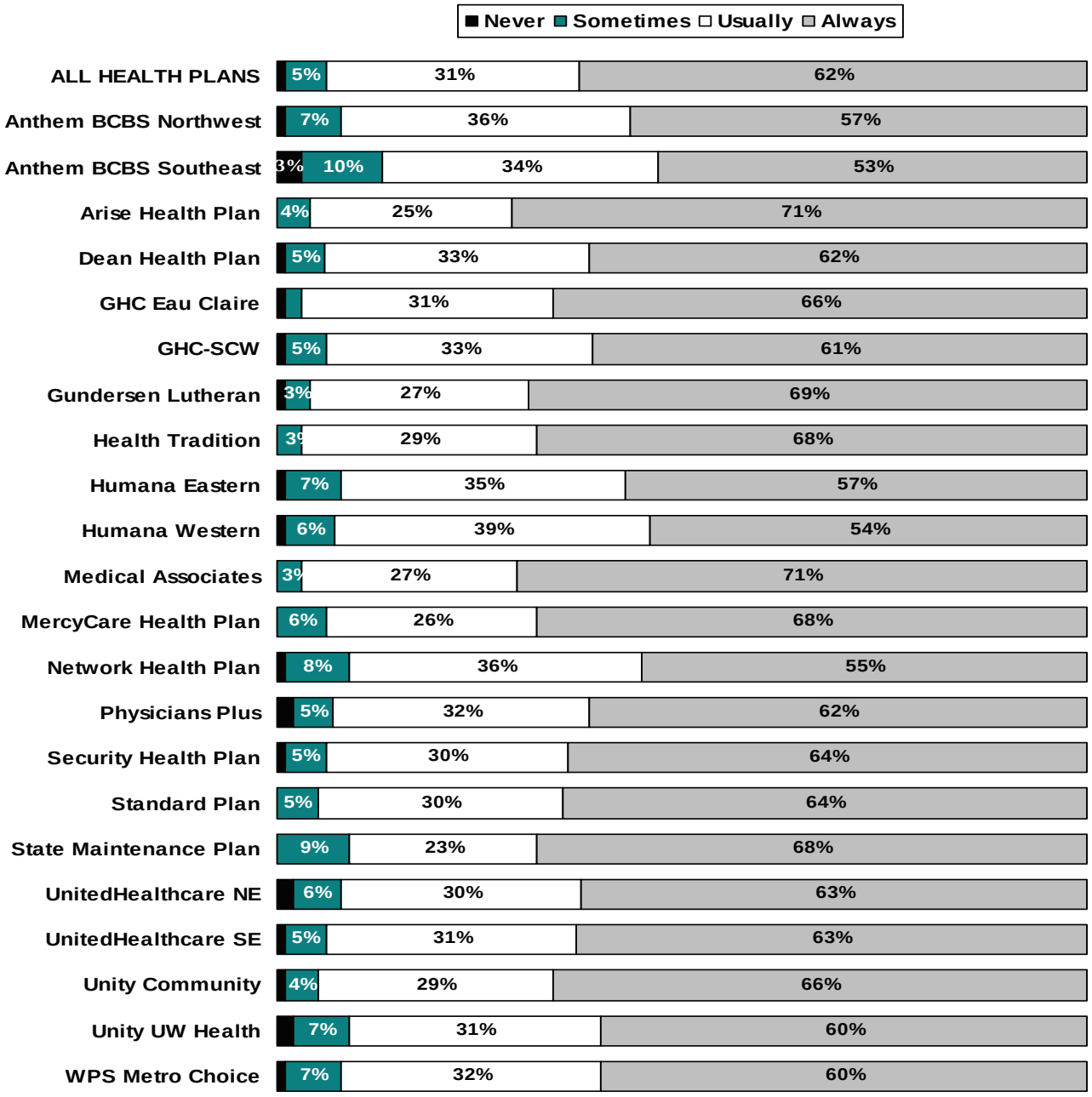


Health Care Detail

Doctor Spent Enough Time With You

Question: "In the last 12 months, how often did your personal doctor spend enough time with you?"
This chart shows:
The percentage of people who responded "never," "sometimes," " usually," or "always"

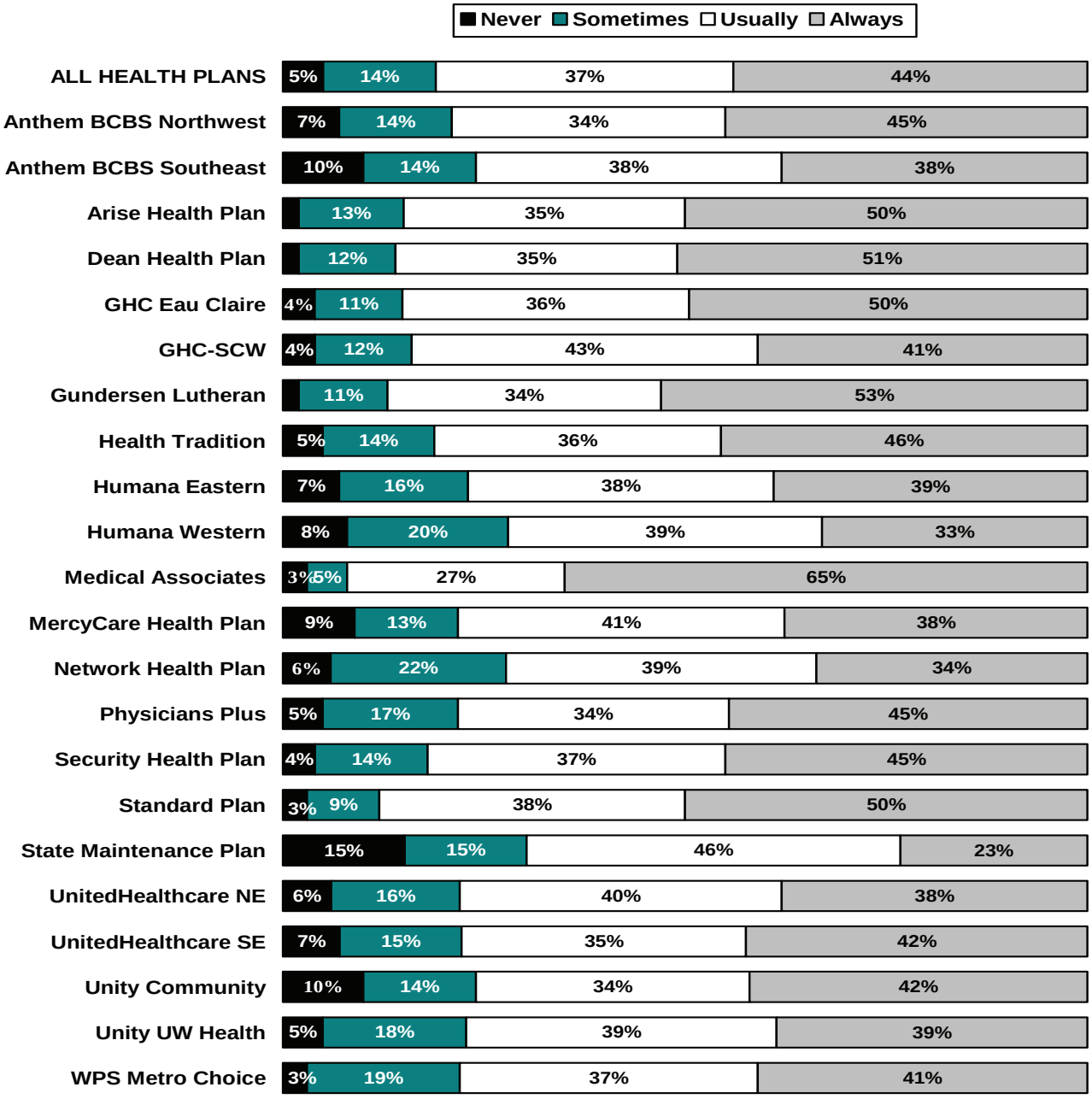
Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Doctor Seemed Informed and Up-to-Date About Your Care

Question: "In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?"
This chart shows:
The percentage of people who responded "never," "sometimes," " usually," or "always"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Health Care Details

Doctor/Nurse Asked You About Your Dietary Habits

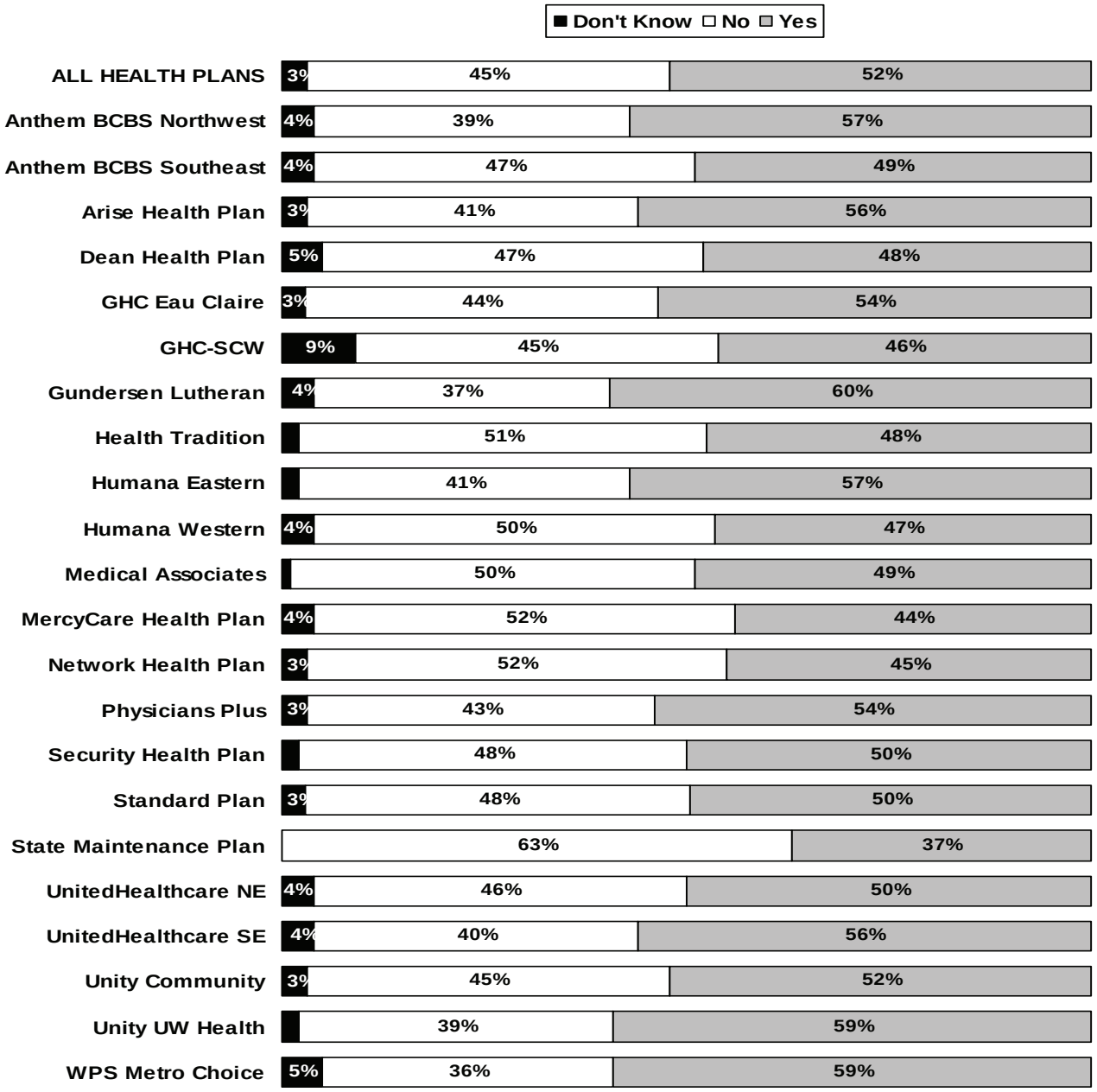
Question: "In the last 12 months, did a doctor, nurse, or other health care professional ask you about your dietary habits?"

This chart shows:

The percentage of people who responded "don't know," "no," or "yes"

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

WPS Metro Choice was formerly known as WPS Patient Choice.



Doctor/Nurse Asked You About Your Exercise Habits

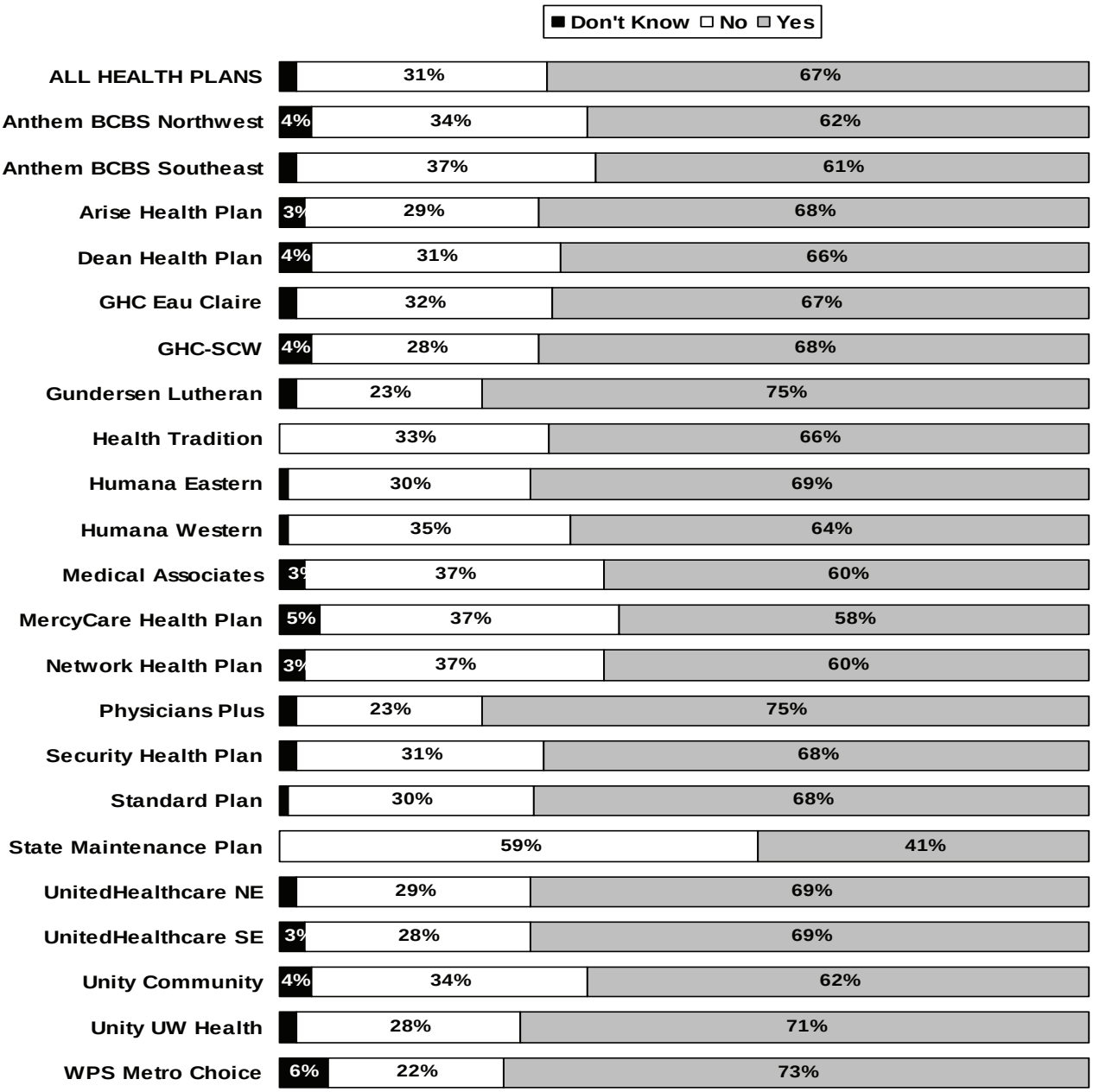
Question: "In the last 12 months, did a doctor, nurse, or other health care professional ask you about your exercise habits?"

This chart shows:

The percentage of people who responded "don't know," "no," or "yes"

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

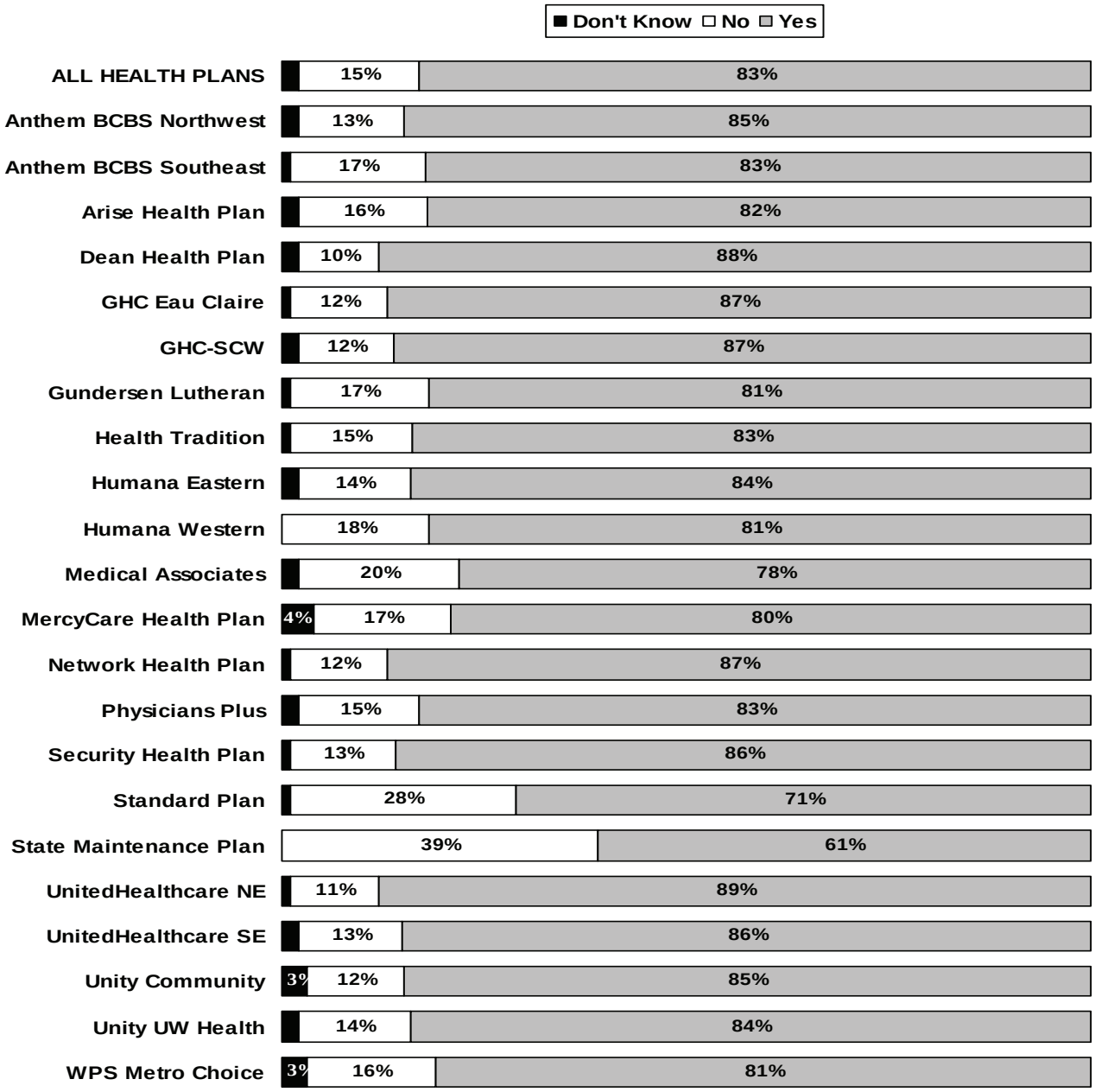
WPS Metro Choice was formerly known as WPS Patient Choice.



Doctor/Nurse Asked Whether or Not You Smoke Tobacco

Question: "In the last 12 months, did a doctor, nurse, or other health care professional ask whether or not you smoke or use tobacco in any form?"
This chart shows:
The percentage of people who responded "don't know," "no," or "yes"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Received Unsafe Health Care

Question: "In the last 12 months, do you feel you have received unsafe health care in…?"
This chart shows:
The percentage of people who responded "clinic, " "hospital," "urgent care" "surgicenter," or "I do not feel that I received unsafe health care."

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

WPS Metro Choice was formerly known as WPS Patient Choice.

Health Plan Name	Clinic	Hospital	Urgent Care	Surgicenter	Did not receive unsafe health care
Average—All Health Plans	**2.4%**	**1.6%**	**1.1%**	**0.3%**	**95.4%**
Anthem BCBS Northwest	**3.0%**	**0.8%**	**0.8%**	**0.0%**	**95.5%**
Anthem BCBS Southeast	**4.8%**	**4.5%**	**1.3%**	**0.3%**	**90.4%**
Arise Health Plan	**1.0%**	**1.0%**	**0.7%**	**0.7%**	**97.0%**
Dean Health Plan	**2.3%**	**1.3%**	**1.3%**	**0.3%**	**95.6%**
GHC Eau Claire	**2.8%**	**1.4%**	**0.6%**	**0.0%**	**95.5%**
GHC-SCW	**1.1%**	**0.6%**	**1.7%**	**0.0%**	**96.9%**
Gundersen Lutheran	**1.3%**	**1.3%**	**1.0%**	**1.3%**	**96.1%**
Health Tradition	**1.4%**	**1.4%**	**0.7%**	**0.0%**	**96.9%**
Humana Eastern	**2.5%**	**2.8%**	**1.4%**	**0.3%**	**95.0%**
Humana Western	**3.6%**	**2.2%**	**1.4%**	**0.0%**	**93.9%**
Medical Associates	**1.8%**	**0.6%**	**0.0%**	**0.0%**	**98.2%**
MercyCare Health Plan	**1.9%**	**3.3%**	**0.9%**	**0.5%**	**94.3%**
Network Health Plan	**5.2%**	**1.2%**	**1.4%**	**0.3%**	**92.5%**
Physicians Plus	**1.6%**	**1.6%**	**1.3%**	**0.3%**	**95.7%**
Security Health Plan	**2.0%**	**0.3%**	**2.0%**	**0.0%**	**96.0%**
Standard Plan	**2.2%**	**1.6%**	**0.5%**	**0.8%**	**95.4%**
State Maintenance Plan	**0.0%**	**3.3%**	**0.0%**	**0.0%**	**96.7%**
UnitedHealthcare NE	**3.4%**	**1.4%**	**1.1%**	**0.6%**	**94.8%**
UnitedHealthcare SE	**0.5%**	**0.0%**	**0.5%**	**0.0%**	**99.0%**
Unity Community	**1.4%**	**1.4%**	**1.4%**	**0.0%**	**95.7%**
Unity UW Health	**2.5%**	**1.1%**	**0.3%**	**0.0%**	**96.2%**
WPS Metro Choice	**2.2%**	**4.4%**	**1.5%**	**0.0%**	**92.6%**

Health Plan Detail

Tried Getting Care, Tests, or Treatment Through Your Health Plan

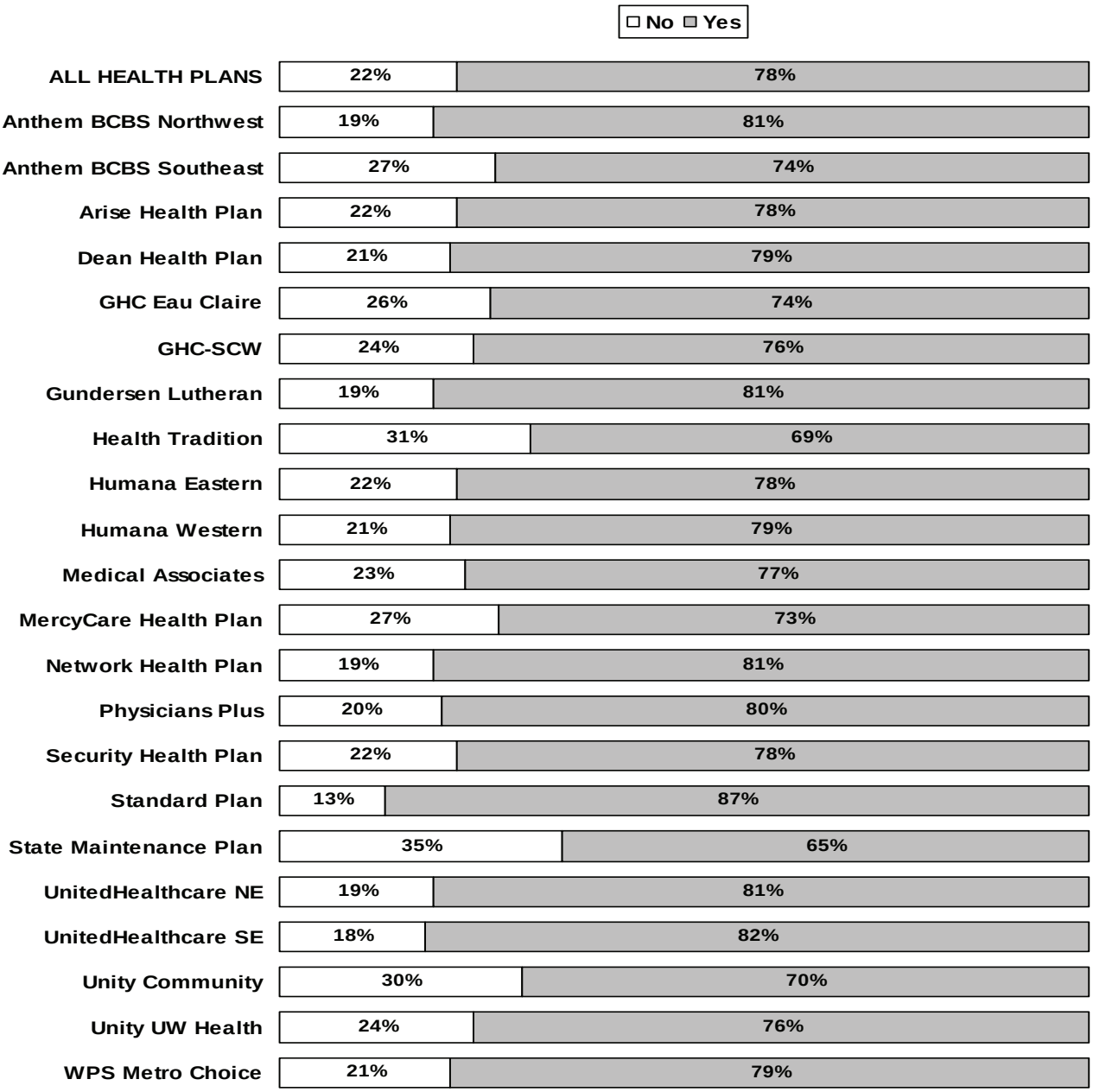
Question: "In the last 12 months, did you try to get any kind of care, tests, or treatment through your health plan?"

This chart shows:

The percentage of people who responded "no," or "yes"

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

WPS Metro Choice was formerly known as WPS Patient Choice.

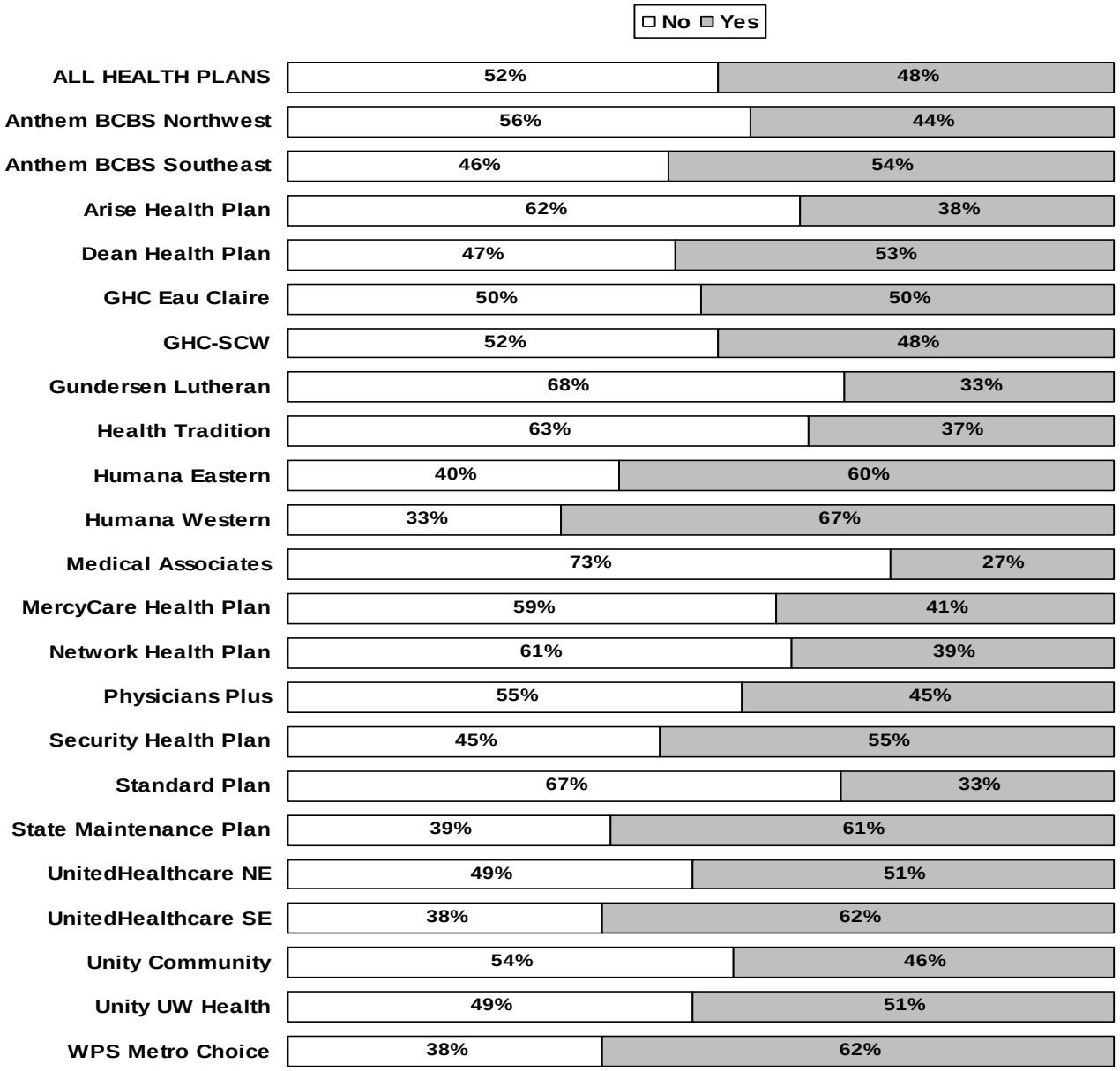


Health Plan Detail

Looked For Information in Written Materials/Internet About Plan

Question: "In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?"
This chart shows:
The percentage of people who responded "no," or "yes"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.

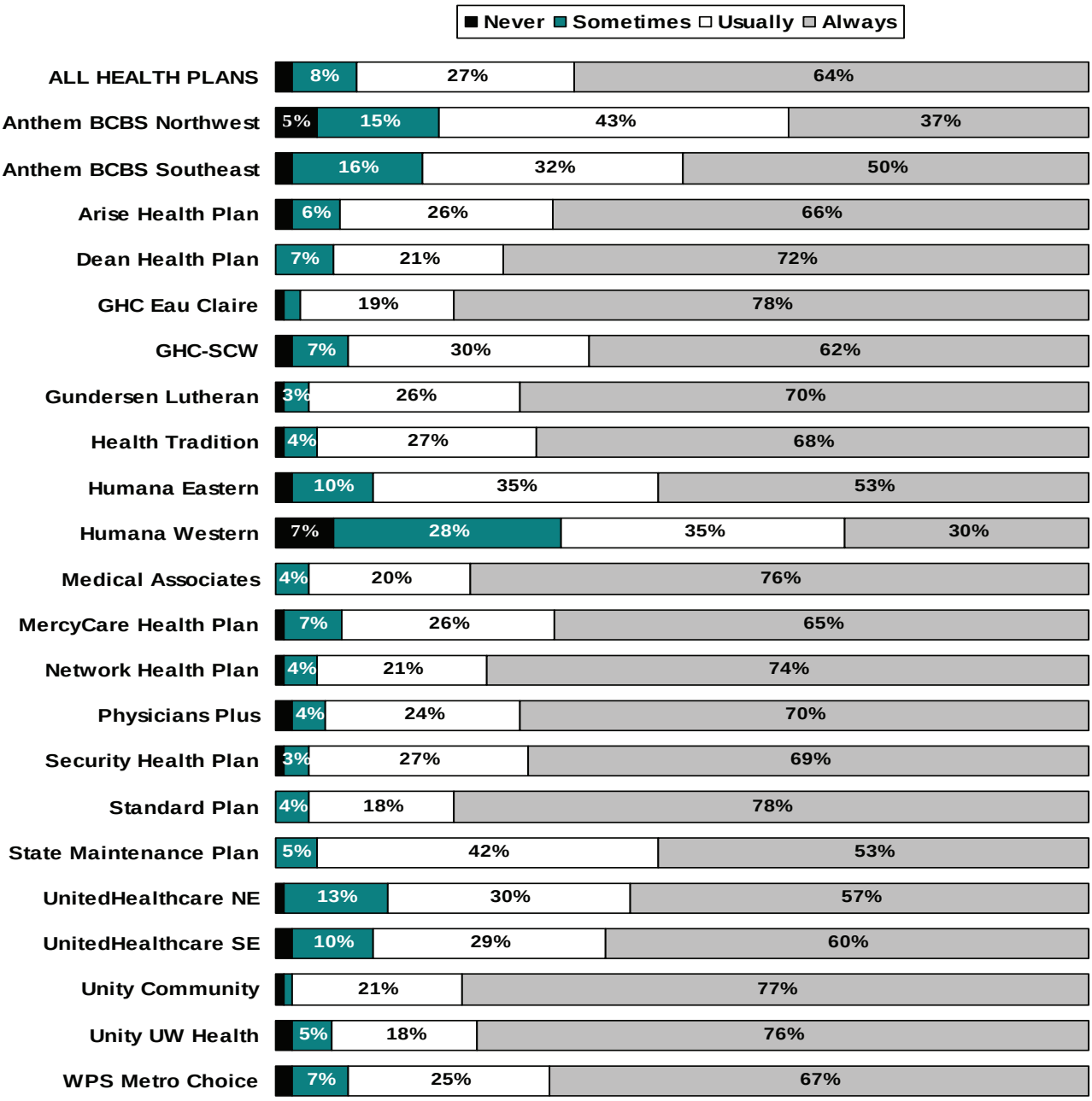


Health Plan Detail

Plan's Customer Service Treated You With Courtesy & Respect

Question: "In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?"
This chart shows:
The percentage of people who responded "never," "sometimes," "usually," or "always"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



Customer Service Representative Was Helpful

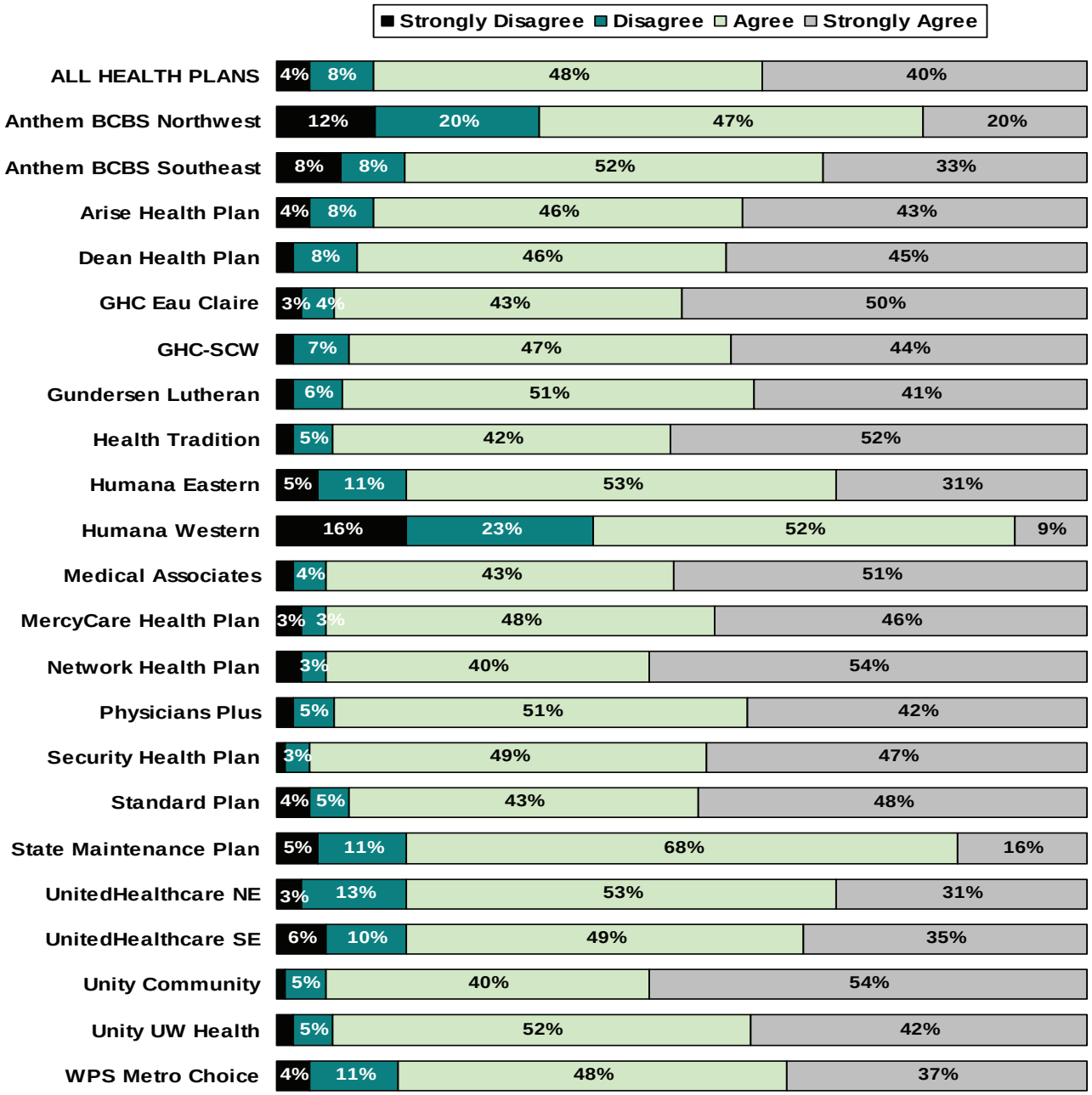
Question: "Please state your level of agreement with the following statements about your most recent experience with a customer service representative: The customer service representative was helpful in answering my questions."

This chart shows:

The percentage of people who responded "strongly disagree," "disagree," "agree," or "strongly agree"

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

WPS Metro Choice was formerly known as WPS Patient Choice.



Health Plan Detail

Customer Service Representative Resolved My Issues In a Timely Manner

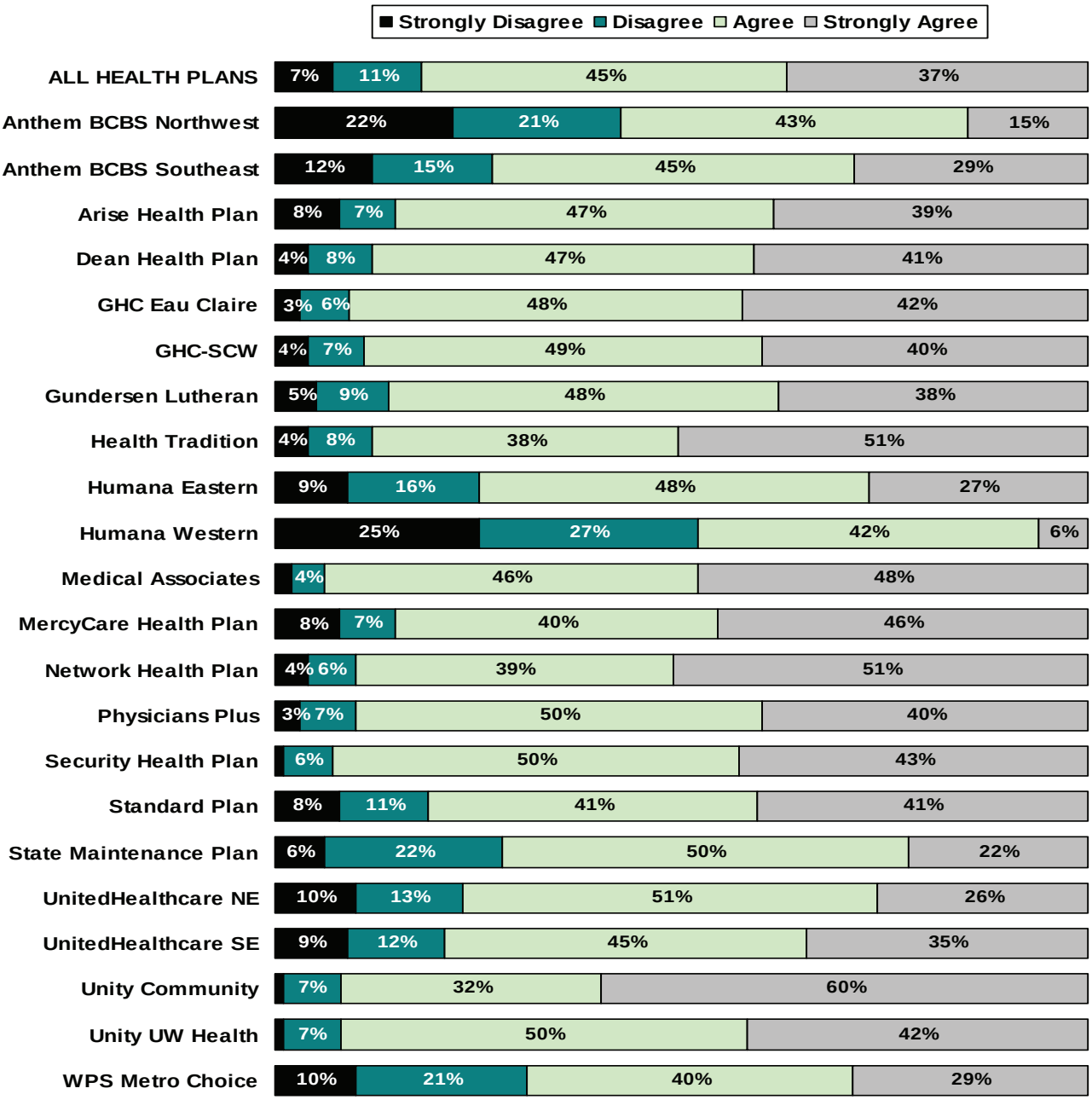
Question: "Please state your level of agreement with the following statements about your most recent experience with a customer service representative: The customer service representative resolved my issue in a timely manner."

This chart shows:

The percentage of people who responded "strongly disagree," "disagree," "agree," or "strongly agree"

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

WPS Metro Choice was formerly known as WPS Patient Choice.

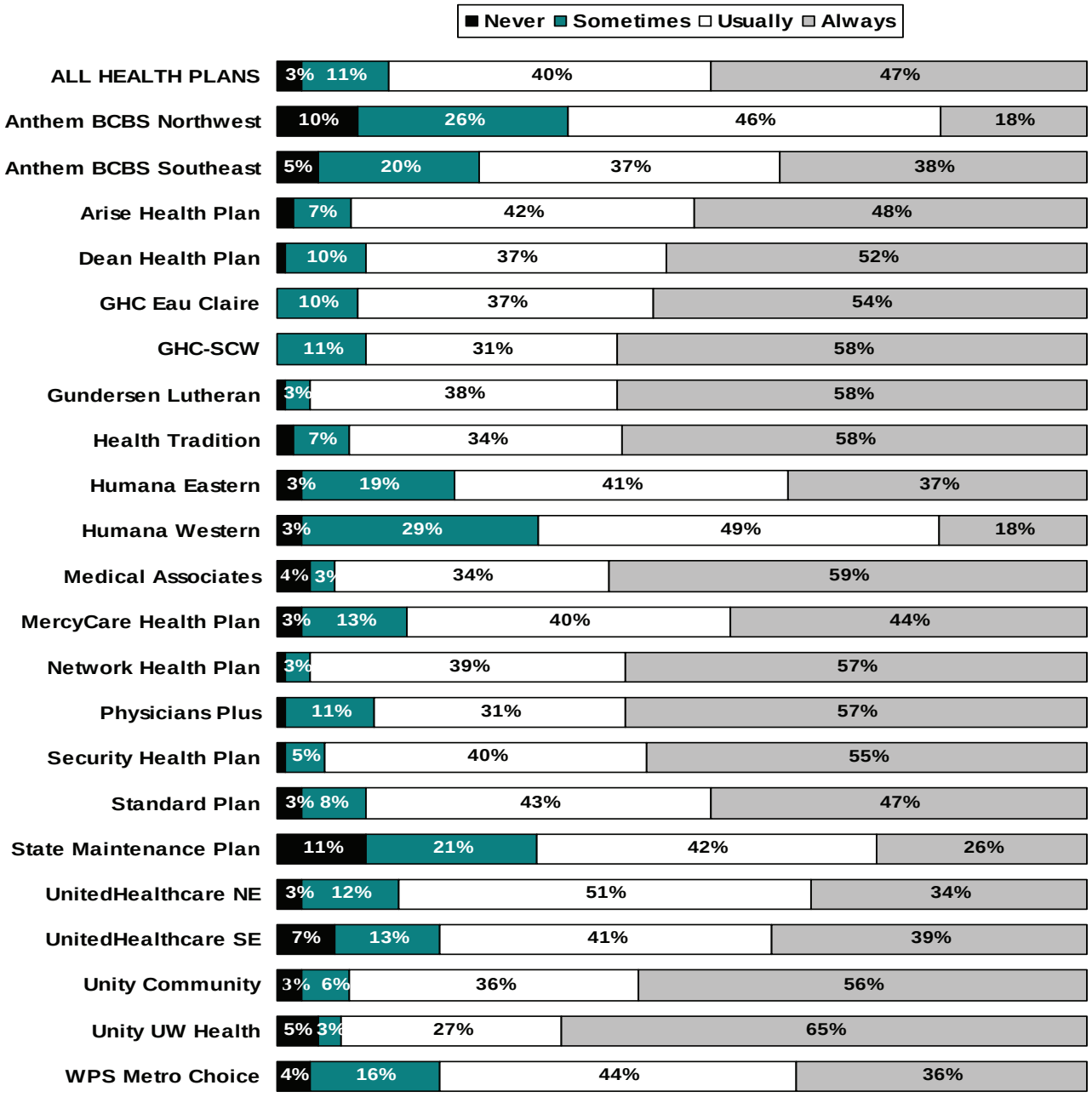


Health Plan Detail

Health Plan Handled Your Claims Quickly

Question: "In the last 12 months, how often did your health plan handle your claims quickly?"
This chart shows:
The percentage of people who responded "never," "sometimes," "usually," or "always"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.

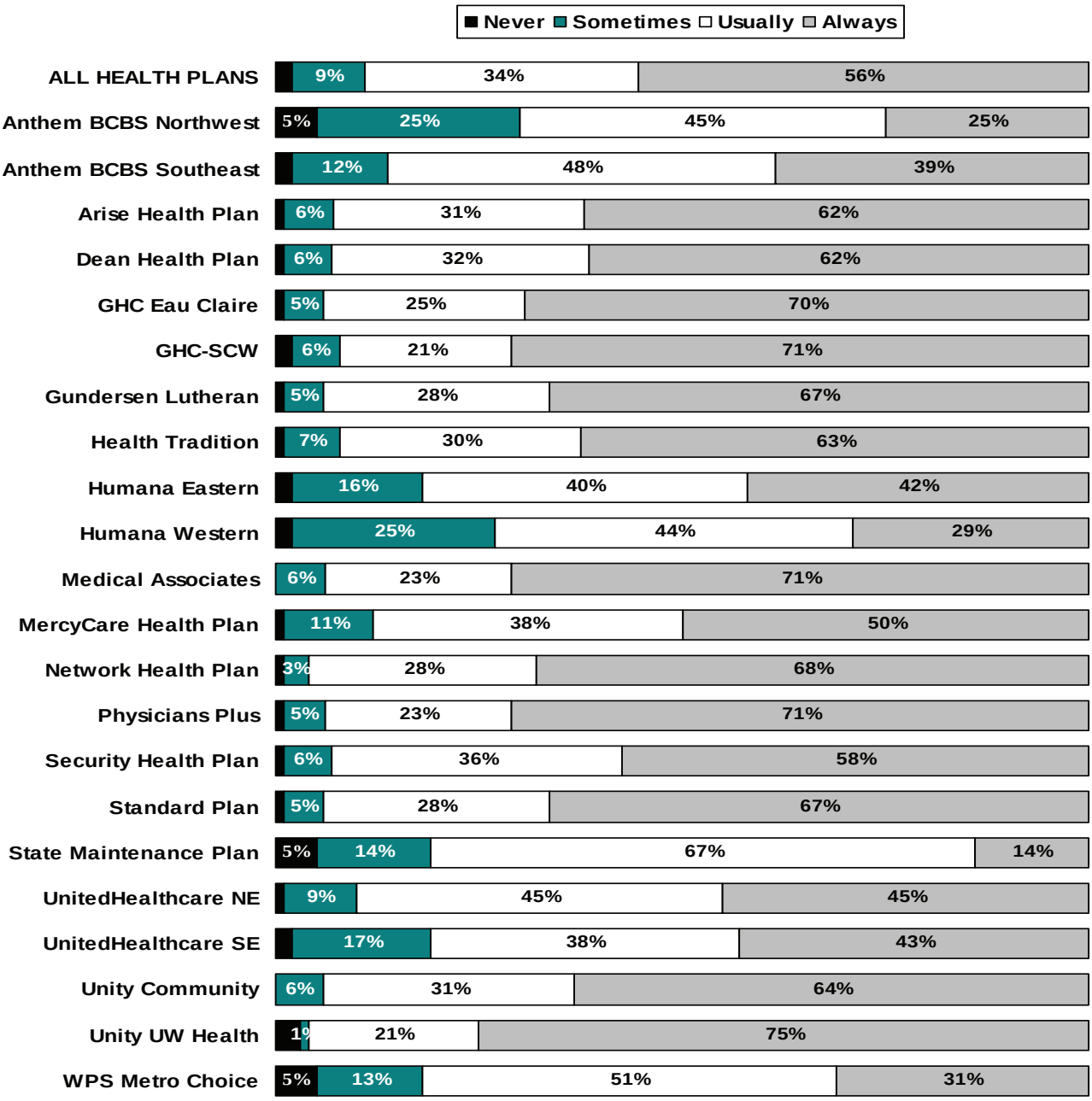


Health Plan Detail

Health Plan Handled Your Claims Correctly

Question: "In the last 12 months, how often did your health plan handle your claims correctly?"
This chart shows:
The percentage of people who responded "never," "sometimes," "usually," or "always"

Due to rounding, total percentages may not add up to exactly 100 percent.
WPS Metro Choice was formerly known as WPS Patient Choice.



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 benef t programs offered, such as the the Group Life Insurance program.

WHO TO CONTACT REGARDING HEALTH INSURANCE

If you need additional information regarding:

Benefits Exclusions Limitations Participating Providers	Contact the health 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	Contact: Employee Trust Funds (ETF) 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, submitted on ETF 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 and annuitants. This provides general information regarding these programs and directs you to the appropriate source to obtain additional information.

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 at 1-608-266-3285 (Madison) or toll free 1-877-533-5020.

Medicare

For information about Medicare benefits and how to enroll contact your local **Social Security Administration** office or call **1-800-772-1213**. In addition, **The State Health Insurance Assistance Program (SHIP)** has counselors in every State and several Territories that are available to provide free one-on-one help with your Medicare questions or problems. A list of SHIP counselor who are in your area can be found at **http://www.medicare.gov/contacts/static/allStateContacts.asp**. The Wisconsin SHIP contact can be reached at either 1-800-242-1060 or 1-866-456-8211.

You and your dependents that are eligible for Medicare must enroll for the Part A (hospital) portion and Part B (medical) portion of Medicare at the time of your retirement. Enrollment in the Part D (prescription drug) portion is voluntary. Upon enrollment in Medicare Parts A and B by either you and/or one of your dependents, coverage will be integrated with Medicare and the monthly premium will be reduced.

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 this book (Section C).

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)
    - 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 2008

Representatives from the area health plans will be available during the 2008 Dual-Choice Enrollment Period at the following locations to answer your questions. At other times of the year, contact the plans directly for information.

[W] Wisconsin Retirement System representatives from ETF anticipate being available
[H] Health Insurance representatives from ETF anticipate being available.
[P] The Pharmacy Benefit Manager (PBM) representatives anticipate being available.

City	Date	Time	Location
Eau Claire	October 8 Wednesday	9:00 a.m. – 12:00 p.m.	Dept. of Transportation 718 W. Clairemont Ave. Chippewa Valley Conference Room
Eau Claire	October 14 Tuesday	10:00 a.m. – 1:00 p.m.	UW-Eau Claire 105 Garfield Tamarack Room, Davies Center
Green Bay[W]	October 7 Tuesday	12:00 p.m.. – 4:00 p.m.	UW–Green Bay 2420 Nicolet Dr. Phoenix Rooms A & B, University Union
Green Bay	October 15 Wednesday	8:00 a.m. – 12:00 p.m.	Dept. of Transportation 944 Vanderperren Way Lake Michigan/Green Bay Conference Rooms
Kenosha[W]	October 15 Wednesday	10:00 a.m. – 2:00 p.m.	UW – Parkside 900 Wood Rd. Wyllie Hall, Upper Main Place
King[H,P]	October 13 Monday	10:00 a.m. – 2:00 p.m.	WI Veterans Home N2665 Cty QQ Marden Memorial Ctr. Multi Purpose Room
La Crosse[W]	October 16 Thursday	10:00 a.m. – 4:00 p.m.	UW-La Crosse 1725 State St. Cartwright Center
Madison	October 6 Monday	10:00 a.m. – 1:00 p.m.	Dept of Corrections 3099 E. Washington Ave.. Central Office – Kansas Room
Madison[W,H,P]	October 7 Tuesday	9:00 a.m. – 3:00 p.m.	UW-Madison 800 Langdon St. Great Hall, Memorial Union
Madison	October 8 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 8 Wednesday	11:00 a.m. – 1:00 p.m.	DATCP 2811 Agriculture Dr. Lobby of the Prairie Oaks Bldg. Rm. 172
Madison	October 16 Thursday	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[W]	October 21 Tuesday	9:00 a.m. – 1:00 p.m.	Dept. of Transportation Hill Farms State Office Bldg 4802 Sheboygan Ave. Room 421

City	Date	Time	Location
Menomonie[W]	October 15 Wednesday	10:00 a.m. – 2:00 p.m.	UW-Stout 302 10th Ave. E. Ballroom BC, Memorial Student Center
Milwaukee[W]	October 8 Wednesday	10:00 a.m. – 3:30 p.m.	UW-Milwaukee 2200 E. Kenwood Blvd. Wisconsin Room, Student Union
Milwaukee[W]	October 14 Tuesday	10:00 a.m. – 1:00 p.m.	Dept. of Administration Milwaukee State Office Bldg. 819 N. 6th Street Room 40
Milwaukee	October 15 Wednesday	10:00 a.m. – 1:00 p.m.	Dept. of Natural Resources 2300 North Martin Luther King Jr Dr. Room 140 & 141
Oshkosh[W,P]	October 15 Wednesday	1:00 p.m. – 3:30 p.m.	UW – Oshkosh 748 Algoma Blvd. Reeve Memorial Union Ballroom, 227 AB
Platteville[W]	October 14 Tuesday	12:00 p.m. – 4:00 p.m.	UW-Platteville Corner of Hickory & Main Velzy Commons, Ullsvik Hall
Rhinelander	October 9 Thursday	9:00 a.m. – 1:00 p.m.	Dept. of Transportation 510 N. Hanson Lake Rd. Oneida Room
River Falls[W]	October 13 Monday	10:00 a.m. – 2:00 p.m.	UW-River Falls University Center St. Croix River Room 321
Stevens Point[W]	October 15 Wednesday	9:00 a.m. – 4:00 p.m.	UW-Stevens Point 1015 Reserve St. Alumni Room, Dreyfus University Center
Superior	October 9 Thursday	9:00 a.m. – 12:00 p.m.	Dept. of Transportation 1701 N. 4th Street Lake Superior Conference Room
Superior	October 9 Thursday	1:00 p.m. – 3:00 p.m.	UW-Superior 1605 Catlin Ave. Room 111, Rothwell Student Center
Waukesha	October 8 Wednesday	8:00 a.m. – 12:00 p.m.	Dept. of Transportation 141 NW Barstow St. Room 1512
Waukesha	October 16 Thursday	10:00 a.m. – 3:00 p.m.	UW – Waukesha 1500 N University Dr. Student Lounge
Whitewater[W]	October 9 Thursday	10:00 a.m. – 2:00 p.m.	UW-Whitewater 800 W. Main. Hamilton Center
Wisconsin Rapids	October 7 Tuesday	9:00 a.m. – 1:00 p.m.	Dept. of Transportation 1681 2nd 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.

Plan Descriptions:
Plans With Uniform Benef ts

This section includes health plan and provider comparison charts and information from each 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.

2009 Health Plan Features Comparison

This comparison provides a brief summary of the different features for each health plan available January 1, 2009.

	Anthem Northeast	Anthem Northwest	Anthem Southeast	Arise Health Plan	Dean Health Plan	GHC Eau Claire	GHC-SCW	Gundersen Lutheran	Health Tradition	Humana Eastern	Humana Western
Tier for 2009	1	2	1	1	1	1	1	1	1	1	1
Demographic Information* (Refer to Question 30 in Section C for more information on the Type of Plan)											
Type of Plan	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Total # of Primary Care Physicians	285	1140	2693	505	624	543	68	512	342	4370	382
Total # of Urgent Care Facilities	3	12	26	26	33	20	3	13	18	55	0
Total # of Hospitals	14	23	36	17	26	39	4	20	21	69	17
Quality Scores [1 Star is Lowest & 4 Stars are Highest] (Refer to Report Card in Section E for more information)											
Overall Quality Score	N/A	★	★	★★★	★★★	★★★	★★★★	★★★	★★★	★	★
Wellness & Prevention Score	N/A	★	★	★★	★★	★★★	★★★★	★★★★	★★	★★	★★
Behavioral Health Score	N/A	★	★	★★★	★★★	★★	★★★	★★	★	★★	★★
Disease Management Score	★	★	★	★★★	★★★	★★★★	★★★	★★★	★★★	★	★
Consumer Experiences	N/A	★	★	★★★	★★★	★★★	★★★	★★★	★★★★	★	★
% That Would Recommend Plan to Family & Friends	N/A	73%	89%	94%	97%	96%	96%	96%	98%	90%	49%
Wellness/Chronic Disease Programs Available* (Refer to plan description pages in Section G for more information)											
Health Risk Assessments	Yes-O	Yes-O	Yes-O	None	Yes-All	Yes-O	Yes-O,P	None	Yes-O	Yes-All	Yes-All
24-Hour Nurseline	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes
Tobacco Cessation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Electronic Diabetes Registry	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dental Benefits* (Refer to plan description pages in Section G for more information)											
Preventive Services Deductible	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Restorative Services Deductible	$0	$0	$0	$25/Indiv	$0	N/A	$0	$0	$0	$25/Indiv	$25/Indiv
Orthodontic Benefits	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	N/A	Yes	Yes
Annual Benefit Maximum / Member	None	None	None	$1,000	$2,000	None	None	$500	$500	None	None
Total # of Dentist in Network	103	72	185	930	Open	67	24	Open	Open	Open	Open
Online Services Available Through Health Plans or Major Clinic(s) In Its Network* (Refer to plan description pages in Section G for more information)											
Searchable Provider Directory	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Update Member Contact Information	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes
Communicate with Providers Through a Message Center	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes	Yes
Communicate with Member Services Through a Message	No	No	No	Yes	Yes	No	Yes	No	No	Yes	Yes
Request and View Appointments	No	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No
Review Preventative Test Results	No	No	No	Yes	Yes	Yes	Yes	Yes	No	No	No
View Electronic Health Records	No	No	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes

2009 Health Plan Features Comparison Continued	Medical Associates	MercyCare	Network Health Plan	Physicians Plus	Security Health Plan	State Mainten-ance Plan	United Healthcare Northeast	United Healthcare Southeast	Unity Community	Unity UW	WPS Metro Choice
Tier for 2009	1	1	1	1	1	1	1	1	1	1	1
Demographic Information* (Refer to Question 30 in Section C for more information on the Type of Plan)											
Type of Plan	HMO	HMO	HMO	HMO	HMO	SMP	HMO	HMO	HMO	HMO	PPP
Total # of Primary Care Physicians	121	99	423	384	734	219	1590	2287	388	205	2005
Total # of Urgent Care Facilities	6	9	10	15	30	2	11	32	31	4	62
Total # of Hospitals	15	5	18	16	40	10	21	23	33	4	19
Quality Scores [1 Star is Lowest & 4 Stars are Highest] (Refer to Report Card in Section E for more information)											
Overall Quality Score	★★★	★★	★★★★	★★	★★★	★	★	★★	★★★	★★★	★★
Wellness & Prevention Score	★★★	★★	★★★	★★★	★★★	N/A	★★	★★	★★★★	★★★★	N/A
Behavioral Health Score	★	★★	★★★	★★★★	★★★★	N/A	★★	★★	★★★	★★★★	N/A
Disease Management Score	★★★★	★★	★★★★	★★	★★★★	N/A	★	★	★★★	★★★	N/A
Consumer Experiences	★★★★	★★	★★★	★★★	★★★	N/A	★	★★	★★★	★★★	N/A
% That Would Recommend Plan to Family & Friends	96%	90%	94%	97%	94%	68%	91%	91%	96%	96%	87%
Wellness/Chronic Disease Programs Available* (Refer to plan description pages in Section G for more information)											
Health Risk Assessments	None	Yes-O,P	Yes-O	Yes-O	Yes-O,T	None	Yes-O	Yes-O	Yes-O	Yes-O	None
24-Hour Nurseline	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	No
Tobacco Cessation	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No
Electronic Diabetes Registry	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Dental Benefits* (Refer to plan description pages in Section G for more information)											
Preventive Services Deductible	$0	$0	$0	$0	$0	N/A	$0	$0	$0	$0	$25/Indiv
Restorative Services Deductible	$0	$25/Indiv	$25/Indiv	$0	None	N/A	$50/Indiv	$50/Indiv	$0	$0	$25/Indiv
Orthodontic Benefits	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
Annual Benefit Maximum / Member	$1,000	$1,000	$1,000	None	None	N/A	$1,000	$1,000	$1,000	$1,000	$500
Total # of Dentist in Network	Open	Open	908	68	209	N/A	Open	Open	396	248	1162
Online Services Available Through Health Plans or Major Clinic(s) In Its Network* (Refer to plan description pages in Section G for more information)											
Searchable Provider Directory	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Update Member Contact Information	No	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No
Communicate with Providers Through a Message Center	No	No	Yes	Yes	No	No	No	No	No	No	No
Communicate with Member Services Through a Message	No	No	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes
Request and View Appointments	No	No	No	No	Yes	No	No	No	No	No	No
Review Preventative Test Results	No	No	No	No	Yes	No	No	No	No	No	No
View Electronic Health Records	No	No	No	Yes	Yes	No	No	No	No	No	No

**** Information was self-reported by each individual health plan.***

Health Plan Features Descriptions

Tier

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 or 3, resulting in higher premium contributions for members. 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 and you should compare the SMP plan to other health plans in your area. For more information on tiers see page A-2 of this booklet.

Wellness & Chronic Disease Programs Available Through Health Plans

- **Health Risk Assessment (HRA)** – A tool to help you assess your health history and lifestyle choices in order to identify certain characteristics that may, over time, develop into diseases such as cancer, diabetes, heart disease and osteoporosis. In order to receive a "Yes" the health plan must offer the HRA at no cost either Online = O, Telephonic = T, and/or Paper = P. *("No" = the health plan does not offer an HRA or it is available for a fee)*
- **24-Hour Nurse Line** – In order to receive a "Yes" the health plan must have 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.
- **Tobacco Cessation** - In order to receive a "Yes", the health plan must offer a financial incentive such as a class discount or a covered counseling benefit such as Quit line.
- **Electronic Diabetes Registry** - In order to receive a "Yes", the health plan 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. Health 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-40 through E-42 of the Health Plan Report Cards in this booklet.

Dental Benefits Available Through Health Plans

The Uniform Benefits package does not include coverage for routine dental care. However, the Group Insurance Board permits participating health plans the option to offer dental coverage to its members. The Health Plan Features Comparison lists the plans that have elected to provide some level of dental coverage. Benefits vary from health plan to health plan with no requirements regarding the minimum levels of coverage offered. Members who place a high value on dental services should refer to the Plan Description pages in this section or contact the health plan directly if you have specific questions regarding the dental coverage or dental provider availability carefully before making a health plan selection. *("N/A" = the health plan does not offer optional dental coverage or selected benefits)*

Online Services Available Through Health Plans or Major Clinic(s) In Its Network

In order to receive a "Yes", the health plan must have information that that is specific to state and local employees, continuants, and retirees on their website that is easy to identify and offer 24 hours a day access. *(Some secure areas of the website may require members to enroll to gain access using a specified login identification and password)*

- **Searchable Provider Directory** – a provider listing that is easy to identify and access.
- **Update Member Contact Information** – an area where members can update their name, address & telephone information through your health plan and/or major clinic(s) in their network.
- **Communicate with Providers Through Message Center** – a dedicated area where members can correspond with their providers and/or major clinic(s) in their health plans network by sending messages through a designated message center.
- **Communicate with Member Services Through Message Center** – a dedicated area where members can correspond with their health plan by sending messages through a designated message center.
- **Request and View Appointments** – a dedicated area where members can verify and request appointments with providers.
- **Access Results to Preventive Test** – a dedicated area where members can access a secure area to view the results of preventive tests for example cholesterol screenings, etc.
- **View Electronic Health Records** – a dedicated area where members can access a secure area to view such health records like immunizations and drug prescriptions.

Physician Group Quality and Safety Information

The Wisconsin Collaborative for Healthcare Quality (WCHQ) is a voluntary organization of Wisconsin physician groups and health systems dedicated to improving the quality and cost of health care. WCHQ develops and publicly reports standardized measure fo health care performance and sponsors quality improvement initiatives. To view WCHQ public reports on participating providers, visit www.wchq.org.

Participating Physician Groups	In the Network of the Following Health Plans (code description page G-9)
Affinity Medical Group	N
Aurora Advanced Healthcare	AE, HE, UN, US
Aurora Medical Group	AS, HE, UN, US
Aurora UW Medical Group	AE
Bellin Medical Group	AE, A, HE, UN
Columbia St. Mary's Community Physicians	AS, HE, US, W
Dean Health System	D, GSC
Franciscan Skemp Medical Center Clinics	GEC, HT
Gundersen Clinic, Ltd.	GL
LakeShore Medical Clinic	AS, HE, N, US, W
Luther Midelfort	AW, GEC, HT
Marshfield Clinic	GEC, HW, S
Medical Associates Health Centers (in SE WI)	AS, HE, W
Medical College Physicians	AS, A, HE, UN, W
Mercy Health System	AS, HE, MC, UC, US
Monroe Clinic	D, UC
Prevea Health	A, HE, N, UN
ProHealth Care Medical Centers	AS, HE, US, W
West Bend Clinic	AS, HE, N, US, W
ThedaCare Physicians	A, HE, UN
UW Health Physicians	AS, A, GEC, GSC, N, PP, UC, UU
Wheaton Franciscan Medical Group	AS, HE, US, W

Hospital Health Care Quality and Safety Information

The quality and safety of health care services is important to us. The chart below shows the quality and safety efforts of hospitals affiliated with our health plans. If a hospital has not met any of the criteria below, it does not appear on the chart.
This information may be useful as you make important healthcare decisions. (See Section C, questions 36 - 40 for more information.)

	Under the frog symbol the first box is shaded to reward a hospital who has recently submitted data to the Leapfrog Hospital Survey. The Leapfrog Group (www.leapfroggroup.org) 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. The second box under the frog symbol is shaded to award either: 1. urban hospitals that have fully implemented one of the first three leaps (Prevention Medication Errors, Appropriate ICU Staffing or any of the High Risk Treatment Safety Ratings), or 2. rural hospitals who are in the top half of hospitals on the fourth leap on safe practices (Steps to Avoid Harm) which have been endorsed by the National Quality Forum.
✔	The check mark box is shaded to recognize hospitals that have reported to CheckPoint (www.wicheckpoint.org) on all error prevention measures *and* 3 of 4 best practice measure sets for heart attack, heart failure, pneumonia or surgical infection prevention.
RX	The Rx box is shaded to recognize hospitals that are at or above the state average of CheckPoint's Medication Reconciliation error prevention measure (www.wicheckpoint.org).

Hospital	City	County			✔	RX	In the Network of the Following Health Plans* (code description below)
Appleton Medical Center	Appleton	Outagamie					AE, A, HE, UN
Aspirus Wausau Hospital	Wausau	Marathon					A, S
Aurora BayCare Medical Center	Green Bay	Brown					AE, HE, UN
Aurora Lakeland Medical Center	Elkhorn	Walworth					AS, HE, US
Aurora Medical Center Manitowoc County-Two Rivers	Two Rivers	Manitowoc					AE, HE, UN
Aurora Medical Center-Hartford, Washington County	Hartford	Washington					AS, HE, US
Aurora Medical Center-Kenosha	Kenosha	Kenosha					AS, HE, US
Aurora Medical Center-Oshkosh	Oshkosh	Winnebago					AE, HE, UN
Aurora Memorial Hospital of Burlington	Burlington	Kenosha					AS, HE, US
Aurora Sheboygan Memorial Medical Center	Sheboygan	Sheboygan					AE, HE, UN
Aurora Sinai Medical Center	Milwaukee	Milwaukee					AS, HE, US
Aurora St. Luke's Medical Center	Milwaukee	Milwaukee					AS, HE, US
Aurora St. Luke's South Shore	Cudahy	Milwaukee					AS, HE, US
Aurora West Allis Medical Center	West Allis	Milwaukee					AS, HE, US
Bay Area Medical Center	Marinette	Marinette					AE, A, HE, UN
Bellin Hospital	Green Bay	Brown					AE, A, HE, UN
Beloit Memorial Hospital	Beloit	Rock					AS, D, HE, UC

*Referrals may be necessary to go to some of these hospitals. Check with your HMO.
The Standard Plan includes all of these hospitals so does not appear in the chart, but Aurora hospitals are out-of-network.

Hospital	City	County			✔	RX	In the Network of the Following Health Plans* (code description below)
Berlin Memorial Hospital	Berlin	Green Lake	■		■	■	AE, HE, N, PP, S, SMP, UC, UN
Black River Memorial Hospital	Black River Falls	Jackson			■		GEC, GL, HT, S
Boscobel Area Health Care	Boscobel	Grant			■	■	D, GL, HT, MA, PP, UC
Calumet Medical Center	Chilton	Calumet			■	■	N
Children's Hospital of WI-Kenosha	Kenosha	Kenosha	■				AS, A, HE, US
Children's Hospital of WI	Milwaukee	Milwaukee	■	■			AS, A, HE, US, W
Children's Hospital of WI-Fox Valley	Neenah	Winnebago	■				AE, A, HE, UN
Columbia St. Mary's, Inc.	Milwaukee	Milwaukee	■	■	■	■	AS, A, HE, US, W
Columbia St. Mary's, Inc. - Ozaukee Campus	Mequon	Ozaukee	■	■	■	■	AS, A, HE, US, W
Columbus Community Hospital	Columbus	Columbia	■		■		D, PP, UC
Community Memorial Hospital	Menomonee Falls	Waukesha	■	■			AS, HE, US, W
Cumberland Memorial Hospital, Inc.	Cumberland	Barron			■	■	GEC, HW, S
Divine Savior Healthcare	Portage	Columbia	■		■	■	D, PP, UC
Fort Memorial Hospital	Fort Atkinson	Jefferson	■				AS, D, HE, MC, UC
Franciscan Skemp - Mayo Health System	La Crosse	La Crosse	■		■		GEC, HT
Franciscan Skemp - Mayo Health System	Sparta	Monroe	■				GEC, HT
Franciscan Skemp - Mayo Health System	Arcadia	Trempeleau	■				GEC, HT
Froedtert Memorial Lutheran Hospital	Milwaukee	Milwaukee	■	■	■	■	AS, A, HE, US, W
Grant Regional Health Center	Lancaster	Grant	■			■	D, GL, MA, PP, UC
Gundersen Lutheran Health System	La Crosse	La Crosse	■	■	■		GL
Hayward Area Memorial Hospital	Hayward	Sawyer			■		GEC, S
Hess Memorial Hospital	Mauston	Juneau	■		■		GL, HT, S
Holy Family Memorial Medical Center	Manitowoc	Manitowoc	■		■		AE, A, HE, N
Hudson Hospital	Hudson	St. Croix	■		■	■	AW, HW
Indianhead Medical Center	Shell Lake	Washburn			■	■	GEC, S
Lakeview Medical Center	Rice Lake	Barron			■	■	GEC, HW, S
Luther Hospital - Mayo Health System	Eau Claire	Eau Claire	■		■		GEC, HT
Luther Midelfort Chippewa Valley	Bloomer	Chippewa	■		■	■	GEC, HT
Luther Midelfort Northland	Barron	Barron	■		■	■	GEC, HT
Luther Midelfort Oakridge	Osseo	Trempealeau	■		n/a	■	GEC, HT
Memorial Health Center	Medford	Taylor	■				A, S
Memorial Hospital	Neillsville	Clark	■				GEC, GL, S
Memorial Hospital of Lafayette County	Darlington	Lafayette	■		■		D, MA, PP
Memorial Medical Center	Ashland	Ashland			■	■	AW, GEC, S, SMP
Mercy Health System Corporation	Janesville	Rock			■	■	AS, D, HE, MC, UC
Mercy Medical Center	Oshkosh	Winnebago			■		N
Mercy Walworth Hospital & Medical Center	Lake Geneva	Walworth				■	AS, HE, MC, UC, US
Meriter Health Services	Madison	Dane	■	■	■	■	GSC, PP, UC, UU

*Referrals may be necessary to go to some of these hospitals. Check with your HMO.
The Standard Plan includes all of these hospitals so does not appear in the chart, but Aurora hospitals are out-of-network.

Hospital	City	County			✔	RX	In the Network of the Following Health Plans* (code description below)
Ministry Health Care-Door County Memorial Hospital	Sturgeon Bay	Door					A, GEC, HE, N, UN
Ministry Health Care-Good Samaritan Health Center	Merrill	Lincoln					GEC, S
Ministry Health Care-Howard Young Medical Center	Woodruff	Oneida					GEC, S
Ministry Health Care-Our Lady of Victory Hospital	Stanley	Chippewa					GEC, HW, S
Ministry Health Care-Saint Clare's Hospital	Weston	Marathon					GEC, S
Ministry Health Care-Saint Joseph's Hospital	Marshfield	Wood					GEC, S
Ministry Health Care-Saint Mary's Hospital	Rhinelander	Oneida					GEC, S
Ministry Health Care-Saint Michael's Hospital	Stevens Point	Portage					GEC, S
Monroe Clinic, The	Monroe	Green					D, UC
New London Family Medical Center	New London	Outagamie					A, HE, N, UN
Oconomowoc Memorial Hospital	Oconomowoc	Waukesha					AS, D, HE, US, W
Osceola Medical Center	Osceola	Polk					HW
Prairie du Chien Memorial Hospital	Prairie du Chien	Crawford					GL, HT, MA, UC
Reedsburg Area Medical Center	Reedsburg	Sauk					D, GL, HT, UC
Richland Hospital, The	Richland Center	Richland					D, GL, HT, PP, UC
Sacred Heart Hospital	Eau Claire	Eau Claire					AW, GEC, GL, HW, S
Sacred Heart Hospital	Tomahawk	Lincoln					GEC, S
Sauk Prairie Memorial Hospital & Clinics	Prairie du Sac	Sauk					D, PP, UC
Shawano Medical Center	Shawano	Shawano					AE, HE, UN
Southwest Health Center	Platteville	Grant					D, MA, UC
St. Agnes Hospital	Fond du Lac	Fond du Lac					AE, D, HE, N, UC, UN
St. Clare Hospital & Health Services	Baraboo	Sauk					D, PP, UC
St. Joseph's Community Health Services	Hillsboro	Vernon					D, GL, HT, S, UC
St. Joseph's Hospital	Chippewa Falls	Chippewa					GEC, HW, S
St. Joseph's Hospital	West Bend	Washington					HE, N, US, W
St. Mary's Hospital	Madison	Dane					D, GSC
St. Mary's Hospital Medical Center	Green Bay	Brown					AE, A, HE, N, UN
St. Mary's Hospital of Superior	Superior	Douglas					AW, GEC, HW, S
St. Nicholas Hospital	Sheboygan	Sheboygan					AE, A, HE, N, UN
St. Vincent Hospital	Green Bay	Brown					AE, A, HE, N, UN
Stoughton Hospital	Stoughton	Dane					D, GSC, PP, UU
Theda Clark Medical Center	Neenah	Winnebago					A, HE, UN
Tomah Memorial Hospital	Tomah	Monroe					GL, HT
University of Wisconsin Hospital & Clinics	Madison	Dane					A, GEC, GSC, N, PP, UC, UU
Upland Hills Health, Inc.	Dodgeville	Iowa					D, MA, PP, UC
Watertown Memorial Hospital	Watertown	Jefferson					AS, D, HE, MC, UC
Waukesha Memorial Hospital	Waukesha	Waukesha					AS, HE, US, W
Waupun Memorial Hospital	Waupun	Fond du Lac					D, HE, N, UC

*Referrals may be necessary to go to some of these hospitals. Check with your HMO.
The Standard Plan includes all of these hospitals so does not appear in the chart, but Aurora hospitals are out-of-network.

Hospital	City	County			✔	RX	In the Network of the Following Health Plans* (code description below)
Westfields Hospital	New Richmond	St. Croix					AW, HW, S
Wheaton Franciscan Healthcare - All Saints	Racine	Racine					AS, HE, US, W
Wheaton Franciscan Healthcare-Elmbrook Memorial	Brookfield	Waukesha					AS, HE, US, W
Wheaton Franciscan Healthcare-St. Francis, Inc.	Milwaukee	Milwaukee					AS, HE, US, W
Wheaton Franciscan Healthcare-St. Joseph, Inc	Milwaukee	Milwaukee					AS, HE, US, W
Wild Rose Community Memorial Hospital	Wild Rose	Waushara			n/a		AE, HE, N, PP, S, SMP, UN
Wisconsin Heart Hospital, The	Wauwatosa	Milwaukee					AS, HE

2009 Health Plans	Plan Code
Anthem BCBS-Northeast	AE
Anthem BCBS-Northwest	AW
Anthem BCBS-Southeast	AS
Arise Health Plan	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 Health	PP
Security Health Plan	S
State Maintenance Plan	SMP
UnitedHealthcare Northeast	UN
UnitedHealthcare Southeast	US
Unity Community	UC
Unity UW Health	UU
WPS Metro Choice-formerly WPS Patient Choice Plan 1&2	W

*Referrals may be necessary to go to some of these hospitals. Check with your HMO.
The Standard Plan includes all of these hospitals so does not appear in the chart, but Aurora hospitals are out-of-network.

COMPARISON OF STATE PROGRAM TYPES FOR 2009

The Chart below is designed to compare Uniform Benefits, Medicare + $1,000,000 and the Standard Plan.

- 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).
- Medicare pays as primary for annuitants over age 65.
- Annuitants on the Standard Plan are converted to the Medicare Plus $1,000,000 plan upon reaching Medicare eligibility.

This outline is not intended to be a complete description of coverage. For details, see specific language in Uniform Benefits section D, the Medicare + $1,000,000 (ET-4113) and Standard Plan (ET-2112) benefit booklets. Wherever percentage of payment is listed, it means percent of charges. Charges may be subject to Usual, Customary and Reasonable (UCR) determination. All services subject to medical necessity. Custodial care is not covered.

BENEFIT	UNIFORM BENEFITS	MEDICARE + $1,000,000 (Over Medicare Age)	STANDARD PLAN (If under Medicare Age)	
			Preferred Provider	Non-Preferred Provider
Annual Deductible	No deductible[1]	No deductible	$100 individual / $200 family	$500 individual / $1,000 family
Annual Co-insurance	As described below[2]	As described below	None (except for mental health/alcohol & drug treatment)	80% / 20% *Annual OOP maximum (includes deductible):* $2,000 individual / $4,000 family
Maximum	$2 Million	$1 Million	$2 Million	$2 Million
Hospital Days	As medically necessary, plan providers only. No day limit.	120 days; semi-private room	365 per admission	365 per admission
ER	$60 copay per visit	100%, no copay	100%, no copay	100%, no copay
Ambulance	100%	100%	100%	100%
Transplants *(May cover these and others listed)*	Lifetime benefit of $1,000,000 *Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung*	100% *Bone marrow, parathyroid, musculoskeletal, corneal, and kidney*	100% *Bone marrow, musculoskeletal, corneal, and kidney*	80% *Bone marrow, musculoskeletal, corneal, and kidney*
Mental Health[3]	Inpatient 30 days Outpatient 100% Transitional 100%	Inpatient 120 days Outpatient 90% Transitional 90%	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 100% 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	Inpatient 90% to $6,300 Outpatient 90% to $1,800 Transitional 90% to $2,700
Routine Physical	One per year	Very limited benefit see pages G-54, 55	One per year	One per year

BENEFIT	UNIFORM BENEFITS	MEDICARE + $1,000,000 (Over Medicare Age)	STANDARD PLAN (If under Medicare Age)	
			Preferred Provider	Non-Preferred Provider
Hearing Exam	100%	Benefit for illness or disease, 100%	Benefit for illness or disease, 100%	Benefit for illness or disease, 80%
Hearing Aid (per ear)	80% up to $1,000 every 3 years	No benefit	No benefit	No benefit
Routine Vision Exam	One per year	No Benefit for routine. Illness or disease only, 100%	No Benefit for routine. Illness or disease only, 100%	No Benefit for routine, for illness or disease only, 80%
Skilled Nursing Facility *(non custodial care)*	120 days per benefit period	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 *(non custodial)*	50 per year; Plan may approve an additional 50	100% up to 365 visits	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	100%, no limit on visits or days	80%, no limit on visits or days
Durable Medical Equipment	20% co-insurance, $500 OOP maximum	100%	100%	80%
Hospital Pre-Certification	Varies by plan	None required	Value Care Program for inpatient stays. Voluntary 2nd surgical opinion	Value Care Program for inpatient stays. Voluntary 2nd surgical opinion
Referrals	In network varies by plan. Out of network required.	None required	Not required	Not required
Primary Care Provider	Varies by plan	Allows freedom of choice of providers	Not required	Not required
Treatment for Morbid Obesity	Excluded	Not specifically excluded	100% at Center of Excellence in-network provider	80%
Oral Surgery	11 procedures	23 procedures. 100%	23 procedures. 100%	23 procedures. 80%
Dental Care	Varies by plan	No benefit	No benefit	No benefit
Drug Out-of-Pocket Maximum[4]	$385 individual / $770 family	$385 individual / $770 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.

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Blue Preferred Northeast Network

PO Box 34210
Louisville, KY 40232-4210
Phone: 1-800-490-6201
www.anthem.com

During the Dual Choice Enrollment period, please call 1-800-490-6201. Non-members should select "1", then "0#", then "0#" from automated menu.

Managed Care Organization ★★★★ NCQA Accreditation EXCELLENT

What's new for 2009?	Anthem is excited to offer **Anthem 360° Health,** which includes online tools, resources and guidance to help you reach your own personal healthy best. From Web-based resources to personalized interactions with a registered nurse, Anthem 360° Health can help you become more engaged in your health and empower you to make the health care decisions that are right for you. It's all part of your Blue Preferred plan.
Do I need to select a Primary Care Physician (PCP)?	No. Members are not required to select a **primary care physician** (or PCP) and Anthem will not auto-assign one.
When do I need a referral?	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 Northeast Network. You need a written referral from your PCP and authorization from Anthem to obtain services from a specialist who is not participating in the Northeast Network. Anthem will provide a written response to the referral request to you and your PCP.
When do I need to get a prior authorization?	Certain health care procedures require pre-authorization as initiated by your PCP or specialist. Pre-certification is required for non-emergency hospital stays. Contact Anthem for more information about procedures that require pre-certification by calling the number on the back of your ID card. Anthem will provide a written response to you and your provider.
How do I get care when I am outside the service area?	**Emergency Care:** You should go to the nearest health care facility for treatment, and contact your primary care physician (PCP) and Anthem within 24 hours or as soon as reasonably possible. **Urgent Care:** You should call your primary care physician (PCP) for advice about appropriate treatment. **All Other Care:** You must receive prior authorization from Anthem for all other care outside the Blue Preferred Northeast Network. Please call the pre-certification number on the back of your ID card.
How do I get mental/ behavioral health care?	You do not need a referral to see a Northeast Network mental health provider. Precertification is only required for inpatient hospital stays. To find a behavioral health provider, go to our online provider directory at www.anthem.com. Under "Provider Type" select Behavioral Health. Please refer to the *"What providers can I use?"* section on the next page for detailed instructions on how to search for an Anthem provider online.
What are the dental benefits?	**Deductible:** None **Preventive Services:** Once every 6 months. 100% coverage for comprehensive and periodic exams. **Other Services:** 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. **Orthodontics:** 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. **Annual Benefit Maximum:** No lifetime maximum except for orthodontics.

	Dental Network: 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 can be requested by calling Anthem Customer Service. **Dental ID Cards:** Show your Anthem medical ID card for dental services.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Go to www.anthem.com - Click on "Find a Doctor". - Under "State/Directory Selection" select Wisconsin and click "Next". - Under the "Plan Information" pull-down menu, **select Blue Preferred HMO Northeast - State of Wisconsin**. - Select the Provider Type and Specialty, and then click "Next". - Search for providers near a location or download the entire provider directory. • Or call Anthem Customer Service to receive a printed directory.

County	Hospital(s)	Major Clinic(s)
Brown	Aurora Baycare Medical Bellin Memorial Hospital St. Mary's Hospital Medical Center St. Vincent Hospital	Aurora Health Center Baycare Clinic Bellin Health Prevea Clinic
Calumet		Aurora Health Center
Door	Door County Memorial Hospital	Aurora Health Center Baycare Clinic North Shore Medical Clinic
Fond du Lac	Ripon Medical Center St. Agnes Hospital	Aurora Health Center Fond du Lac Regional Clinic
Green Lake	Berlin Memorial Hospital	Aurora Health Center CHN Medical Center
Kewaunee		Baycare Clinic
Manitowoc	Aurora Medical Center Manitowoc Holy Family Memorial Medical Center	Aurora Health Center Baycare Clinic
Marinette	Bay Area Medical Center	Aurora Health Center Bay Area Medical Center Baycare Clinic Northreach Healthcare
Oconto	Bond Health Center Inc. Community Memorial Hospital	Aurora Health Center Baycare Clinic CMH Primary Care Clinic
Outagamie	Appleton Medical Center	Aurora Health Center Baycare Clinic Thedacare Physicians
Shawano	Shawano Medical Center	Aurora Health Center Thedacare Physicians
Sheboygan	Aurora Sheboygan Memorial Medical Ctr. St. Nicholas Hospital	Aurora Health Center
Waupaca	New London Family Medical Center Riverside Medical Center	Thedacare Physicians
Waushara	Wild Rose Community Memorial Hospital	Aurora Health Center CHN Medical Center
Winnebago	Aurora Medical Center-Oshkosh Children's Hospital of Wisconsin Fox Valley Theda Clark Regional Medical Center	Aurora Health Center Baycare Clinic Thedacare Physicians

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Blue Preferred Northwest Network

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Phone: 1-800-490-6201
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During the Dual Choice Enrollment period, please call 1-800-490-6201. Non-members should select "1", then "0#", then "0#" from automated menu.

Managed Care Organization ★★★★ NCQA Accreditation EXCELLENT

What's new for 2009?	Anthem is excited to offer **Anthem 360° Health,** which includes online tools, resources and guidance to help you reach your own personal healthy best. From Web-based resources to personalized interactions with a registered nurse, Anthem 360° Health can help you become more engaged in your health and empower you to make the health care decisions that are right for you. It's all part of your Blue Preferred plan.
Do I need to select a Primary Care Physician (PCP)?	No. Members are not required to select a **primary care physician** (or PCP) and Anthem will not auto-assign one.
When do I need a referral?	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 to obtain services from a specialist who is not participating in the Northwest Network. Anthem will provide a written response to the referral request to you and your PCP.
When do I need to get a prior authorization?	Certain health care procedures require pre-authorization as initiated by your PCP or specialist. Pre-certification is required for non-emergency hospital stays. Contact Anthem for more information about procedures that require pre-certification by calling the number on the back of your ID card. Anthem will provide a written response to you and your provider.
How do I get care when I am outside the service area?	**Emergency Care:** You should go to the nearest health care facility for treatment, and contact your primary care physician (PCP) and Anthem within 24 hours or as soon as reasonably possible. **Urgent Care:** You should call your primary care physician (PCP) for advice about appropriate treatment. **All Other Care:** You must receive prior authorization from Anthem for all other care outside the Blue Preferred Northwest Network. Please call the pre-certification number on the back of your ID card.
How do I get mental/ behavioral health care?	You do not need a referral to see a Northwest Network mental health provider. Precertification is only required for inpatient hospital stays. To find a behavioral health provider, go to our online provider directory at www.anthem.com. Under "Provider Type" select Behavioral Health. Please refer to the *"What providers can I use?"* section on the next page for detailed instructions on how to search for an Anthem provider online.
What are the dental benefits?	**Deductible:** None **Preventive Services:** Once every 6 months. 100% coverage for comprehensive and periodic exams. **Other Services:** 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. **Orthodontics:** 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.

	Annual Benefit Maximum: No lifetime maximum except for orthodontics. **Dental Network:** 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 can be requested by calling Anthem Customer Service. **Dental ID Cards:** Show your Anthem medical ID card for dental services.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Go to www.anthem.com - Click on "Find a Doctor". - Under "State/Directory Selection" select Wisconsin and click "Next". - Under the "Plan Information" pull-down menu, select **Blue Preferred HMO Northwest - State of Wisconsin**. - Select the Provider Type and Specialty, and then click "Next". - Search for providers near a location or download the entire provider directory. • Or call Anthem Customer Service to receive a printed directory.

County	Hospital(s)	Major Clinic(s)
Ashland	Memorial Medical Center	
Burnett	Burnett Medical Center	
Douglas	St. Mary's Hospital of Superior	Mariner Medical Clinic SMDC
Eau Claire	Oak Leaf Surgical Hospital Sacred Heart Hospital	Marshfield Clinic
Pierce	River Falls Area Hospital	
Polk	Amery Regional Medical Center Ladd Memorial Hospital St. Croix Regional Medical Center	Amery Regional Medical Center St. Croix Regional Medical Center
Saint Croix	Baldwin Area Medical Center Hudson Hospital Westfields Hospital	Baldwin Area Medical Center Hudson Physicians New Richmond Clinic
Washburn	Indianhead Medical Center Spooner Health System	
Saint Louis, MN	Miller Dwan Medical Center St. Luke's Hospital	Duluth Clinic Northland Medical Associates Northstar Physicians
Goodhue, MN	Fairview Red Wing Hospital	Fairview Red Wing Health Services

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Blue Preferred Southeast Network

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Louisville, KY 40232-4210
Phone: 1-800-490-6201
www.anthem.com

During the Dual Choice Enrollment period, please call 1-800-490-6201. Non-members should select "1", then "0#", then "0#" from automated menu.

Managed Care Organization ★★★★ NCQA Accreditation EXCELLENT

What's new for 2009?	Anthem is excited to offer **Anthem 360° Health,** which includes online tools, resources and guidance to help you reach your own personal healthy best. From Web-based resources to personalized interactions with a registered nurse, Anthem 360° Health can help you become more engaged in your health and empower you to make the health care decisions that are right for you. It's all part of your Blue Preferred plan.
Do I need to select a Primary Care Physician (PCP)?	No. Members are not required to select a **primary care physician** (or PCP) and Anthem will not auto-assign one.
When do I need a referral?	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 to obtain services from a specialist who is not participating in the Southeast Network. Anthem will provide a written response to the referral request to you and your PCP.
When do I need to get a prior authorization?	Certain health care procedures require pre-authorization as initiated by your PCP or specialist. Pre-certification is required for non-emergency hospital stays. Contact Anthem for more information about procedures that require pre-certification by calling the number on the back of your ID card. Anthem will provide a written response to you and your provider.
How do I get care when I am outside the service area?	**Emergency Care:** You should go to the nearest health care facility for treatment, and contact your primary care physician (PCP) and Anthem within 24 hours or as soon as reasonably possible. **Urgent Care:** You should call your primary care physician (PCP) for advice about appropriate treatment. **All Other Care:** You must receive prior authorization from Anthem for all other care outside the Blue Preferred Southeast Network. Please call the pre-certification number on the back of your ID card.
How do I get mental/ behavioral health care?	You do not need a referral to see a Southeast Network mental health provider. Precertification is only required for inpatient hospital stays. To find a behavioral health provider, go to our online provider directory at www.anthem.com. Under "Provider Type" select Behavioral Health. Please refer to the *"What providers can I use?"* section on the next page for detailed instructions on how to search for an Anthem provider online.
What are the dental benefits?	**Deductible:** None **Preventive Services:** Once every 6 months. 100% coverage for comprehensive and periodic exams. **Other Services:** 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. **Orthodontics:** 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. **Annual Benefit Maximum:** No lifetime maximum except for orthodontics. **Dental Network:** 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 can be requested by calling Anthem Customer Service. **Dental ID Cards:** Show your Anthem medical ID card for dental services.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Go to www.anthem.com - Click on "Find a Doctor". - Under "State/Directory Selection" select Wisconsin and click "Next". - Under the "Plan Information" pull-down menu, select **Blue Preferred HMO Southeast - State of Wisconsin**. - Select the Provider Type and Specialty, and then click "Next". - Search for providers near a location or download the entire provider directory. • Or call Anthem Customer Service to receive a printed directory.

County	Hospital(s)	Major Clinic(s)
Dodge	Beaver Dam Community Hospital Watertown Memorial Hospital	Aurora Health Center Watertown Physician Health Org.
Jefferson	Fort Memorial Hospital	Fort Healthcare
Kenosha	Aurora Medical Center Kenosha Children's Hospital Of Wisconsin Kenosha United Hospital System	Aurora Health Center Children's Medical Group Kenosha Medical Center Clinic
Milwaukee	Aurora Sinai Medical Center Aurora St. Luke's Medical Center Aurora Women's Pavilion of West Allis Medical Ctr. Children's Hospital of Wisconsin Columbia St. Mary's Hospital Milwaukee Froedtert Hospital Lifecare Hospitals of Milwaukee Orthopaedic Hospital of Wisconsin Select Specialty Hospital Milwaukee St. Luke's South Shore The Wisconsin Heart Hospital Wheaton Franciscan Healthcare St. Francis Wheaton Franciscan Healthcare St. Joseph	Aurora Advanced Healthcare Aurora Health Center Children's Medical Group Columbia St. Mary's Community Physicians Medical College Of Wisconsin Wheaton Franciscan Medical Group Wisconsin Health Fund
Ozaukee	Columbia Center St. Mary's Hospital Ozaukee	Aurora Advanced Healthcare Aurora Health Center Columbia St. Mary's Community Physicians
Racine	Aurora Memorial Hospital of Burlington Lakeview Rehabilitation Center Wheaton Franciscan Healthcare All Saints	Aurora Health Center Children's Medical Group Wheaton Franciscan Medical Group
Rock	Beloit Memorial Hospital Edgerton Hospital and Health Services Mercy Hospital	Beloit Clinic Mercy Health System
Walworth	Aurora Lakeland Medical Center Mercy Walworth Hospital and Medical Center	Aurora Health Center Fort Healthcare Mercy Health System
Washington	Aurora Medical Center Hartford St. Joseph's Community Hospital	Aurora Health Center Medical Associates West Bend Clinic
Waukesha	Community Memorial Hospital Oconomowoc Memorial Hospital Waukesha Memorial Hospital Wheaton Franciscan Healthcare Elmbrook	Aurora Advanced Healthcare Aurora Health Center Medical Associates Medical College Of Wisconsin Prohealth Care

Arise Health Plan

2710 Executive Drive
Green Bay, WI 54304
920-490-6900 or 1-888-711-1444
www.WeCareForWisconsin.com

What's new for 2009?	Arise Health Plan has enhanced its provider network to include Bellin Health, Aspirus, ThedaCare and Shawano Medical Center. This expands the scope of providers in Green Bay, Fox Valley, Wausau, and Shawano.
Do I need to select a Primary Care Physician (PCP)?	Yes, members must select a Primary Care Practitioner (PCP) 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.
When do I need a referral?	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.
When do I need to get a prior authorization?	Pre-service authorization is required for all non-participating providers and tertiary care specialists. Pre-service authorization is required for specialized services including: 1. Inpatient stay in a hospital or skilled nursing facility 2. Transplants 3. Home health care 4. Hospice care 5. Durable medical equipment (DME) over $500 or rental 6. Home infusion 7. Prosthetics over $1,000 8. New medical or biomedical technology 9. New surgical methods or techniques 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.
How do I get care when I am outside the service area?	**Emergency Care:** Emergency care is covered wherever it is received. If you are seen in the emergency room, and then admitted to the hospital, you must notify us within 48 hours of being medically able. Please call 920-490-6900 or 1-888-711-1444 toll-free. **Urgent Care:** If you are out of area, go to the nearest appropriate facility, unless you can safely return to the service area to receive care from a participating provider. **All Other Care:** If you are out of area and an acute medical problem develops, please contact your PCP for instructions. If additional medical services are needed for care that is not a medical emergency, or for follow up care, you will need an approved pre-service authorization prior to services being rendered. You may need to return home to receive treatment from a participating provider or you will be responsible for the service. (Refer above to *When do I need to get a prior authorization?*)
How do I get mental/ behavioral health care?	Members must use participating providers for all mental health and AODA services. Pre-service authorization is required for inpatient services and transitional care; however, it is not required for outpatient care.

What are the dental benefits?	**Deductible:** $25 single/$75 family - applies to basic restorative and orthodontic services. **Preventive Services:** Exams, cleanings, fluoride treatments, x-rays, and space maintainers are covered at 100%. Limited to 6 month intervals. Full mouth x-rays limited to 36 month intervals. **Other Services:** Basic restorative services including, sealants, fillings, emergency treatment to relieve pain are covered at 80%. Sealants limited to one application per tooth per lifetime to age 14. **Orthodontics:** Orthodontic Service for eligible dependent children: 50% Dependent Lifetime Orthodontic Maximum: $1,500 **Annual Benefit Maximum:** Individual Annual Maximum is $1,000. **Dental Network:** You can see any dentist; however, dental services provided by non-Delta Dental premier providers will be limited to the usual & customary rate as determined by Delta Dental. For more detailed coverage questions, please call Delta Dental at 1-800-23-3712. Visit www.WeCareForWisconsin.com to find a network dentist by selecting "Member", click on "Find-A-Doc", select group "State of Wisconsin", and enter group number "087889". **Dental ID Cards:** Members will receive a separate dental ID card from Delta Dental.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Go to www.WeCareForWisconsin.com and select "Member" - Click on "Find-A-Doc" - Select group "State of Wisconsin" - Enter group number "087889" • Contact our Member Services Department for at 1-888-711-1444 or 920-490-6900, option 1.

County	Hospital(s)	Major Clinic(s)
Brown	Bellin Memorial Hospital St Mary's Hospital St Vincent Hospital	Bellin Health Partners Prevea Health
Calumet		Bellin Health Partners
Door	Door County Memorial Hospital	Northshore Medical Clinic
Kewaunee		Bellin Health Partners Luxemburg Medical Clinic Northshore Medical Clinic
Langlade	Langlade Hospital	Aspirus Network
Lincoln		Aspirus Network
Manitowoc	Holy Family Memorial Medical Center (HFM)	HFM Network Clinics
Marathon	Aspirus Wausau Hospital	Aspirus Network
Marinette	Bay Area Medical Center	NorthReach Healthcare
Oconto	Community Memorial Hospital	Bellin Health Partners CMH Primary Care Clinics
Oneida		Aspirus Network
Outagamie	Appleton Medical Center	ThedaCare Physicians
Portage		Aspirus Network
Shawano	Shawano Medical Center	Bellin Health Partners ThedaCare Physicians
Sheboygan	St Nicholas Hospital	Physicians' Health Network
Taylor	Memorial Health Center Hospital	Aspirus Network
Vilas		Aspirus Network
Waupaca	New London Family Medical Center Riverside Medical Center	ThedaCare Physicians
Winnebago	Theda Clark Medical Center	ThedaCare Physicians
Wood	Riverview Hospital	Aspirus Network

Dean Health Plan, Inc.

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(608) 828-1301 (608) 279-1301
www.deancare.com

What's new for 2009?	**MyChart:** Dean Health Plan members can access portions of their medical records online through MyChart. Visit www.deancare.com for details. **Customer Service:** Dean Health Plan opened a new Customer Care Contact Center designed to improve call handling and the overall member experience. If you have Dean Health Plan questions, call 1-800-279-1301.
Do I need to select a Primary Care Physician (PCP)?	Yes, members must select a primary care provider (PCP) from one of the following specialties: Family Practice, General Practice, Pediatrics, Obstetrics/Gynecology or Internal Medicine. If a PCP is not selected, one will automatically be assigned. 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. There are no limitations on the number of times a member changes their PCP.
When do I need a referral?	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.
When do I need to get a prior authorization?	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 our Customer Service Department. If you go to a plan provider, the provider is responsible for requesting any required prior authorization for services. Prior authorization is needed for all services requested to a provider who is not listed in the Dean Health Plan Provider Directory. You must inform your provider to contact Dean Health Plan to obtain the prior authorization.
How do I get care when I am outside the service area?	**Emergency Care:** Go to the nearest appropriate medical facility. Contact our Customer Service Department by the next business day or as soon as possible regarding the care received. **Urgent Care:** Go to the nearest appropriate medical facility. Contact our Customer Service Department by the next business day or as soon as possible regarding the care received. **All Other Care:** Non emergent/urgent care is not covered unless an approved referral request is obtained prior to services being received and it is determined the care cannot wait until your return to the service area. (See the *When do I need a referral?* section above.)
How do I get mental/ behavioral health care?	Behavioral health services can be obtained by contacting a member's primary care physician, Dean Medical Center behavioral health consultants, Dean Health Plan's utilization management staff, Dean on Call, and through the emergency room. 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. Inpatient mental health and transitional care must be prior authorized.

What are the dental benefits?	**Deductible:** $0 Individual/$0 Family In Network $25 Individual/$75 Family Out of Network **Preventive Services:** Covered at 100%, subject to deductible. Exams and bitewing x-rays (2 per year), cleanings (4 per year) **Other Services:** Covered at 80%, subject to deductible. Sealants, restorative amalgams/composites **Orthodontics:** Covered at 50%. Orthodontics is a benefit for dependent children, if orthodontic treatment begins before 19 years of age. There is an individual lifetime orthodontic maximum of $1,750. **Annual Benefit Maximum:** The annual benefit maximum is $2,000 and is a combined benefit, including in-network and out-of-network providers. **Dental Network:** You are free to use any dental provider. Usual & Customary (U & C) charges apply to orthodontics when using an out of network provider. **Dental ID Cards:** Separate dental ID cards will be issued.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Use our Online Provider Directory 1. Go to ***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. • Contact our Customer Service Department at (608) 828-1301 or (800) 279-1301

County	Hospital(s)	Major Clinic(s)
Adams	Moundview Memorial Hospital	
Columbia	Columbus Community Hospital Divine Savior Hospital	Dean Specialty Clinics Dean/St. Mary's Regional Clinics
Dane	St. Mary's Hospital Stoughton Hospital	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	Dean Specialty Clinics Dean/St. Mary's Regional Clinics
Green	Monroe Clinic Hospital	Monroe Clinic
Iowa	Upland Hills Health	Dean Specialty Clinics Dean/St. Mary's Regional Clinics
Jefferson	Fort Health Care, Inc.	Dean Specialty Clinics Dean/St. Mary's Regional Clinics
Lafayette	Memorial Hospital of Lafayette County	Dean Specialty Clinic
Richland	Richland Medical Center	Dean Specialty Clinic
Rock	Beloit Memorial Hospital Edgerton Hospital & Health Services Mercy Hospital	Dean Clinic Locations Beloit Clinic
Sauk	St. Clare Hospital & Health Services Reedsburg Area Medical Center Sauk Prairie Memorial Hospital	Dean Specialty Clinics Dean/St. Mary's Regional Clinics
Vernon	St. Joseph's Memorial Hospital	
Waukesha	Oconomowoc Memorial Hospital	

Group Health Cooperative of Eau Claire

PO Box 3217
Eau Claire, WI 54702-3217
Phone: (888) 203-7770 Fax: (715) 552-3500
www.group-health.com

What's new for 2009?	• The Group Health Cooperative of Eau Claire (GHC) network has been expanded to include more providers in Burnett, Clark and Pepin counties. • Online 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. • Health and Wellness Blog - Visit our new Groupie Blog at www.group-health.com to read about a vast spectrum of health and wellness topics.
Do I need to select a Primary Care Physician (PCP)?	Yes, members 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 a Member Services Advocate at (715) 552-4300 or (888) 203-7770.
When do I need a referral?	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 a referral event authorization from the GHC Health Management Department. GHC will send written notification of approval or denial to you and the ordering Physician.
When do I need to get a prior authorization?	Event Authorization (authorization for a referral, service, or admission) is required for all admissions, selected outpatient services, and all out-of-network care. GHC will send written notification of approval or denial to you and the ordering Physician. For further information regarding Authorization Guidelines, please contact a Member Service Advocate at (715) 552-4300 or (888) 203-7770.
How do I get care when I am outside the service area?	**Emergency Care:** No referral is needed; however, GHC has the right to review for medical necessity. You can contact our FirstCare Nurseline listed on your ID card for help determining the appropriate level of care and locate the nearest facility. Follow up care must be received by an in-network provider. **Urgent Care:** No referral is needed; however, GHC has the right to review for medical necessity. You can contact the FirstCare Nurseline listed on your ID card for help determining the appropriate level of care and nearest facility. **All Other Care:** Prior to receiving out-of-network care you must obtain a referral event authorization from the GHC Health Management Department. (Refer to *When do I need to get a prior authorization?*)
How do I get mental/ behavioral health care?	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.
What are the dental benefits?	**Deductible:** $0 **Preventive Services:** 100% coverage for routine exams and cleanings (twice a year), fluoride treatments, routine x-rays and sealants. **Other Services:** None **Orthodontics:** 50% orthodontic coverage; limited to $600 per member per calendar year and $1,200 per member per lifetime. Coverage is limited to dependent children through age 18. **Annual Benefit Maximum:** None **Dental Network:** You must seek services at a GHC contracted provider. Please refer to the GHC Dental Provider Directory for a list of our participating dental providers. **Dental ID Cards:** Members should use their GHC ID card.

What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Go to www.group-health.com and click on 'Find a Provider' 1. Select the plan type 'Medical' or 'Dental' 2. Select 'Member Through Your Employer' 3. Select 'GHC Network' to view the directory of your choice • Contact a Member Services Advocate at (715) 552-4300 or (888) 203-7770.

County	Hospital(s)	Major Clinic(s)
Ashland	Memorial Medical Center	Ashland Clinic Chequamegon Clinic Ashland Mainstreet Clinic
Barron	Cumberland Memorial Hospital Lakeview Medical Center Luther Midelfort Northland MHS	Cumberland Medical Clinic Marshfield Clinic (Lake Country, Rice Lake Center) Luther Midelfort Northland MHS (Barron, Cameron, Chetek, Prairie Farm, Rice Lake) Turtle Lake Medical Clinic
Burnett	Burnett Medical Center	Burnett Medical Clinic
Chippewa	St. Joseph's Hospital Luther Midelfort Chippewa Valley MHS Our Lady of Victory Hospital	Family Health Associates Luther Midelfort Chippewa Valley MHS (Bloomer, Chippewa Falls) Victory Medical Group Stanley Center Marshfield Clinic (Chippewa, Cadott, Cornell)
Clark	Memorial Medical Center	Neillsville Memorial Medical Clinic Marshfield Clinic Thorp Center Victory Medical Group (Thorp, Owen-Withee)
Douglas	St. Mary's Hospital – Superior	Mariner Clinic, Superior Clinic
Dunn	Red Cedar Medical Center	Red Cedar Medical Center – MHS Luther Midelfort Chippewa Valley MHS Marshfield Clinic Menomonie Center
Eau Claire	Sacred Heart Hospital Luther Midelfort – MHS OakLeaf Surgical Hospital	Marshfield Clinic (Eau Claire, Oakwood, Riverview) Luther Midelfort MHS (Clairemont, Luther Campus) OakLeaf Pediatrics Eau Claire Family Medicine Clinic Eau Claire Medical Clinic Eau Claire Women's Care OB/GYN Clinic Pine Grove Family Practice Southside Medical Clinic Stenzel Clinic for Women's Health
Pepin	Chippewa Valley Hospital	Castleberg Clinic
Polk	Amery Regional Medical Center St. Croix Regional Medical Center	Amery Regional Medical Center St. Croix Regional Medical Center Clear Lake Clinic Frederic Clinic Luck Medical Clinic Unity Clinic
Rusk	Rusk County Memorial Hospital	Marshfield Clinic Ladysmith
Sawyer	Hayward Area Memorial Hospital	Hayward Clinic Marshfield Clinic Radisson Center Northwoods Community Health Center
St. Croix	Baldwin Area Medical Center	Baldwin Area Medical Clinic
Trempealeau	Luther Midelfort Oakridge MHS	Luther Midelfort Oakridge MHS Buffalo River Clinic Osseo Family Medicine Clinic
Washburn	Spooner Health System	Spooner Clinic, Shell Lake Clinic

Group Health Cooperative

Group Health Cooperative of South Central Wisconsin

P.O. Box 44971
1265 John Q. Hammons Drive
Madison, WI 53744-4971
(608) 828-4853 or (800) 605-4327
Fax (608) 662-4186
www.ghc-hmo.com

Managed Care Organization ★★★★ NCQA Accreditation EXCELLENT HMO

What's new for 2009?	Group Health Cooperative of South Central Wisconsin (GHC-SCW) will continue to offer preventive and diagnostic dental benefits in the 2009 contract year. **However, the prosthodontic, endodontic, and periodontic (PEP) benefits will no longer be available.** The GHC-SCW dental plan has no deductible and continues to use Dental Health Associates as the dental care provider.
Do I need to select a Primary Care Physician (PCP)?	Yes. All GHC-SCW members choose a personal PCP from amongst our high-quality group of medical professionals. 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 providers along with their professional qualifications. PCP changes are limited to once per month.
When do I need a referral?	Your Primary Care Provider will submit a referral to certified Case Managers in the GHC-SCW Care Management Department when you need to receive services outside of a GHC-SCW Clinic or through a specialty care area. Upon the receipt of the referral, 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 *When do I need to get a prior authorization?* section.
When do I need to get a prior authorization?	A Prior Authorization is needed when you need to receive services outside of a GHC-SCW Clinic or through a specialty care area. Upon approval of the referral request made by your PCP, the Care Management Department will mail you a written Prior Authorization letter, as well as place the document in your GHCMyChart online account. 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.

How do I get care when I am outside the service area?	**Emergency Care:** When outside of the Service Area, and medical care cannot be safely delayed until returning to the Service Area, treatment should be obtained from the nearest medical facility or by calling 911. Report Emergency Care and hospital admissions to GHC-SCW within 48 hours of receiving care. Call the GHC-SCW Care Management Department at (608) 257-5294 or (800) 605-4327, x4514. **Urgent Care:** If you require Urgent Care services outside of the Service Area, treatment for an Urgent Condition should be obtained from the nearest medical facility. GHC-SCW must be notified prior to receiving Out-of-Area Care for an Urgent Condition. Please call your Primary Care Clinic for instructions. Clinic phone lines are answered any time, day or night. **All Other Care:** Medically necessary out-of-area care may be covered with Prior Authorization from the GHC-SCW Care Management Department. Please refer to the *When do I need to get a prior authorization?* section..
How do I get mental/ behavioral health care?	When you need a mental health provider, you must contact a GHC-SCW staff Outpatient mental health provider by calling the mental health provider directly. Please refer to the GHC-SCW provider directory. A referral is not required for Outpatient mental health care. However, Prior Authorization is required for Inpatient and Transitional mental health care.
What are the dental benefits?	**Deductible:** None **Preventive Services:** GHC-SCW pays 100% on Exams; X-rays; Cleaning treatments twice per calendar year; Fluoride treatments twice per calendar year through age 15; Topical application of sealants through age 18; and Space maintenance for primary teeth (the first set of teeth). **Other Services:** GHC-SCW pays 100% on Restorative Services: Amalgam fillings; Composite fillings for anterior teeth; Stainless steel crowns for primary teeth; and simple and surgical extractions. ***NOTE:*** *Restorative dental services performed strictly for cosmetic purposes are excluded. Patient is responsible for cost difference between posterior composite and amalgam fillings.* **Orthodontics:** GHC-SCW pays 50% of the first $3,500 in billed charges (maximum payment by GHC-SCW of $1,750) for dependent children through age 18. **Annual Benefit Maximum:** None **Dental Network:** All dental services must be obtained from Dental Health Associates in Madison. **Dental ID Cards:** Please show your GHC-SCW ID card at Dental Health Associates.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing, please: • Contact GHC-SCW at (608) 828-4853 or (800) 605-4327 • Visit the GHC-SCW website at www.ghc-hmo.com and select the 'Provider Search' option to access a provider directory.

County	Hospital(s)	Major Clinic(s)
Dane	University of Wisconsin Hospital & Clinics (inpatient) St. Mary's Hospital Medical Center (maternity) Meriter Hospital (specific referrals) Stoughton Hospital (UW Health - Stoughton members only)	Group Health Cooperative Clinics: Capitol, DeForest, East, Hatchery Hill, Sauk Trails University of Wisconsin Department of Family Medicine Clinics (DFM): Belleville, Northeast, Verona, Wingra UW Health Clinics: Cottage Grove, Stoughton.

Gundersen Lutheran Health Plan

1836 South Avenue
La Crosse WI 54601
Phone (608)775-8007 (800)897-1923
Fax (608)775-8060
www.glhealthplan.org

What's new for 2009?	Our network of providers has been expanded to include providers in the Eau Claire area. See our online provider directory at www.glhealthplan.org for a complete listing of providers.
Do I need to select a Primary Care Physician (PCP)?	No. Members are not required to select a Primary Care Physician (PCP). However, Gundersen Lutheran Health Plan (GLHP) encourages members to see a PCP to coordinate all of their health care needs.
When do I need a referral?	A member may seek services from any GLHP network 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 an approved referral are subject to the exclusions and limitations of your benefits.
When do I need to get a prior authorization?	Selected medical procedures and services covered by GLHP require you to obtain prior written authorization, including but not limited to: oral surgery, TMJ services, diabetic insulin infusion pumps, durable medical equipment purchases over $750 and all rentals, transitional mental health services, home care and skilled nursing care. Your provider should submit a written prior authorization request to us for review. GLHP will respond in writing to you and your provider. Failure to obtain necessary prior authorization may result in a denial of coverage and as a result, the responsibility of payment may be yours. If you have questions about the prior authorization process, call the GLHP Customer Service department.
How do I get care when I am outside the service area?	**Emergency Care:** In case of an emergency medical condition, you should seek care from the nearest provider of health care equipped to handle your condition. If you are admitted to a non-plan hospital, please call us the next business day to notify us of the admission. If you require follow up care before being able to return to the service area, you must obtain prior authorization as described above for the follow-up care. **Urgent Care:** Urgent Care is care that you need sooner than a scheduled physician's visit, but is not an emergency. If you are outside of the GLHP service area and you require urgent care, go to the nearest facility that can provide treatment. You do not need to notify GLHP of an urgent care visit. If you are in the GLHP service area, treatment should be obtained by a plan provider; urgent care provided by a non-plan provider within the service area is not covered. **All Other Care:** Must be with a plan provider, unless there is an approved referral in-place as described above.
How do I get mental/ behavioral health care?	Referrals are not required for services received from a GLHP behavioral health provider. However, prior authorization is required for transitional treatment. To obtain prior authorization your participating provider should submit a written request to GLHP for review and approval before any recommended transitional treatment or services are obtained.
What are the dental benefits?	**Deductible:** No deductible. **Preventive Services:** No deductible, 100% coverage (two per calendar year). Examples of covered preventative services include, but are not limited to: initial or periodic oral examinations, prophylaxis, topical fluoride treatments (through age 18), dental sealants (through age 18) and bitewing x-rays.

	Other Services: Basic (Restorative Services) - No deductible, 80% coverage. Examples of covered basic services include, but are not limited to: bridgework, implants, dentures, partial dentures, crowns and root canal procedures. **Orthodontics:** No orthodontia coverage **Annual Benefit Maximum:** $500 per person per calendar year **Dental Network:** Dental services can be obtained from any dental provider and are not subject to a Usual and Customary fee schedule. **Dental ID Cards:** Use your regular medical GLHP ID card for dental services.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Go to www.glhealthplan.org. Select "Commercial" then "Provider Directory". On the next screen you can select how you would like to view the provider listing. Options are: Location, Facility, Specialty, Provider Type, Map or Index. • Call GLHP Customer Service at (800)897-1923 to request a provider directory.

County	Hospital(s)	Major Clinic(s)
Clark	Memorial Medical Center – Hospital	Memorial Medical Center – Greenwood, Loyal and Neillsville
Crawford	Prairie du Chien Memorial Hospital	Gundersen Lutheran Prairie du Chien Clinic Kickapoo Valley Medical Clinic
Eau Claire	Sacred Heart Hospital	Eau Claire Medical Clinic, S.C. Pine Grove Family Medicine - Stein Boulevard Southside Medical Clinic
Grant	Boscobel Area Health Care Grant Regional Health Center	Bluff Street Clinic Boscobel Clinic, S.C. Fennimore Family Medicine High Point Family Medicine, L.L.C. High Point Family Medicine, L.L.C. – Lancaster Muscoda Health Center Riverside Family Practice
Jackson	Black River Memorial Hospital	Krohn Clinic, Ltd.
Juneau	Hess Memorial Hospital, Inc	Elroy Family Medical Center Gundersen Lutheran Wonewoc Clinic Mile Bluff Clinic, L.L.P. Necedah Family Medical Center New Lisbon Clinic St. Joseph's Family Clinic – Elroy St. Joseph's Family Clinic – Wonewoc
La Crosse	Gundersen Lutheran Medical Center, Inc.	Gundersen Lutheran Gundersen Lutheran Onalaska Clinic
Monroe	Tomah Memorial Hospital	Gundersen Lutheran Sparta Clinic Gundersen Lutheran Tomah Clinic Scenic Bluffs Community Health Centers – Cashton Scenic Bluffs Community Health Centers – Norwalk
Richland	Richland Hospital	Richland Medical Center Viola Health and Osteoporosis Services Center, Ltd.
Trempealeau	Tri-County Memorial Hospital, Inc.	Gundersen Lutheran Blair Clinic Gundersen Lutheran Independence Clinic Gundersen Lutheran Whitehall Clinic
Vernon	St. Joseph's Community Health Services – Hospital Vernon Memorial Hospital	Bland Clinic Gundersen Lutheran Hillsboro Clinic Gundersen Lutheran Viroqua Clinic Hirsch Clinic La Farge Medical Clinic St. Joseph's Family Clinic – Hillsboro

Health Tradition

A Mayo Health System Choice in Wisconsin

Health Tradition Health Plan

P.O. Box 188
La Crosse, WI 54602-0188
(608) 781-9692 or toll-free (888) 459-3020
Customer Service - 1-877-832-1823
www.healthtradition.com

What's new for 2009?	Health Tradition has expanded our service area to include Eau Claire, Dunn, Chippewa, Barron and Pepin Counties. Please refer to our provider directory or the hospital/major clinic listing on the next page to see who is in our network.
Do I need to select a Primary Care Physician (PCP)?	Yes. All members of Health Tradition Health Plan (HTHP) are required to select a clinic location. You can find a list of available clinics by calling HTHP at 1 (877) 832-1823 or by visiting our website at: www.healthtradition.com. You can change your clinic location at any time by calling HTHP. If a clinic location is not selected, HTHP will assign one for you based on your address.
When do I need a referral?	A member may make a direct appointment with any provider in the HTHP network (primary care or specialist) without a referral. Members must obtain a written referral and receive the HTHP's authorization before visiting an out-of-network provider. All referrals to providers that are not in the HTHP network must be prior authorized by HTHP before those services are received in order to be considered for coverage. Your primary care providers will request a referral on your behalf. HTHP will notify you in writing of approvals or denials. *NOTE: Some in-network facilities use outreach specialists that are not in HTHP's network. You must obtain an approved referral from HTHP before seeking care with from the out-of-network outreach specialist.* Call HTHP Customer Service to determine if the provider is in HTHP's network. If it is determined that services cannot be provided at an in-network facility or provider, HTHP utilizes Mayo Clinic as its tertiary referral center.
When do I need to get a prior authorization?	Certain services requiring Prior Authorization include but are not limited to the following: • Ambulance services (non-emergency only) • Durable medical equipment/prosthesis/orthotics • Experimental/investigational services • Home healthcare and hospice services • Inpatient hospitalization • Out-of-area services • Skilled nursing facility care • Mental health - Transitional services, group therapy and psychiatric testing • Additional rehab service (PT, OT and speech) beyond the benefit limit Your HTHP provider will assist you with prior authorization. However, it is your responsibility to ensure prior authorization is obtained. Contact HTHP 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.
How do I get care when I am outside the service area?	**Emergency Care:** Emergency care is covered 24 hours a day, 7 days a week, no matter where you are or when it is needed. You must notify HTHP as soon as medically possible if you are admitted. Emergency care does not include any follow up elective care, unless it is from a provider in HTHP's network. **Urgent Care:** No prior authorization is required for Urgent Care services received out of network. Please note that all subsequent care requires a prior authorization if provided by an out-of-network provider. **All Other Care:** All non-emergent or non-urgent care services rendered by an out-of-network provider require prior authorization by HTHP. (See section above.)
How do I get mental/ behavioral health care?	You must obtain all mental health and substance abuse services from a provider in HTHP's network. Covered services from a provider in HTHP's network are covered at the levels described in your schedule of benefits. Prior authorization from HTHP is required for inpatient care, transitional services, group therapy and psychiatric testing. Your HTHP provider will assist you with obtaining prior authorization. If assistance is needed in selecting a provider in HTHP's network, please contact Customer Service at 1 (877) 832-1823.

What are the dental benefits?	**Deductible:** None **Preventive Services:** 100% coverage (subject to annual benefit maximum) for preventative services that include, but are not limited to: exams, cleanings, fluoride treatments, xrays and sealants. **Other Services:** 80% coverage (subject to annual benefit maximum) for other services that include, but are not limited to: fillings, crowns, and root canals **Orthodontics:** No coverage **Annual Benefit Maximum:** $500 per person per year **Dental Network:** You can see any dentist. However, you are not subject to usual and customary charges when you use the HTHP Preferred Dental Network. **Dental ID Cards:** Use your HTHP ID card for dental services.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: visit www.healthtradition.com or contact HTHP at 1-(877) 832-1823.

County	Hospital(s)	Major Clinic(s)
Barron	Luther Midelfort – Northland	Luther Midelfort - Northland (Barron) Luther Midelfort - Northland (Cameron) Luther Midelfort - Northland (Chetek) Luther Midelfort - Northland (Prairie Farm) Luther Midelfort - Northland (Rice Lake)
Chippewa	Luther Midelfort - Chippewa Valley	Luther Midelfort - Chippewa Valley (Bloomer) Luther Midelfort - Chippewa Valley (Chippewa Falls)
Crawford	Prairie du Chien Memorial Hospital	FSH - Prairie du Chien Clinic Kickapoo Valley Medical Clinic
Dunn	Red Cedar Medical Center	Luther Midelfort - Chippewa Valley (Colfax) Red Cedar Medical Center – Menomonie Red Cedar Medical Center – Elmwood Red Cedar Medical Center - Glenwood City
Eau Claire	Luther Hospital	Luther Midelfort - Eau Claire (2 locations)
Grant	Boscobel Area Health Care	Bluff Street Clinic Fennimore Family Medicine Muscoda Health Center Riverside Family Practice
Jackson	Black River 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 St. Joseph's Family Clinic - Elroy and Wonewoc
La Crosse	Franciscan Skemp Healthcare - La Crosse Medical Center	FSH - Holmen Clinic FSH - La Crosse Clinic FSH - Onalaska Clinic
Monroe	Franciscan Skemp Healthcare - Sparta Medical Center Tomah Memorial Hospital	FSH - Lake Tomah Clinic FSH - Sparta Clinic Scenic Bluffs Community Health Center
Richland	Reedsburg Area Medical Center Richland Hospital	Reedsburg Physicians Groups, S.C. Richland Medical Center
Trempealeau	Franciscan Skemp Healthcare – Arcadia Luther Midelfort – Oakridge	FSH - Arcadia Clinic FSH - Galesville Clinic Luther Midelfort - Oakridge (Mondovi) Luther Midelfort - Oakridge (Osseo)
Vernon	St. Joseph's Memorial Hospital Vernon Memorial Hospital	Bland Clinic Hirsch Clinic La Farge Medical Clinic St. Joseph's Clinic Viola Hlth Svcs Ctr & Osteoporosis Center, Ltd.

FSH – Franciscan Skemp Healthcare

Humana - Eastern Region
Premier HMO and POS

1-800-4HUMANA
www.humana.com
Group Medicare Enrollment: 1-866-396-8810
(TTY 1-800-833-3301)
Enrollment Hotline: 1-888-393-6765

What's new for 2009?	See the Humana handbook for more information about Health Coaches that are available at no cost to you for weight management and various other programs.
I have Medicare. How does Medicare Advantage Private Fee-For-Service (MA-PFFS) affect me?	If you are retired and enrolled in Medicare Parts A & B, Humana will automatically enroll you in its Humana administered Part A and B, known as Medicare Advantage Private Fee-For-Service (MA-PFFS). This may impact your provider selection so you will want to check with Humana to make sure you will be comfortable with these changes since there will not be another enrollment opportunity to switch plans until the next Dual-Choice. **While you will have access to providers nationally, you will need to assure they accept you as a MA-PFFS member.** Please call Humana at 1-866-396-8810 to request an enrollment kit and with any questions regarding MA-PFFS.
Do I need to select a Primary Care Physician (PCP)?	Yes, each family member must select a network PCP. If no selection is made, a PCP will be assigned based on your zip code. PCP selection may be changed at any time by calling customer service (1-800-4HUMANA); or online through MyHumana. For information on how to create or log into your MyHumana web page please see Humana's member handbook.
When do I need a referral?	A referral is not required to see most network specialists. Referrals are required for all Oral Surgery, Therapy (see handbook for list of therapies) and all requests for non-network provider services. You must have your PCP contact Humana at 1-800-626-2698 to request a referral. Written response is provided only when a referral has been denied; referral status can be obtained by logging into your MyHumana web page or calling 1-800-4HUMANA.
When do I need to get a prior authorization?	A prior authorization is required for all inpatient admissions and for durable medical equipment purchases. You must have your PCP or Specialist call Humana at 1-800-626-2698 before your admission or as soon as reasonably possible after an emergency admission. You may verify whether or not a prior authorization has been received by logging into your MyHumana web page or calling 1-800-4HUMANA.
How do I get care when I am outside the service area?	**Emergency Care:** Go to the nearest hospital for treatment. As soon as possible, notify your PCP and have him/her call Humana to receive a referral for care. **Urgent Care:** If you need urgent care, contact your PCP as soon as possible to have him/her call Humana to request a referral and coordinate care. **All Other Care:** All other care requires a referral. Your PCP will need to contact Humana to request a referral. (Please refer to the *When do I need a referral?* section above.) *You risk the chance of benefit denial if no call is made.*
How do I get mental/ behavioral health care?	Before seeking any mental/behavioral health services, you must call 1-877-948-6262 between 8:00 a.m. - 5:30 p.m. CST for assessment and access to care. You will be directed to an emergency line for after hours calls.
What are the dental benefits?	**Deductible:** $25 per individual; $75 per family **Preventive Services:** 100% reimbursement limit (no deductible). Services include oral exams (2 per year), X-rays, cleanings (2 per year), topical fluoride treatment and sealants (both through age 14). **Other Services:** Basic services: 50% reimbursement after deductible. Services include space maintainers (through age 14), emergency care, oral surgery (some oral surgery can be paid under medical for higher benefits, see the Humana handbook for more information) amalgam, routine extractions, periodontics and endodontics. **Orthodontics:** Paid at 50% (no deductible) of the maximum allowable fee up to a lifetime benefit of $1,200 for each dependent under age 18. **Annual Benefit Maximum:** No annual maximum. Lifetime orthodontic benefit limit. **Dental Network:** You can see any dentist. However, when you see a HumanaDental provider you may save up to 30% on out of pocket costs. Locate HumanaDental providers by accessing www.humana.com (see directions below). **Dental ID Cards:** You will receive a separate dental ID card with a Humana Specialty logo.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: Call 1-800-4HUMANA or go to www.humana.com and use the 'physician finder.' Instructions on using 'physician finder' can be found on the landing page at http://apps.humana.com/egroups/wisconsin/home.asp and the Western region description page.

County	Hospital(s)	Major Clinic(s)
Brown	Aurora BayCare Medical Center Bellin Memorial Hospital St Vincent Hospital St Mary's Hospital Medical Center	Aurora Medical Group BayCare Clinic LLP Bellin Medical Group Prevea Clinic
Dodge	Watertown Memorial Hospital Waupun Memorial Hospital	Aurora Medical Group Watertown PHO
Fond du Lac	St Agnes Hospital of Fond du Lac Ripon Medical Center	Agnesian Healthcare Aurora Medical Group
Green Lake	Berlin Memorial Hospital	Community Health Network
Jefferson	Fort Memorial Hospital	Fort Healthcare
Kenosha	Aurora Health Center Kenosha Children's Hospital of WI UHS: Kenosha Medical Ctr. & 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
Marinette	Bay Area Medical Center	Aurora Medical Group Baycare Clinic LLP NorthReach Healthcare LLC
Milwaukee	Aurora: Sinai Medical Center, St Luke's Medical Center, West Allis Memorial, Women's Pavillion Children's Hospital of WI Columbia St Mary's (Lake Dr & Newport Ave Froedtert Hospital Kindred Hospital Milwaukee Orthopaedic Hospital of WI Sacred Heart Rehabilitation Center St Francis Hospital St Joseph's Regional Medical St Luke's South Shore Hosp Wisconsin Heart Hospital Wheaton Franciscan Healthcare	Aurora Advanced Healthcare Aurora Medical Group Childrens Medical Group Columbia St Mary's Lakeshore Medical Clinic Medical College of WI Wheaton Franciscan Medical Group
Oconto	Bond Health Center Community Memorial Hospital	Bellin Medical Group North Shore Health Network Prevea Clinic
Outagamie	Appleton Medical Center	Aurora Medical Group Prevea Clinic ThedaCare Physicians
Ozaukee	St Mary's Hospital – Ozaukee Columbia Center LLC	Aurora Advanced Healthcare Columbia St Mary's
Racine	All Saints Medical Center (St Luke's and St Mary's) Memorial Hospital of Burlington	Wheaton Franciscan Medical Group Aurora Medical Group
Rock	Beloit Medical Center Mercy Hospital of Janesville	Beloit PHO
Shawano	Shawano Medical Center	ThedaCare Physicians Aurora Medical Group
Sheboygan	Sheboygan Memorial Hospital St Nicholas Hospital	Aurora Medical Group Physicians Health Network
Walworth	Aurora Lakeland Medical Center Mercy Walworth Medical Center	Aurora Lakeland Medical Center Fort Healthcare
Washington	Aurora Medical Center Wash. County St Joseph Regional Medical Center	Aurora Advanced Healthcare Aurora Medical Group Medical Associates Health Center West Bend Clinic
Waukesha	Community Memorial of Menomonee Falls Elmbrook Memorial Hospital Waukesha Memorial Hospital Oconomowoc Memorial Hospital	Aurora Advanced Healthcare Aurora Medical Group Lakeshore Medical Clinic Medical Associates Health Center
Waupaca	New London Family Medical Center Riverside Medical Center	Aurora Medical Group ThedaCare Physicians
Waushara	Wild Rose Community Memorial Hospital	Aurora Medical Group Community Health Network
Winnebago	Aurora Medical Center – Oshkosh Children's Hospital of WI Theda Clark Medical Center	Aurora Medical Group ThedaCare Physicians

HUMANA
Guidance when you need it most

Humana - Western Region
Premier HMO and POS

1-800-4HUMANA
www.humana.com
Group Medicare Enrollment: 1-866-396-8810
(TTY 1-800-833-3301)
Enrollment Hotline: 1-888-393-6765

HEALTH PLAN NCQA ACCREDITATION EXCELLENT

What's new for 2009?	• HealthPartners SPECIALISTS have been added to the Premier HMO and POS network. • Please review changes to referral and prior authorization processes below. • See Humana's handbook for more information the following services that are available at no cost to you: - Health Coaches for weight management, smoking cessation, back care, nutrition and stress management. - Telephonic Employee Assistance Program (EAP) services
I have Medicare. How does Medicare Advantage Private Fee-For-Service (MA-PFFS) affect me?	If you are retired and enrolled in Medicare Parts A & B, Humana will automatically enroll you in its Humana administered Part A and B, known as Medicare Advantage Private Fee-For-Service (MA-PFFS). This may impact your provider selection so you will want to check with Humana to make sure you will be comfortable with these changes since there will not be another enrollment opportunity to switch plans until the next Dual-Choice. **While you will have access to providers nationally, you will need to assure they accept you as a MA-PFFS member.** Please call Humana at 1-866-396-8810 to request an enrollment kit and with any questions regarding MA-PFFS.
Do I need to select a Primary Care Physician (PCP)?	Yes, each family member must select a network PCP. If no selection is made, you will be assigned a Wisconsin based PCP based on your zip code. PCP selection may be changed at any time by calling customer service (1-800-4HUMANA); or online through MyHumana. For information on how to create or log into your MyHumana web page, please see Humana's member handbook.
When do I need a referral?	A referral is not required to see most Premier HMO and POS network specialists. Referrals are required for all Oral Surgery, Therapy (see handbook for list of therapies), and all requests for non-network provider services. You must have your PCP contact Humana at 1-800-626-2698 to request a referral. Written response is provided only when a referral has been denied; referral status can be obtained by logging into your MyHumana web page or calling 1-800-4HUMANA.
When do I need to get a prior authorization?	A prior authorization is required for all inpatient admissions and for durable medical equipment purchases. You must have your PCP or Specialist call Humana at 1-800-626-2698 before your admission or as soon as reasonably possible after an emergency admission. You may verify whether or not a prior authorization has been received by logging into your MyHumana web page or calling 1-800-4HUMANA.
How do I get care when I am outside the service area?	**Emergency Care:** Go to the nearest hospital for treatment. As soon as possible, notify your PCP and have him/her call Humana to receive a referral for care. **Urgent Care:** If you need urgent care, contact your PCP as soon as possible to have him/her call Humana to request a referral and coordinate care. **All Other Care:** All other care requires a referral. Your PCP will need to contact Humana to request a referral. (Please refer to *When do I need a referral?*) *You risk the chance of benefit denial if no call is made.*
How do I get mental/ behavioral health care?	Before seeking any mental/behavioral health services, you must call 1-877-948-6262 between 8:00 a.m. - 5:30 p.m. CST for assessment and access to care. You will be directed to an emergency line for after hours calls.

What are the dental benefits?	**Deductible:** $25 per individual; $75 per family **Preventive Services:** 100% reimbursement limit (no deductible). Services include oral exams (2 per year), X-rays, cleanings (2 per year), topical fluoride treatment and sealants (both through age 14). **Other Services:** Basic services: 50% reimbursement after deductible. Services include space maintainers (through age 14), emergency care, oral surgery (some oral surgery can be paid under medical for higher benefits, see the Humana handbook for more information) amalgam, routine extractions, periodontics and endodontics. **Orthodontics:** Paid at 50% (no deductible) of the maximum allowable fee up to a lifetime benefit of $1,200 for each dependent under age 18. **Annual Benefit Maximum:** No annual maximum. Lifetime orthodontic limit. **Dental Network:** You can see any dentist. However, when you see a HumanaDental provider you may save up to 30% on out of pocket costs. Locate HumanaDental providers by accessing www.humana.com (see directions below). **Dental ID Cards:** You will receive a separate dental ID card with a Humana Specialty logo.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Call 1-800-4Humana; or • Go to www.humana.com and use the 'physician finder' by clicking on 'Members' and selecting the type of provider under 'Provider Search'. Enter your zip code and select the 'Premier HMO & POS' network for medical services or the 'PPO/Traditional Preferred' network for dental services. (Instructions on using the 'physician finder' can also be found on the landing page at http://apps.humana.com/egroups/wisconsin/home.asp.)

County	Hospital(s)	Major Clinic(s)
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 Center
Douglas	St Mary's Hospital Superior	SMDC-Superior
Dunn		Marshfield Clinic
Eau Claire	OakLeaf Surgical Hospital Sacred Heart Hospital	Eau Claire Medical Clinic Eau Claire Women's Care Marshfield Clinic Oakleaf Pediatrics Pine Grove Family Practice Assoc. Southside Medical Clinic
Pepin	Chippewa Valley Hospital	Castleberg Clinic
Pierce	River Falls Area Hospital	Ellsworth Medical Clinic River Falls Medical Clinic Spring Valley Medical Clinic
Polk	Amery Regional Medical Center Osceola Medical Center St Croix Regional Medical Center	Frederic Regional Medical Clinic St Croix Regional Medical Center Unity Clinic
St Croix	Baldwin Medical Center Hudson Hospital Westfields Hospital	Hudson Physicians New Richmond Clinic
St Paul, MN		HealthPartners - **SPECIALISTS**
Duluth, MN		SMDC - Duluth

Medical Associates Health Plans

P.O. Box 5002
1605 Associates Drive, Suite 101
Dubuque, IA 52004-5002
563-556-8070 or 800-747-8900
www.mahealthcare.com

What's new for 2009?	Medical Associates Health Plans (MAHP) has expanded the dental benefit for the 2009 plan year, offering additional benefits for basic restorative dental services and preventative dental care and continuing to offer an open access dental provider network.
Do I need to select a Primary Care Physician (PCP)?	No, you are not required to select a Primary Care Physician.
When do I need a referral?	MAHP is an open access HMO. Members are able to seek the services from any MAHP participating Specialist without a referral from their PCP for covered services. Services received from a Non-MAHP provider must have prior authorization. Please see below.
When do I need to get a prior authorization?	When services are obtained from a Non-MAHP Provider, 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 participating provider, 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 prior authorization request before receiving services.
How do I get care when I am outside the service area?	**Emergency Care:** Emergency care is available in and outside of the MAHP service area. Prior to receiving emergency care services, or as soon as reasonably possible, please contact the MAHP Health Care Services Dept. at 1-800-325-7442; they are available 24/7. This toll free number is also found on the back of your Medical Member ID card. **Urgent Care:** Urgent care is available in and outside of the MAHP service area. Prior to receiving urgent care services, outside of the MAHP service area, please contact the MAHP Health Care Services Dept. at 1-800-325-7442, they are available 24/7. This toll free number is also found on the back of your Member ID card. **All Other Care:** Only urgent and emergent care are covered outside of the MAHP services area. All routine and preventative care should be obtained by a participating physician or with a prior authorization from the MAHP Medical Director, as explained above.
How do I get mental/ behavioral health care?	Mental/behavioral health services must be provided by MAHP participating physicians and providers. No referral or prior authorization is required.
What are the dental benefits?	**Deductible:** None **Preventive Services:** Exams-100% covered, 2 per calendar year Bitewing x-ray-100% covered, 1 per calendar year Full mouth x-ray-100% covered in any 3 year period Cleanings-100% covered, 2 per calendar year Fluoride-100% covered, 2 per calendar year, under age19 Other Services:Sealants-100% covered (under age 14) **Other Services:** Restorative amalgams (silver) -80% covered, up to annual $1,000 max. Restorative compositions (tooth colored-front teeth only)-80% covered, up to annual $1,000 max **Orthodontics:** 50% covered, up to $1,500 lifetime maximum for children, up to 19 years of age.

	Annual Benefit Maximum: $1,000 per member **Dental Participating Providers:** The dental network is open access to your dental provider of choice and are not subject to a Usual and Customary fee schedule. **Dental ID Cards:** You will need to present your MAHP medical ID card. A separate dental card will not be generated.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in the MAHP participating provider network that you are able to access for 2009. For a complete listing: • Visit our web site at www.mahealthcare.com, or • Contact our office at 800-747-8900 to request a provider listing.

County	Hospital(s)	Major Clinic(s)
Crawford	Prairie du Chien Memorial Hospital	Prairie Medicine
Grant	Boscobel Area Health Care Grant Regional Health Center Southwest Health Center	Associates Hearing & Balance Clinic (Audiologist) Boscobel Clinic Bluff Street Clinic Family Resource Center-Platteville (Behavioral Health) High Point Family Medicine, LLC 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	Upland Hills Health	Dodgeville Clinic Dr. McKenzie Optometry Office Mineral Point Medical Center
Lafayette	Memorial Hospital of Lafayette Co.	Argyle Clinic Eye Care Centre, Ltd. Family Resource Center-Darlington (Behavioral Health) Medical Associates Family Practice Clinic-Darlington Memorial Hospital of Lafayette County-Outpatient Clinic Shullsburg Clinic
Dubuque, IA	Finley Hospital Mercy Medical Center	Medical Associates Clinic, PC-East & West Campus & all Medical Associates Clinics and Satellites Women's Wellness Center
Out-of-State Providers	Available in IL & IA	See a MAHP Provider Directory or visit our web site for complete listing of participating providers • www.mahealthcare.com • 1- 800-747-8900

MERCYCARE HEALTH PLANS
MERCYCARE INSURANCE COMPANY
MERCYCARE HMO, INC.
P.O. BOX 2770, JANESVILLE, WI 53547-2770

MercyCare Health Plans
3430 Palmer Drive
P.O. Box 2770
Janesville, WI 53547-2770
608-752-3431 or 800-752-3431
Customer Service 800-895-2421
FAX 608-752-3751
www.mercycarehealthplans.com

What's new for 2009?	• No significant network changes for 2009 • Online Health Risk Assessment (HRA) available on our web site at www.mercycarehealthplans.com. Go to 'For Members', then 'Health Education', and then 'Health Risk Assessment'.
Do I need to select a Primary Care Physician (PCP)?	Yes, 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 800-895-2421.
When do I need a referral?	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 with 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 the *When do I need to get a prior authorization?* section.)
When do I need to get a prior authorization?	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 participation 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 from your PCP and prior authorization 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 800-895-2421. MercyCare will notify you in writing whether your prior authorization is approved or denied.
How do I get care when I am outside the service area?	**Emergency Care:** If you require emergency care, you should seek care from the nearest physician, hospital or clinic. Call Customer Service at 800-895-2421 for all emergency or out-of-state inpatient admissions within 48 hours or as soon as reasonably possible. **Urgent Care:** If you require urgent care and you are outside the service area and cannot return home without medical harm, you should seek care by the nearest physician, hospital or clinic. **All Other Care:** No coverage for out-of-area non-emergency or non-urgent care unless you have obtained prior authorization from MercyCare. (Please see the *When do I need to get a prior authorization?* section above.)
How do I get mental/ behavioral health care?	All mental health and substance abuse services must be provided by a participating provider. Outpatient visits do not require prior authorization. Inpatient and transitional care do require prior authorization. If you need assistance in selecting a participating provider, please contact Customer Service at 800-895-2421.

What are the dental benefits?	**Deductible:** $25 Individual/$75 Family on Basic Restorative Services, Endodontics and Periodontics **Preventive Services:** *100% Coverage - No Deductible Applies* Examinations at 6 month intervals, teeth cleaning (prophylaxis), sealants to age 14, bitewing and full mouth x-rays, fluoride treatments, space maintainers (limited to one check-up every 6 months) **Other Services:** *Basic Restorative – 80% Coverage, Subject to Deductible* Amalgam (Silver) restoration on back teeth, simple extractions, composite restoration (white) fillings on front teeth, local anesthetics, emergency treatment to relieve pain *Endodontics & Periodontics –50% Coverage, Subject to Deductible* Root canal fillings, gum disease treatment **Orthodontics:** 50% coverage up to a lifetime maximum of $1,500 - includes coverage for orthodontic treatment in progression. Orthodontics coverage for dependents to age 19 - includes appliances and treatment, related services to include examinations, x-rays, extractions, photographs, study models **Annual Benefit Maximum:** $1,000 Annual Maximum **Dental Network:** Delta Dental Preferred Option or Premier Providers - visit Delta Dental's web site at www.deltadentalwi.com and click on 'Dentist Search' under 'Looking for a Dentist?' **Dental ID Cards:** Members will receive a separate ID card from Delta Dental.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Call Customer Service at 800-895-2421 • Visit 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**

County	Hospital(s)	Major Clinic(s)
Green		Brodhead Chiropractic Center Mercy Brodhead Medical Clinic
Jefferson	Ft. Atkinson Memorial Hospital Watertown Memorial Hospital	Fort HealthCare Clinics Fort HealthCare Internal Meds/Peds UW Health Fort Atkinson Watertown Area Health Services Clinics Watertown Chiropractic
Rock	Edgerton Memorial Hospital Mercy Hospital	Mercy Health System Clinics
Walworth	Lakeland Hospital - if admitted by a Mercy Physician	Mercy Health System Clinics

Network Health Plan

1570 Midway Place
Menasha, WI 54952
920-720-1200, 800-826-0940
www.networkhealth.com

What's new for 2009?	• Network Health Plan (NHP) will no longer require a referral to see an in-network specialist. • The Community Memorial Hospital and their affiliated providers in Oconto Falls have been added to the network for 2009.
Do I need to select a Primary Care Physician (PCP)?	• Yes, all members of 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 change your PCP at anytime by calling NHP's Customer Service with no restrictions on how often you can change your PCP. • NHP will automatically assign a PCP if one is not chosen.
When do I need a referral?	• A referral is not required to see participating in-network specialists. • If care is needed from a non-network specialist, prior authorization must be obtained from NHP. Please refer to the prior authorization section below.
When do I need to get a prior authorization?	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. Some health services will not be covered without prior written authorization from NHP's Health Management Department. Inpatient hospitalization, out-of-plan services or care at tertiary facilities are a few examples of health services that require prior authorization. A member should contact his or her PCP or NHP Customer Service 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.
How do I get care when I am outside the service area?	**Emergency Care:** NHP will cover emergency services furnished by a non-participating provider only if provided in an emergency room facility. NHP will cover such services only when, due to the member's location when care became necessary, an in-network provider or practitioner could not practically furnish the care. All follow-up care must be coordinated with member's PCP. You must notify NHP within 48 hours if admitted or if you are at a non-network facility. **Urgent Care:** NHP will cover urgent care only when furnished by a hospital-based urgent care facility. NHP will cover such services only when, due to the members location when care became necessary, an in-network provider or practitioner could not practically furnish the care. All follow-up care must be coordinated with member's PCP. You must notify NHP within 48 hours if admitted or if you are at a non-network facility. **All Other Care:** Must be done with in-network providers or practitioners unless otherwise authorized by NHP.

How do I get mental/ behavioral health care?	All mental health and substance abuse services must be provided by a in-network provider. Please refer to the provider directory for a listing of our in-network providers. Prior authorization is required for inpatient services, psychological and neuropsychological testing, psychotherapy visits beyond 6 visits, substance abuse treatment and mental health and substance abuse transitional care. If you need assistance please contact NHP's Care Management Behavioral Health Department at 800-555-3616.
What are the dental benefits?	**Deductible:** Individual $25, Family $75 **Preventive Services:** Covered at 100%, not subject to the deductible Exams, Cleanings, FluorideTreatments, X-rays, and Space Maintainers. **Other Services:** Covered at 80%, subject to the deductible Sealants, Emergency treatment to relieve pain, and Fillings. **Orthodontics:** Covered at 50%, subject to the deductible * Individual lifetime maximum $1500.00 * Adult orthodontics - No **Annual Benefit Maximum:** Individual annual maximum $1000.00 **Dental Network:** Members can see a Delta Dental PPO dentist, a Delta Dental Premier dentist, or an out of network dentist. Your lowest out-of-pocket costs will come from seeing a Delta Dental PPO dentist. You can obtain dentist information at www.deltadentalwi.com and clicking on 'Dentist Search', or by calling Delta Dental at 800-236-3712. **Dental ID Cards:** You will receive a dental card from Delta Dental.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Go to www.networkhealth.com, Click on Find a Doctor, Click on **State of Wisconsin Fox Valley Network Provider Directory** • Call Customer Service at 800-826-0940

County	Hospital(s)	Major Clinic(s)
Brown	St. Mary's Hospital Medical Center St. Vincent Hospital	Dousman Clinic SC Prevea Clinic
Calumet	Calumet Medical Center	Affinity Medical Group
Dodge	Waupun Memorial Hospital	Fond du Lac Regional Clinic
Door	Door County Memorial Hospital Ministry Health Care	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	Community Health Network
Kewaunee		North Shore Medical Clinic
Manitowoc	Holy Family Memorial Medical Center	Lakeshore Family Medicine Woodland Clinic
Oconto	Community Memorial Hospital	Community Memorial Hospital
Outagamie	St. Elizabeth Hospital	Affinity Medical Group Kaukauna Clinic SC Primary Care Associates of Appleton UW Health Fox Valley Family Practice
Sheboygan	St. Nicholas Hospital	Marsho Family Medicine Group SC Sheboygan Internal Medicine
Waupaca	Riverside Medical Center New London Family Medical Center	Affinity Medical Group Ministry Medical Group
Waushara	Wild Rose Community Memorial Hospital	CHN Medical Center Waushara Family Physicians
Winnebago	Mercy Medical Center	Affinity Medical Group

Physicians Plus – Meriter & UW Health

PO Box 2078
Madison, WI 53701-2078
(608) 282-8900 or (800) 545-5015
www.HealthyChoicesBigRewards.com

What's new for 2009?	GO-TO Healthy Choices and its online heath risk assessment is still available for creating your own, customized healthy lifestyle plan.
Do I need to select a Primary Care Physician (PCP)?	• Yes. Members must choose a PCP from the network of family & internal medicine doctors, pediatricians and obstetricians/gynecologists listed in our provider directory. • Family members can select different PCPs. • A PCP will be selected automatically for any member not choosing their own. • Members can change their PCP any time by using GO-TO, our online plan management tool, or by calling Member Service.
When do I need a referral?	• No written referrals are required when receiving medically necessary care from network specialists, listed under "Specialty Care Providers" in our provider directory. • Members must have their PCP submit a written referral to Physicians Plus before receiving care from a provider outside our network. Physicians Plus reviews these referrals and notifies members in writing of approval or denial.
When do I need to get a prior authorization?	• For certain inpatient services, cardiac rehabilitation, durable medical equipment and more, members must request that their PCP submit a prior authorization request to Physicians Plus. • Physicians Plus notifies members of prior authorization approval or denial in writing.
How do I get care when I am outside the service area?	**Emergency Care:** Call 911 or go to the nearest emergency room (ER) immediately. Please notify Physicians Plus within 48 hours at (608) 282-8900 or (800) 545-5015. **Urgent Care:** Call your PCP or our NursePlus (866-PPLUSRN) information line before seeking care and follow their instructions. **All Other Care:** All other care, including follow-up care after an ER visit, must be provided by Physicians Plus network doctors for coverage. Please call Member Service with any questions.
How do I get mental/ behavioral health care?	Contact UWMF Behavioral Health Consultation System during business hours at (608) 282-8960 or (800) 683-2300 for prior authorization. A mental health provider will assess your situation and refer you to the appropriate provider. For emergencies, contact your therapist, Meriter hospital or any Physicians Plus network emergency room.
What are the dental benefits?	**Deductible:** None **Preventive Services:** 100% coverage for cleanings (two/calendar year), diagnostic, preventive and specific restorative procedures. **Other Services:** Non-preventive services, including but not limited to crowns and bridges, are covered at 50% up to $100 per member per calendar year. **Orthodontics:** 50% of the first $3,000 in services; treatment must be complete before member turns 19. Extractions of primary teeth for orthodontic purposes covered at 50%. **Annual Benefit Maximum:** None. **Dental Network:** A complete list of network dental providers is available in our provider directory. **Dental ID Cards:** Use your Physicians Plus Member ID card to receive benefits.

What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Visit www.HealthyChoicesBigRewards.com and click "Find A Provider." • Request a printed directory by contacting Member Service at ppicinfo@pplusic.com, (608) 282-8900 or (800) 545-5015.

County	Hospital(s)	Major Clinic(s)
Adams	Moundview Memorial Hospital & Clinics	Moundview Clinic Roche-A-Cri Clinic Wisconsin Heart UW Health Outreach Specialists
Columbia	Columbus Community Hospital Divine Savior Hospital	UW Health-Columbus & Portage Poser Clinic Divine Savior Clinics Portage Clinic Wisconsin Dells Clinic Wisconsin Heart UW Health Outreach Specialists
Dane	Meriter Hospital UW Hospital & Clinics UW Health-American Family Children's Hospital Stoughton Hospital	Meriter Medical Clinics UW Health Clinics Associated Physicians Melius, Schurr & Cardwell Wisconsin Heart Wildwood Family Clinic
Grant	Boscobel Area Health Care Grant Regional Health Center	Boscobel Clinic Bluff Street Clinic Grant Regional Family Practice Family Medical Center Muscoda Health Center Riverside Family Practice
Green Lake	Berlin Memorial Hospital	CHN Medical Centers
Iowa	Upland Hills Health	Dodgeville & Mineral Point Medical Cntrs Family Practice Associates Wisconsin Heart
Lafayette	Memorial Hospital of Lafayette County	Medical Associates Family Practice Wisconsin Heart
Marquette		CHN Medical Center Montello UW Health Crossroads Clinic
Richland	Richland Hospital	Richland Medical Center Wisconsin Heart UW Health Outreach Specialists
Rock	Edgerton Hospital	Edgerton Clinic Betts Family Medical Clinic Wisconsin Heart
Sauk	St. Clare Hospital - Baraboo Sauk Prairie Memorial Hospital & Clinics	Baraboo Internal Medicine Medical Associates Sauk Prairie Memorial Hospital Clinics Prairie Clinic Wisconsin Heart Spring Green Medical Center River Valley Medical Center UW Health Outreach Specialists
Waushara	Wild Rose Community Mem. Hosp.	Waushara Family Physicians

Security Health Plan of Wisconsin, Inc.

1515 Saint Joseph Avenue, P.O. Box 8000
Marshfield, WI 54449
1-800-472-2363 (715)221-9555
www.securityhealth.org/state

What's new for 2009?	One-on-one personalized support through our Nurse Navigator program to help you "navigate" through the health care system. Health risk assessments available.
Do I need to select a Primary Care Physician (PCP)?	No, you are not required to select a PCP. You may receive services from any Security Health Plan (SHP) network provider listed in the Provider Directory, but are encouraged to establish a relationship with a PCP.
When do I need a referral?	As a member of SHP, you are free to see any provider in our network without a referral. **However, prior to seeing a non-affiliated provider, you or your provider must submit a referral request 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.
When do I need to get a prior authorization?	To ensure that services are covered, SHP recommends that you or your provider request prior authorization. Examples of services that require prior authorization are: services that may be considered cosmetic or otherwise not medically necessary or services from providers not affiliated with SHP. SHP will notify the person requesting the authorization (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 us.
How do I get care when I am outside the service area?	**Emergency Care:** Should you be unable to reach an affiliated provider, go to the nearest appropriate medical facility. If you go to a non-affiliated provider for care, you must notify SHP at 1-800-472-2363 of where you received emergency care by the next business day or as soon as possible. **Urgent Care:** If you need urgent care and cannot safely postpone the care until you return to the service area, benefits are payable for services received at the nearest appropriate medical facility. You must notify SHP by the next business day or as soon as reasonably possible to ensure appropriate claim payment. **All Other Care:** Care provided by a non-affiliated provider will not be covered unless prior authorized by a Security Health Plan medical director (see above).
How do I get mental/ behavioral health care?	You may see any affiliated provider for mental/behavioral health care. You do not need a referral or authorization when seeing any provider in our network. For assistance in identifying a specific provider, please review your Provider Directory, contact our Customer Service Department or go online at www.securityhealth.org.
What are the dental benefits?	**Deductible:** There is no individual/family deductible **Preventive Services:** 100% coverage. *Preventive services per member:* Exams & cleanings (2/calendar yr.), X-rays (with frequency limits). *Preventive Services per dependent child under age 19:* Sealants, Fluoride (1/calendar yr.), & Space maintainers (for non-orthodontic treatment) **Other Services:** None **Orthodontics:** 50% up to $1,200 lifetime limit for children under age 19. **Annual Benefit Maximum:** None **Dental Network:** For a listing of network providers, visit www.securityhealth.org/state and click on "Provider Directory". For orthodontic care, members can see a provider of their choice. **Dental ID Cards:** Members need to use their SHP ID cards for their dental benefit.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: Contact Customer Service at 1-800-472-2363 or visit www.securityhealth.org/state and click on "Provider Directory".

County	Hospital(s)	Major Clinic(s)
Adams	Moundview Memorial Hospital	Delton Family Medical Center Moundview Clinic Roche A Cri Clinic SC

Ashland	Memorial Medical Center	Duluth Clinic-Ashland Main Street Clinic 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 Family Health Associates Marshfield Clinic Center
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	Family and Children's Center Krohn Clinic
Juneau	Hess Memorial Hospital	Elroy Family Medical Center Mile Bluff Clinic Necedah Family Medical Center New Lisbon Clinic
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 Clinic
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	Aspirus Clinics Child Health Care Center Marshfield Clinic Center Ministry Medical Group Clinics
Pepin	Chippewa Valley Hospital	Castleberg Clinic SC
Portage	St. Michael's Hospital	Aspirus Clinics Juan B. Lopez M.D. Ministry Medical Group Clinics
Price	Flambeau Hospital Inc.	Marshfield Clinic Centers Memorial Health Center Clinic
Rusk	Rusk County Memorial Hospital	Marshfield Clinic Center
Sawyer	Hayward Area Memorial Hospital	Duluth Clinic-Hayward North Woods Community Health Care Stone Lake Medical Clinic
Taylor	Memorial Health Center	Memorial Health Center Clinics
Vilas	Eagle River Memorial Hospital	Aspirus Clinics Marshfield Clinic Center Ministry Medical Group
Washburn	Indianhead Medical Center	Duluth Clinic-Spooner North Woods Community Health Center
Waupaca	Riverside Medical Center Spooner Health System	Ministry Medical Group Clinics Robert L. Peterson, M.D., S.C. Thedacare Physicians
Waushara	Wild Rose Community Memorial	Community Health Network Clinics Family Health Medical and Dental Center Waushara Family Physicians
Wood	Riverview Hospital St. Joseph's Hospital	Aspirus Clinic Marshfield Clinic Centers Riverview Family Clinic

State Maintenance Plan

1717 West Broadway, PO Box 8190
Madison WI 53708-8190
1-800-634-6448
www.wpsic.com/state

What's new for 2009?	• In **Pepin County**, *Chippewa Valley Hospital* will be in-network. • **SMP** is **no longer available in Burnett County.** Subscribers using providers in this county must consider selecting another plan or will be limited to the SMP providers remaining in other areas. • **SMP will be newly available in Crawford and Pierce Counties.** Note this network change includes providers in counties bordering Wisconsin, for example in **Dakota, Hennepin, Ramsey and Washington Counties for MN and Dickinson, Gogebic and Iron Counties for MI** in order to support the network for SMP counties.
Do I need to select a Primary Care Physician (PCP)?	**No**, selection of a PCP is not required. You may use any provider who is an in-network provider with the WPS State Maintenance Plan (SMP) Network.
When do I need a referral?	You **must** get a referral approved by WPS before getting care outside the WPS SMP network. This includes behavioral health care **(see below)**. *Your provider must request the referral*. WPS will review the request and notify you and the requesting provider in writing of its decision. Retroactive referrals **are not** allowed. You should not utilize an out-of-network provider until the request for referral has been reviewed and approved by WPS. It is ultimately the member's responsibility to make sure the referral is submitted and approved prior to receiving services.
When do I need to get a prior authorization?	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 • Organ transplants • Durable medical equipment over $500 • Pain management injections 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.
How do I get care when I am outside the service area?	**Emergency Care:** In-network hospital emergency rooms should be used whenever possible. Should you be unable to reach an in-network provider, go to the nearest appropriate medical facility. If you must go to an out-of-network provider, contact WPS Member Services by the next business day, or as soon as reasonably possible, and report where you received the emergency care. Non-urgent follow-up care must be received from an in-network provider. Out-of-network emergency care may be subject to Usual and Customary Charges. **Urgent Care:** Urgent Care **is not** Emergency Care. If you cannot safely postpone the care until you are able to return to the service area, go to the nearest appropriate medical facility. Contact WPS Member Services by the next business day and report where you received the urgent care. Non-urgent follow-up care must be received from an in-network provider. Out-of-network Urgent Care may be subject to Usual and Customary Charges. **All Other Care:** You **must** get a referral approved by WPS before getting care outside the WPS SMP network. See *When do I need a referral?* above.

How do I get mental/ behavioral health care?	Benefits are available for services received by any in-network provider without a referral. Services provided by an out-of-network provider are payable at the in-network benefit level with a WPS approved referral from an in-network physician. See above *When do I need a referral?* When seeking services from a behavioral health provider, *WPS will request a treatment plan after 8 combined visits and monitor for medical necessity*.
What are the dental benefits?	No routine dental coverage provided.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Please visit our web site at ***www.wpsic.com/state*** and click on the ***Find a Doctor*** tab along the top of the page. Then select ***State Maintenance Plan (SMP) Network*** from the left of the page. • Call WPS Member Services Department at **1-800-634-6448**.

County	Hospital(s)	Major Clinic(s)
Bayfield	Memorial Medical Center	Duluth Clinic-Ashland Chequamegon Clinic Mainstreet Clinic Red Cliff Health Center
Buffalo		Midelfort Clinic – Mondovi
Crawford	Prairie Du Chien Hospital	Franciscan Skemp-Prairie Du Chien
Dakota **	Fairview Ridges Hospital Regina Medical Center	Allina Clinics Fairview Clinics Park Nicollet Clinics
Florence	Dickinson Memorial Hospital	Florence Medical Center - Dickinson
Forest	Dickinson Memorial Hospital	Crandon Medical Group - Ministry Health Care
Hennepin **	Abbott NW Hospital Children's Health Care-Minneapolis Fairview Southdale Hospital Hennepin County Medical Center North Memorial Medical Hospital Phillips Eye Institute Park Nicollet Methodist Hospital University of Minnesota Medical Center-Fairview	Allina Clinics Aspen Medical Group Clinics Children's Medical Clinics Fairview Clinics Health Partners Clinics Park Nicollet Clinics
Iron	Grandview Hospital	Grandview Clinic – Hurley Marshfield Clinic - Mercer Center
Marquette	Berlin Memorial Hospital Moundview Memorial Hospital	CHN Medical Center Montello Family Practice UW Health CrossRoads Westfield Family Medical Center
Menominee		
Pierce	River Falls Area Hospital-River Falls	River Falls Medical Clinics: Ellsworth, River Falls and Spring Valley
Pepin	Chippewa Valley Hospital-Durand	Castleburg Clinic-Durand
Ramsey **	Children's Health Care-St. Paul Gillette Children's Hospital Health East Bethesda Hospital Health East St John's Hospital Health East St Joseph's Hospital Mercy Hospital of Devil's Lake Regions Hospital United Hospital	Allina Clinics Aspen Medical Group Clinics Children's Medical Clinics Fairview Clinics Health East Clinics Health Partners Clinics
Washington **	Lakeview Hospital Woodwinds Health Campus	Allina Clinics Health East Clinics Health Partners Clinic

**** Minnesota County**

UnitedHealthcare of Wisconsin Northeast

Phone: (800) 357-0974
Fax: (920) 662-8349
For questions during Dual Choice, please call the Enrollment Hotline toll free at (866) 873-3903

What's new for 2009?	The following hospitals were added to our network in 2008. • St. Nicholas Hospital • St. Vincent Hospital • St. Mary's Hospital
Do I need to select a Primary Care Physician (PCP)?	No, you do not need to select a Primary Care Physician (PCP). However, for plan benefits to apply, you will need to select from our broad network of physician, hospitals and other health plan professionals for necessary services.
When do I need a referral?	If a specific covered health service is not available from a network physician/ hospital, you may be eligible for benefits when covered health services are received from non-network physicians. In this situation, your network physician must notify UnitedHealthcare(UHC) Care Coordination to request a "Network Gap Exception". You and your physician will be notified in writing of UHC's decision.
When do I need to get a prior authorization?	You are responsible for notifying UHC's Care Coordination before obtaining services for: • Dental/Oral surgery • Emergency admission to non-network hospital (within 24 hrs or as soon as possible) • Mental/behavioral health - please see mental health section below. You and your physician will be notified in writing of the coverage determination. Questions concerning Care coordination can be answered by calling the telephone number on your medical ID card.
How do I get care when I am outside the service area?	**Emergency Care:** Access the nearest facility available for your care. Please contact UHC's customer service area at the number on back of your ID card as soon as possible. **Urgent Care:** Access the nearest facility available for your care. Please contact UHC's customer service area at the number on back of your ID card as soon as possible. **All Other Care:** Care other than emergency or urgent care is not covered outside of the service area. Follow up care will need to be completed back in the service area. Please call the customer service number on the back of your ID card for assistance.
How do I get mental/ behavioral health care?	Members must call for an initial assessment. The managed mental health and substance abuse program for UHC is administered by UnitedHealth Groups' wholly owned subsidiary, United Behavioral Health (UBH). Simply call our 24 hour access line at 1-800-851-5188 for triage and authorization with network providers for any and all services. *Please note: After standard business hours representatives can only manage inpatient benefits & authorizations.*
What are the dental benefits?	**Deductible:** $50 per individual / $100 per family per calendar year **Preventive Services:** No deductible, coverage at 100%. Examinations limited to 2 times per calendar year, bitewing x-rays, complete series or panorex x-rays, prophylaxis (cleanings), fluoride treatments and sealants.

	Other Services: The following basic services are covered at 50% after the deductible is met: amalgam restorations (fillings) composite resin restorations (fillings), general anesthesia, palliative treatment (relief of pain), and space maintainers. *No coverage for major restorative services.* **Orthodontics:** No deductible, coverage at 50%. Services must be completed before attaining age 19. Coverage up to an individual ortho lifetime maximum of $1,200. **Annual Benefit Maximum:** $1,000 per person per calendar year **Dental Network:** The UHC dental plan has an open dental network to allow members to go to the dentist of their choice. Charges are payable up to UHC's maximum allowable fees. **Dental ID Cards:** Subscribers will be sent a separate dental ID card.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Please go to www.myuhc.com/groups/state and login: state. • Contact customer service and request provider directory #FWOAH20WI-608 • Search www.myuhc.com. Select UnitedHealthcare Choice HMO/Choice POS

County	Hospital(s)	Major Clinic(s)
Brown	Aurora Baycare Medical Center Bellin Memorial Hospital St. Mary's Hospital St. Vincent Hospital	Aurora Medical Group Bellin Medical Group Prevea Health
Door	Door County Memorial Hospital	Northshore Medical Clinic
Fond du Lac	Ripon Medical Center St. Agnes Hospital	Fond du Lac Regional Clinic
Green Lake	Berlin Memorial Hopsital	
Manitowoc	Aurora Medical Center	Aurora Medical Group
Marinette	Bay Area Medical Center	
Oconto	Bond Health Center Community Memorial Hospital	
Outagamie	Appleton Medical Center New London Family Medical Center	Thedacare
Shawano	Shawano Medical Center	Thedacare
Sheboygan	Aurora Sheboygan Memorial Medical Center St. Nicholas Hospital	Aurora Medical Group Physicians Health Network
Waupaca	Riverside Medical Center	Thedacare
Waushara	Wild Rose Community Hospital	
Winnebago	Aurora Medical Center – Oshkosh Theda Clark Medical Center Children's Hospital of WI - Fox	Aurora Medical Group Thedacare

UnitedHealthcare of Wisconsin Southeast

Phone: (800) 357-0974
Fax: (920) 662-8349
For questions during Dual Choice, please call the Enrollment Hotline toll free at (866) 873-3903

What's new for 2009?	The following hospital was added in 2008. • Mercy Walworth Hospital & Medical Center
Do I need to select a Primary Care Physician (PCP)?	No, you do not need to select a Primary Care Physician (PCP). However, for plan benefits to apply, you will need to select from our broad network of physician, hospitals and other health plan professionals for necessary services.
When do I need a referral?	If a specific covered health service is not available from a network physician/hospital, you may be eligible for benefits when covered health services are received from non-network physicians. In this situation, your network physician must notify UnitedHealthcare(UHC) Care Coordination to request a "Network Gap Exception". You and your physician will be notified in writing of UHC's decision.
When do I need to get a prior authorization?	You are responsible for notifying UHC's Care Coordination before obtaining services for: • Dental/oral surgery • Emergency admission to non-network hospital (within 24 hrs or as soon as possible) • Mental/behavioral health - please see mental health section below. You and your physician will be notified in writing of the coverage determination. Questions concerning Care Coordination can be answered by calling the telephone number on your medical ID card.
How do I get care when I am outside the service area?	**Emergency Care:** Access the nearest facility available for your care. Please contact UHC's customer service area at the number on back of your ID card as soon as possible. **Urgent Care:** Access the nearest facility available for your care. Please contact UHC's customer service area at the number on back of your ID card as soon as possible. **All Other Care:** Care other than emergency or urgent care is not covered outside of the service area. Follow up care will need to be completed back in the service area. Please call the customer service number on the back of your ID card for assistance.
How do I get mental/ behavioral health care?	Members must call for an initial assessment. The managed mental health and substance abuse program for UHC is administered by UnitedHealth Groups' wholly owned subsidiary, United Behavioral Health (UBH). Simply call our 24 hour access line at 1-800-851-5188 for triage and authorization with network providers for any and all services. *Please note: After standard business hours representatives can only manage inpatient benefits & authorizations.*
What are the dental benefits?	**Deductible:** $50 per individual / $100 per family per calendar year **Preventive Services:** No deductible, coverage at 100%. Examinations limited to 2 times per calendar year, bitewing x-rays, complete series or panorex x-rays, prophylaxis (cleanings), fluoride treatments and sealants. **Other Services:** The following basic services are covered at 50% after the deductible is met: amalgam restorations (fillings) composite resin restorations (fillings), general anesthesia, palliative treatment (relief of pain), and space maintainers. *No coverage for major restorative services.*

	Orthodontics: No deductible, coverage at 50%. Services must be completed before attaining age 19. Coverage up to an individual ortho lifetime maximum of $1,200. **Annual Benefit Maximum:** $1,000 per person per calendar year **Dental Network:** The UHC dental plan has an open dental network to allow members to go to the dentist of their choice. Charges are payable up to UHC's maximum allowable fees. **Dental ID Cards:** Subscribers will be sent a separate dental ID card.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Please go to www.myuhc.com/groups/state and login: state. • Contact customer service and request provider directory #FWOAH20WI-606 • Search www.myuhc.com. Select UnitedHealthcare Choice HMO/Choice POS

County	Hospital(s)	Major Clinic(s)
Kenosha	Aurora Medical Center United-Kenosha Medical Center United-St. Catherine's Medical Center	Aurora Medical Group United-Kenosha Medical Center
Milwaukee	Aurora St. Luke's Hospital Aurora Sinai Medical Center Children's Hospital of Wisconsin Columbia St. Mary's Hospital Froedtert Memorial Lutheran Hospital Kindred Hospital St. Francis Hospital St. Joseph's Hospital St. Lukes South Shore West Allis Memorial Hospital	Aurora Medical Group Childrens Medical Group Columbia St. Mary's Hospital of Milwaukee Physicians Medical College of Wisconsin Wheaton Franciscan Medical Group
Ozaukee	Columbia St. Mary's Hospital	Columbia St.Mary's Hospital of Milwaukee Physicians
Racine	All Saints Medical Center Aurora Memorial Burlington	Wheaton Franciscan Medical Group
Walworth	Aurora Lakeland Medical Center Mercy Walworth Hospital & Medical Center	
Washington	St. Joseph's Community Memorial Hospital of West Bend	Aurora Medical Group Medical Associates Health Centers West Bend Clinic
Waukesha	Community Memorial Hospital of Menomonee Falls Elmbrook Memorial Hospital Oconomowoc Memorial Hospital Waukesha Memorial Hospital	Medical Associates Health Centers Waukesha Health Care

Unity Health Insurance
Community Network

840 Carolina Street
Sauk City, WI 53583
1-800-362-3310
unityhealth.com

Unity Health Insurance
A UW Health Affiliated Company

Commercial HMO and POS

What's new for 2009?	• Visit Unity's new web site at unityhealth.com. Members can now take a health risk assessment online. Also, you can register for MyUnity, a secure portal through which you will receive your Explanation of Benefits (EOBs). • Root canal therapy will not be covered in 2009.
Do I need to select a Primary Care Physician (PCP)?	Yes, 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, a PCP will be assigned. You can change your PCP on Unity's web site, unityhealth.com or by calling Unity Customer Service at 1-800-362-3310. The change will be effective the first day of the month following Unity's receipt of your request.
When do I need a referral?	No written referral requests are needed when you seek care for medically necessary covered services from a Community Network provider. Out-of-plan provider requests ***do*** require a written referral request from your physician that must be approved by Unity in advance of services being received 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 are being referred will receive notification in writing from Unity stating the decision on your referral request.
When do I need to get a prior author-ization?	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 notification in writing from Unity stating the decision on your referral request. Refer to the *2009 Community Network Provider Directory & Member Information* for more detail.
How do I get care when I am outside the service area?	**Emergency Care:** Whenever possible use a Unity participating hospital. Have someone show your Unity ID card to the emergency room staff. You must notify Unity at 1-800-362-3310 within three (3) business days or as soon as reasonably possible following any emergency treatment. Also, notify your PCP of your emergency care as they will coordinate any necessary follow-up care. **Urgent Care:** Contact your PCP first. He/she will tell you how to get appropriate care. If you receive urgent care from a non-Unity provider outside of the service area, call Unity Customer Service at 1-800-362-3310 within three (3) business days or as soon as reasonably possible following receipt of urgent care. **All Other Care:** Any routine, follow-up care following emergent or urgent care, and specialty care provided by out-of-plan providers require a written referral request from your physician that must be approved by Unity in advance of services being received and will be reviewed only for services that are not available from participating providers in the Community Network. See the *When do I need a referral?* section above.
How do I get mental/ behavioral health care?	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 need. You must call BHCS at (608) 282-8960 or toll-free at 1-800-683-2300 between the hours of 8 AM and 4:30 PM, Monday through Friday, for prior authorization of all mental health and AODA assessments and treatment.
What are the dental benefits?	**Deductible:** None *Covered preventive and other services paid at 100%.* **Preventive Services:** * Exams twice per calendar year ***** Prophylaxis (teeth cleaning) twice per calendar year ***** X-rays - full mouth x-rays at three year intervals ***** Bitewing x-rays (limited to set of 4 films) twice per calendar year **Other Services: *** Amalgam (silver) restorations ***** Composite (tooth colored) restorations in front teeth ***** Fluoride treatments twice per calendar year for dependents to age 19 ***** Space maintainers for retaining space when a primary tooth is prematurely lost ***** One topical sealant application per tooth for dependents through the age 15 ***** Extractions - non-surgical ***** Palliative (emergency) treatment of dental pain - minor procedure **Orthodontics:** For dependent children up to 19 years. Coverage at 50% of the first $3,000 in covered services for a lifetime maximum payment of $1,500.

	Annual Benefit Maximum: $1,000/member each calendar year for preventive & other services. **Dental Network:** You have access to both Delta Dental's Premier and PPO provider networks. To find a network dentist, go to deltadentalwi.com and select *Delta Dental Premier* or *Delta Dental PPO* as your Dental Plan. Call Delta Dental at 1-800-236-3712 for more information. **Dental ID Cards:** Delta Dental issues a separate ID card for your dental services.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: * Visit unityhealth.com, click on *Find a Doctor*, select *State & Local Government Participant* and then *the Community Network* ***** Refer to the *2009 Community Network Provider Directory* * Call Unity Customer Service at 1-800-362-3310. *** You also have access to UW Hospital, Meriter Hospital and the UW Health specialists in Madison.**

County	Hospital(s)	Major Clinic(s)
Adams	Moundview Memorial Hospital & Clinics	Moundview Clinic Roche-A-Cri Clinic
Columbia	Columbus Community Hospital Divine Savior Healthcare, Inc.	UW Health Clinics – Columbus and Portage Divine Savior Familycare and Healthcare Clinics Lodi Medical Clinic Bruce A. Kraus, MD Poser Clinic Randolph Community Clinic
Crawford	Prairie du Chien Memorial Hospital	Great River Community Medical Center Kickapoo Valley Medical Clinic
Dodge	Beaver Dam Community Hospital Watertown Memorial Hospital Waupun Memorial Hospital	UW Health Clinics – Beaver Dam and Horicon Fond du Lac Regional Clinics Juneau Clinic Watertown Area Health Services Clinics
Fond du Lac	St. Agnes Hospital Ripon Medical Center	Fond du Lac Regional Clinics CHN Medical Center - Ripon
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 High Point Family Medicine, LLC Maski & Maski Medical Associates Clinic, PC Muscoda Health Center Riverside Family Practice
Green	Monroe Clinic Hospital	Monroe Clinics (all) Mercy Brodhead Medical Center
Iowa	Upland Hills Health	Blackhawk Area Health Care Dodgeville Clinic Dodgeville Medical Center Mineral Point Medical Center
Jefferson	Fort Memorial Hospital	UW Health Clinics – Fort Atkinson and Palmyra Fort HealthCare Clinics
Marquette		CHN Medical Center - Montello
Richland	Richland Hospital	Richland Medical Center Viola Family Health Services and Osteoporosis
Rock	Beloit Memorial Hospital Edgerton Hospital & Health Services Mercy Hospital	Beloit Clinics (all) Betts Family Medical Clinic Mercy Clinics (all)
Sauk	St Clare Hospital Health Services Sauk Prairie Memorial Hospital Reedsburg Area Medical Center	Prairie Clinic, SC Plain Medical Clinic Reedsburg Physicians Group Spring Green Medical Associates LLC Spring Green Medical Center River Valley Medical Clinic
Vernon	St Joseph's Memorial Hospital & Home Vernon Memorial Hospital	St. Joseph's Family Clinic Hirsch Clinic LaFarge Medical Clinic - VMH Bland Clinic
Walworth	Mercy Walworth Hospital	Fort Healthcare Clinics (all) Mercy Clinics (all)

Unity Health Insurance

UW Health Network

840 Carolina Street
Sauk City, WI 53583
1-800-362-3310
unityhealth.com

Unity Health Insurance
A UW Health Affiliated Company

Commercial
HMO and POS

What's new for 2009?	Visit Unity's new web site at unityhealth.com. Members can now take a health risk assessment online. Also, you can register for MyUnity, a secure portal through which you will receive your Explanation of Benefits (EOBs) electronically.
Do I need to select a Primary Care Physician (PCP)?	Yes, 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, a PCP will be assigned. You can change your PCP on Unity's web site, unityhealth.com or by calling Unity Customer Service at 1-800-362-3310. The change will be effective the first day of the month following Unity's receipt of your request.
When do I need a referral?	No written referral requests are needed when you seek care for medically necessary covered services from a UW Health Network provider in Dane County. Out-of-plan provider requests ***do*** require a written referral request from your physician that must be approved by Unity in advance of services being received 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 are being referred will receive notification in writing from Unity stating the decision on your referral request.
When do I need to get a prior authorization?	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 notification in writing from Unity stating the decision on your referral request. Refer to the *2009 UW Health Network Provider Directory & Member Information* for more detail.
How do I get care when I am outside the service area?	**Emergency Care:** Whenever possible use a Unity participating hospital. Have someone show your Unity ID card to the emergency room staff. You must notify Unity at 1-800-362-3310 within three (3) business days or as soon as reasonably possible following any emergency treatment. Also, notify your PCP of your emergency care as they will coordinate any necessary follow-up services. **Urgent Care:** Contact your PCP first. He/she will tell you how to get appropriate care. If you receive urgent care from a non-Unity provider outside of the service area, call Unity Customer Service at 1-800-362-3310 within three (3) business days or as soon as reasonably possible following receipt of urgent care. **All Other Care:** Any routine, follow-up care following emergent or urgent care, and specialty care provided by out-of-plan providers require a written referral request from your physician that must be approved by Unity in advance of services being received and will be reviewed only for services that are not available from participating providers in the UW Health Network. See the *When do I need a referral?* section above.

How do I get mental/ behavioral health care?	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 need. You must call BHCS at (608) 282-8960 or toll-free at 1-800-683-2300 between the hours of 8 AM and 4:30 PM, Monday through Friday, for prior authorization of all mental health assessments and treatment. For AODA needs, call Gateway Recovery at (608) 278-8200 or toll-free at 1-800-785-1720 between the hours of 8 AM and 4:30 PM, Monday through Friday. A referral from your PCP is not needed for either mental health or AODA care.
What are the dental benefits?	**Deductible:** $0 **Preventive Services:** *All covered preventive services paid at 100%.* • Exams twice per calendar year • Prophylaxis (teeth cleaning) twice per calendar year • X-rays - full mouth x-rays at three year intervals • Bitewing x-rays (limited to set of 4 films) twice per calendar year **Other Services:** *All covered other services paid at 100%.* • Amalgam (silver) restorations • Composite (tooth colored) restorations in front teeth • Fluoride treatments twice per calendar year for dependents to age 19 • One topical sealant application per tooth for dependents through age 15 • Space maintainers for retaining space when a primary tooth is prematurely lost • Extractions - non-surgical • Palliative (emergency) treatment of dental pain - minor procedure **Orthodontics:** 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. **Annual Benefit Maximum:** $1,000 per member each calendar year for covered preventive and other services. **Dental Network:** You have access to both Delta Dental's Premier and PPO provider networks. To find a network dentist near you go to deltadentalwi.com and select either Delta Dental Premier or Delta Dental PPO as your Dental Plan. Call Delta Dental at 1-800-236-3712 for more information about benefits. **Dental ID Cards:** Delta Dental issues you a separate ID card to use for your dental services.
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Visit unityhealth.com, click on *Find a Doctor*, select *State & Local Government Participant* and then the *UW Health Network.* • Refer to the *2009 UW Health Network Provider Directory.* • Call Unity Customer Service at 1-800-362-3310. • Unity is a UW Health affiliated company.

County	Hospital(s)	Major Clinic(s)
Dane	UW Health - UW Hospital & Clinics UW Health - American Family Children's Hospital Meriter Hospital Stoughton Hospital	UW Health Clinics throughout Dane County Associated Physicians, LLP Access Community Health Centers

WPS Metro Choice

1717 West Broadway, PO Box 8190
Madison WI 53708-8190
1-800-634-6448
www.wpsic.com/state

What's new for 2009?	• **Our name has changed.** - Previously ***WPS Patient Choice***, now ***WPS Metro Choice.*** - The plan remains a **preferred provider plan.** • Members do not need to select Care System. • Members have access to all providers in this network. • Advanced HealthCare will not be available for 2009.
How is this plan different from an HMO?	This preferred provider plan includes benefits for services received both in and outside of your network. You will receive coverage as stated in the Uniform Benefits by utilizing providers in the WPS Metro Choice network. Medical services received from providers that are not in the WPS Metro Choice network are payable subject to a deductible of $1,000 individual/$2,000 family. After the deductible is met, benefits are payable at 70%.
Do I need to select a Primary Care Physician (PCP)?	**No**, selection of a PCP is not required. You have the freedom of choice to use any provider you choose. By choosing a provider within the WPS Metro Choice network you will have less cost sharing then if you utilize a provider outside of the network.
When do I need a referral?	• Referrals are not necessary under this plan. • If you utilize providers in the WPS Metro Choice network, your benefits are as described in the Uniform Benefits section of this book. • If you utilize providers outside the WPS Metro Choice network, you do not need a referral but the services are subject to a **deductible of $1,000 individual/$2,000 family and then payable at 70%**.
When do I need to get a prior authorization?	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, Organ transplants, Durable medical equipment over $500, and Pain management injections. 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.
How do I get care when I am outside the service area?	**Emergency Care:** In-network Hospital emergency rooms should be used whenever possible. Should you be unable to reach an in-network provider, go to the nearest appropriate medical facility. If you must go to an out-of-network provider, please contact WPS Member Services by the next business day or as soon as reasonably possible so that services may be reviewed for coverage at the in-network benefit level. Non-urgent follow-up care should be received from an in-network provider for the highest level for benefits. Out-of-network Emergency Care may be subject to Usual and Customary Charges. **Urgent Care:** Urgent Care **is not** Emergency Care. It does not include care that can be safely postponed until you are able to receive such care from an in-network provider. You should receive Urgent Care from an in-network provider unless it is not reasonably possible. If you are not able to reach an in-network Urgent Care, go to the nearest appropriate medical facility. If you must go to an out-of-network provider, please contact WPS Member Services by the next business day or as soon as reasonably possible so that services may be reviewed for coverage at the in-network benefit level. Non-urgent follow-up care should be received from an in-network provider for the highest level of

	benefits. Out-of-network Urgent Care may be subject to Usual and Customary Charges. **All Other Care:** Medical Services received outside your network are payable subject to a deductible of $1,000 individual/$2,000 family. After the deductible is met, benefits are payable at 70%.
How do I get mental/ behavioral health care?	• If you utilize providers in the WPS Metro Choice network, your benefits are as described in the Uniform Benefits section of this book. • If you utilize providers outside the WPS Metro Choice network, you do not need a referral but the services are subject to a **deductible of $1,000 individual/$2,000 family and then payable at 70%**. • *Referrals are not necessary*
What are the dental benefits?	**Deductible:** $25 single/$75 family **Preventive Services:** Covered at 100% after deductible is met: - Exams - Cleanings - Fluoride Treatments - X-Rays **Other Services:** Basic Restorative Services covered at 50% after deductible is met: - Sealants - Fillings **Orthodontics:** 50% coverage after deductible is met for dependents up to age 19 *Individual Lifetime Orthodontic Maximum $1,200* **Annual Benefit Maximum:** .$500 per individual **Dental Network:** *Delta Dental Premier* Please visit www.deltadentalwi.com to find a network dentist by clicking "Dentist Search" and then selecting “Delta Dental Premier” or by contacting Delta Dental at **1-800-236-3712**. **Dental ID Cards:** Delta Dental ID cards will be sent with your WPS member materials
What providers can I use?	Below is a partial summary of the major hospitals and clinics in our network that you can use in 2009. For a complete listing: • Please visit our web site at ***www.wpsic.com/state*** and click on the ***Find a Doctor*** tab along the top of the page. Then select ***WPS Metro Choice*** from the left of the page. • Call WPS Member Services Department at **1-800-634-6448**.

County	Hospital(s)	Major Clinic(s)
Milwaukee	Children's Hospital of Wisconsin Columbia Center Columbia St. Mary's-Columbia, Milwaukee Campuses Franklin Hospital Froedtert Memorial Lutheran Hospital Orthopaedic Hospital of Wisconsin Sacred Heart Rehabilitation Institute St. Joseph Regional Medical Center The Wisconsin Heart Hospital WFH - St. Francis Hospital	Children's Medical Group Columbia St. Mary's Providers Medical College of Wisconsin Wheaton Franciscan Providers
Ozaukee	Columbia St. Mary's-Ozaukee	Columbia St. Mary's Providers
Racine	All Saints - Racine	Wheaton Franciscan Providers
Washington	St. Joseph's Community Hospital	West Bend Clinics
Waukesha	Community Hospital Oconomowoc Memorial Hospital Waukesha Memorial Hospital WFH - Elmbrook Memorial	Medical Associates/Prohealth Wheaton Franciscan Providers

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Plan Descriptions: The PBM and Plans Without Uniform Benef ts

Medicare Plus $1,000,000 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 Medicare Plus $1,000,000 Plan is designed to supplement, not duplicate, the benefits available under the Federal Medicare program for State of Wisconsin annuitants. Eligibility is limited to individuals enrolling in both Part A and Part B Medicare (when eligible) and Medicare is the primary payor. It is administered by WPS Health Insurance

What's New for 2009

Benefits for immunization and skilled nursing facility confinements have been updated to reflect what Uniform Benefits offers. The skilled nursing facilty benefit is now easier to understand and more closely aligns with Medicare.

Benefit Maximum

Each Plan participant has a $1,000,000 lifetime aggregate benefit maximum to which all medical and prescription claims will apply.

Exclusions and limitations

- Benefits will be limited to the charges for treatments, services, and supplies less payments available from Medicare and/or other coverage
- Routine care unless allowed by Medicare
- Services or supplies for custodial care or rest cures as defined by the contract
- Services, supplies or equipment that are not medically necessary, or which are experimental/investigational
- Eyeglasses or contact lenses or hearing aids, or examinations for their prescription or fitting
- In vitro fertilization or artificial fertilization
- Weight loss programs, services or supplies
- Dental services except as specifically provided
- Cosmetic surgery
- Organ transplants except as specifically provided
- Reversals of sterilization

Freedom of choice

This plan allows you complete freedom of choice in selecting a physician or hospital that is convenient for you. If you go on vacation or reside away from home during the year, this freedom of choice allows your health coverage to "go with you," including when traveling abroad. If you have already established relationships with physicians of your choice, this plan will allow you uninterrupted access to those health care providers.

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.

This is intended as a general outline of benefits. It is not intended to be a complete description of coverage and does not serve as a legal document. For a complete listing of benefits, limitations, and exclusions please refer to your Medicare + $1,000,000 benefit handbook (ET-4113) or contact WPS Health Insurance.

Service Centers

We also provide convenient walk-in service at each of our 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

Medicare Plus $1,000,000 Plan

Administered by WPS Health Insurance

HEALTH BENEFITS	Plan Pays*	Limitations (see exclusions & limitations on previous page)
Physician	100%	Subject to contract provisions.
Hospital	100%	120 days in semi-private room.
Laboratory and X-rays	100%	Subject to contract provisions.
Behavioral Health (Combined w/Alcohol & Drug Abuse)	100% 90% 90%	*In 2009, Annual dollar maximums for Behavioral Health services are suspended* INPATIENT—120 days or $6,300 per calendar year, whichever is less. OUTPATIENT - of the first $2,000 per calendar year. TRANSITIONAL - of the first $3,000 per calendar year.
Alcohol & Drug Abuse (Combined w/Behavioral Health) .	100% 90% 90%	*Annual combined benefit is $7,000* INPATIENT—30 days or $6,300 per calendar year, whichever is less. OUTPATIENT—of the first $2,000 per calendar year. TRANSITIONAL—of first $3,000 per calendar year.
Emergency Room	100%	None.
Extended Care Facility ***	100%	120 days Medicare-approved service and facility-contract maximum – if admitted after a hospital stay of 3 days or more. Medicare approved services** at non-Medicare approved facility - if admitted within 14 days after a hospital stay of 3 days or more: $50 per day for first 100 days, then the contract maximum. Excludes custodial care as defined in the contract.
Vision Care	100%	For illness or disease only.
Prescribed medical services/supplies	100%	Subject to contract provisions.
Transplants	100%	Kidney, cornea, bone marrow, parathyroid, musculoskeletal, as listed in booklet. Excludes all services related to non-covered transplants.
Chiropractic Care	100%	Subject to contract provisions.
Ambulance	100%	Subject to contract provisions.
Physical, speech & occupational therapy	100%	Subject to contract provisions.
Home Health Care	100%	365 visits per calendar year.
Home Hospice Care	100%	80 visits per six months.
Hearing Aid	0%	Not a covered benefit.
Routine Annual Exams	0%	Not a covered benefit unless allowed by Medicare
Immunizations ***	100%	Subject to contract provisions
Oral Surgery	100%	Excludes non-surgical extractions, root canals, dental implants, filling, capping, recapping or other routine repair or maintenance of teeth.
Prescription Drugs		Separate PBM administration through Navitus. Annual out-of-pocket maximums are $385 single/ $770 family.

* Includes Medicare payment.
** Approved services means services which would be paid by Medicare if provided in a Medicare-approved facility.
*** Benefit change for 2009

- This plan provides benefits and reimbursement for Medicare deductibles for covered services.
- The maximum benefit of this plan is $1,000,000 lifetime aggregate, in addition to benefits paid by Medicare.
- Medicare Plus $1,000,000 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 Insurance 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' or if a charge dispute arises, please call WPS Member Services at 1-800-634-6448.

Navitus Health Solutions™

5 Innovation Court Suite B
Appleton WI 54914

999 Fourier Drive Suite 301
Madison WI 53717

(866) 333-2757
Fax: (920)831-1930
TTY: (920) 225-7005
www.navitus.com

New for 2009 Out of Pocket Maximum:	The out-of-pocket maximum changes to $385 per individual and $770 per family for all participants, **EXCEPT:** $1,000 per individual or $2,000 per family for Participants enrolled in the Standard Plan, effective January 1, 2009.
Formulary Information	Detailed and updated formulary information is available on the Navitus Web site, www.navitus.com, under the "Members" section (State of WI and WI Public Employers (administered through ETF) Formulary). . Included is a list of recent changes made to the formulary. You can also call Navitus Customer Care toll-free at (866) 333-2757, 24 hours a day seven days a week to receive a copy of the formulary.
Changes in Your Information	Changes in your personal information must be reported to your employer or, if you are an annuitant, to ETF. Changes include, but are not limited to: • Name change • Address change • Other insurance coverage • Adding or deleting dependents from your policy (including changes in student status)
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.** Navitus will review the prior authorization request within two business days of receiving complete information from your physician. More information about which medications require prior authorizations, as well as the prior authorization process, is available on the Navitus Web site, www.navitus.com. Medications that require prior authorization for coverage can be identified on the Navitus Drug Formulary by a notation of **"PA."**
Tablet Splitting (RxCENTS)	Through this program, you pay up to one-half of your usual cost for a select group of prescription medications. Medications included in the Navitus Tablet Splitting 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. Your physician needs only to write a prescription for one of the program medications – 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. Medications included in the Navitus Copay Waiver Program are denoted with **"GW"** in the Navitus Formulary.

Mail Order	You can obtain your prescriptions through our mail order service. The use of mail order is generally recommended only 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 can be purchased for only two copayments for Level 1 and Level 2 medications. To register for mail order service or to order refills once mail order service is in place you can: • Complete the mail order service enrollment form provided with your enrollment materials. • Call Prescription Solutions Customer Service at1-800-908-9097, 24 hours a day seven days a week. If you are hearing impaired, you can call 1-800-947-8642. • Refills may be requested electronically through the Prescription Solutions Web site, www.rxsolutions.com.
Specialty Drug Program (Self-injectables and specialty medications)	If you are on a specialty medication, Navitus SpecialtyRX was designed in conjunction with SpecialtyScripts Pharmacy to help members and their health care providers with specialty pharmacy needs. Medications available through this program are denoted with **"SP"** in the Navitus Formulary. 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. Once you have contacted them, they will take care of calling your health care provider and initiating or transferring your prescription.
Diabetic Supply Coverage	Diabetic supplies and glucometers are covered with a 20% coinsurance. This coinsurance applies to your out-of-pocket maximum, unless other coverage picks up the 20% coinsurance.
Medicare Part B	Claims for certain drugs/supplies need to be submitted to Medicare Part B first (primary). Navitus covers the remaining cost up to the allowed amount under your policy as secondary coverage. These drugs include test strips, lancets, inhalation drugs, and IV drugs requiring a pump. In many instances your pharmacy will be able to submit the secondary claim to Navitus electronically. However, in cases where this is not possible you can either submit the Medicare Summary Notice of your claims from CMS to Navitus or you can submit a ***Direct Member Reimbursement Form*** completed in full. You can get the ***Direct Member Reimbursement Form*** at Navitus' web site or by calling Navitus Customer Care. Most of the information needed to complete the form can be found on your Medicare Summary Notice, which Medicare usually provides on a quarterly basis.
Medicare Part D	Beginning January 1, 2006, prescription drug coverage for State members on Medicare is to be provided under an arrangement known by the Centers for Medicare and Medicaid Services (CMS) as the Retiree Drug Subsidy (RDS). Under this program, retirees are not required to enroll in a Medicare Part D prescription drug plan (PDP). Nor are they assessed any penalty by CMS, because the coverage administered by Navitus is considered "Creditable Coverage." The State group health insurance program is eligible for a reimbursement, or subsidy, from Medicare for a portion of the pharmacy claims. The monthly premium you pay is reduced to reflect this subsidy amount. Claims for members who do enroll in a Medicare Part D PDP are not eligible for any subsidy. Instead, your Medicare Part D PDP will pay for your coverage first (primary), and then Navitus will cover the remaining cost of any covered prescriptions up to the allowed amount under your policies. In either case you continue to be responsible for any copayment/coinsurance that is applied.
Coordination of Benefits (COB)	Coordination of benefits applies when you have coverage under another policy and it is determined by the order of benefit determination rules that Navitus is your secondary coverage and your other policy is your primary coverage. This means that if 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 policies. COB does not guarantee that all of your out of pocket costs will be covered.

Standard Plan

Administered by WPS Health Insurance

1717 West Broadway, PO Box 8190
Madison, WI 53708
1-800-634-6448
www.wpsic.com/state

Standard Plan

The Standard Plan is a Preferred Provider Plan (PPP). The Standard Plan is a comprehensive health plan that provides you with freedom of choice among hospitals and physicians in Wisconsin and nationwide. The amount paid for covered benefits varies depending upon the provider selected. A higher level of benefits is available by using a preferred provider.

What's New for 2009

The medical policy criteria used to determine coverage for gastric bypass surgery has been updated to reflect evolving standards of care. This change includes eligibility for some members with a body mass index (BMI) of 35, lowered from 40 as long as other criteria are met. The criteria appears in the booklet, available from WPS.

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 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

We also provide convenient walk-in service at each of our 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% 90% 90%	*In 2009, Annual dollar maximums for Behavioral Health services are suspended.* Deductible does not apply. INPATIENT—120 days or $6,300 per calendar year, whichever is less. OUTPATIENT*—of the first $2,000 per calendar year. TRANSITIONAL—of the first $3,000 per calendar year.
Alcohol & Drug Abuse (Combined w/Behavioral Health)	In & Out	100% 90% 90%	*Annual combined benefit is $7,000*. Deductible does not apply. INPATIENT—30 days or $6,300 per calendar year, whichever is less. OUTPATIENT*—of the first $2,000 per calendar year. 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.

*Conforms with Wisconsin State mandates that includes care performed by a physician or payable psychologist. Payable psychologists must be billed by a medical clinic and supervised by a physician, or, if billing independently, must be listed in the National Register of Health Service Providers or certified by the American Board of Professional Psychology.

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.

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Application Form for Annuitants & Continuants

Only annuitants and continuants should use the application in this section. If you are an active employee, see your benef ts/ payroll/personnel representative for the appropriate application.

If you want to change health plans or change to family coverage for next year, submit one completed application and retain one for your records.

State Annuitants or Continuants Group Health Insurance Application

Instructions for Dual-Choice Enrollment

If you want to change to a different health insurance plan or change to family coverage for the following year you must file this application by the end of the Dual-Choice Enrollment period. If you wish to keep the same plan, but have other changes (for example, adding or dropping a dependent, change of physician only, change of address or name) contact ETF to obtain the appropriate form.

Please read the instructions carefully. To avoid delays it is very important that you complete your application accurately.

1. **Name –** Complete your full name, including your middle name.

2. **Plan Name** - This information is needed so that your current health insurance can be cancelled and your new plan can take effect.

3. **New Group Health Insurance Plan Selected** - In this box write: “Standard Plan,” "Medicare Plus $1,000,000" or the name of the alternate plan you have selected.

4. **Other coverage** - Complete this indicating if you or anyone you list on your application is currently insured by another group health insurance policy**. This area must be completed in order to process the application.** If you or anyone you list on your application is enrolled in Medicare, list and provide Medicare effective dates and HIC number.

5. **Persons to be covered** - Make sure you list each person to be covered under the health insurance plan you are selecting and include their Social Security numbers.

6. **Appl. Rel.** - Indicate your listed dependent’s relationship to you (S-Son, D-Daughter, SS-Stepson, SD-Stepdaughter, G-Grandchild, LW-Legal Ward).

7. **Student Status –** Indicate your dependent’s student status if age 19 or older for 2008 (Y=Yes, has student status, N=No, does not have student status).

8. **Selected Physician or Clinic** – For yourself and all eligible dependents, provide the name of the physician or clinic. If you have selected the Standard Plan, please indicate none.

9. **Sign and date** - Make sure you sign and date your application.

10. Send your application to:

    Employee Trust Funds
    P. O. Box 7931
    Madison, WI 53707-7931

11. If you are an annuitant, you may FAX your application to (608) 267-4549.

12. **Your application must be postmarked or faxed by the last day of the Dual-Choice Enrollment period (October 24, 2008). LATE APPLICATIONS WILL NOT BE ACCEPTED.**

STATE OF WISCONSIN ANNUITANT OR CONTINUANT ONLY

Instructions:

To change health plans or change to Family coverage, complete all sections of this form in ink. See page H-2 in the Dual-Choice book for more information. If you want to retain your current coverage, do not complete this form.

PLEASE PRINT

GROUP: **STATE OF WISCONSIN ANNUITANT OR CONTINUANT** **DUAL-CHOICE** HEALTH INSURANCE APPLICATION

Applicant – Last Name	First	Middle	Maiden Name	Social Security Number

Address – Street & No.	City	State	Zip	County	Country (if not USA)

Marital Status
☐ Single ☐ Married Date_____ ☐ Divorced Date_____ ☐ Separated Date_____ ☐ Widowed Date_____

Home Telephone Number
( )

CURRENT GROUP HEALTH INSURANCE PLAN

Plan Name _____

NEW GROUP HEALTH INSURANCE PLAN SELECTED

Plan Name _____
(list complete name, including location if part of name)

COVERAGE DESIRED

☐ Single ☐ Family

OTHER HEALTH INSURANCE COVERAGE (*You must complete this section*)

Are you or a family member insured under Medicare? ☐ No ☐ Yes

If yes, list names of insured and Medicare effective dates.

Name: _____ Dates: Part A _____ Part B _____ HIC#_____

Name: _____ Dates: Part A _____ Part B _____ HIC#_____

Other health insurance coverage? ☐ No ☐ Yes

If yes, list names of insured and plan.

Name: _____ Insurance Co. _____

Name: _____ Insurance Co: _____

Last Name First Middle	Birthdate MO	Birthdate DAY	Birthdate YR	Gender M/F	Social Security Number	(see page H-2) Appl. Rel. Code	(see page H-2) Student Status	YOU MUST INDICATE SELECTED PHYSICIAN OR CLINIC (Indicate **NONE** if electing Standard Plan or Medicare Plus $1,000,000.) Physician, Clinic, or WPS Patient Choice Care System	10-digit National Provider Identifier (NPI) (if available)
Applicant						N/A	N/A		
Spouse						N/A	N/A		
Eligible Dependent(s)									

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the terms and conditions as described on the reverse side of this application. A copy of this application is to be considered as valid as the original. **Submit form with original signature.**

☐ I am a retiree or surviving spouse/dependent ☐ I am on continuation (eligible for a maximum of 36 months' coverage)	DATE SIGNED (MM/DD/CCYY)	APPLICANT SIGNATURE **SIGN HERE**

Return completed form to: Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Upon receipt and acceptance by ETF, coverage will be **effective 01/01/2009**

FOR DEPARTMENT OF EMPLOYEE TRUST FUNDS USE ONLY

ENROLLMENT TYPE	EMPLOYEE TYPE	COVERAGE CODE	CARRIER SUFFIX	PARTICIPANT'S COUNTY	PHYSICIAN'S COUNTY
40					

EIN	Group Number	ETF Contact Person	Telephone
0000-001	83		(608)

Monthly Premium	Date Received	COBRA Coverage Expires	Effective Date
$			01/01/2009

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information on this application, I may face criminal charges/sanctions under Wis. Stat. § 943.395.

2. I authorize the Department of Employee Trust Funds (ETF) to obtain any information from any source necessary to administer this insurance.

3. I agree to pay in advance the current premium for this insurance and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.

4. I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me, my spouse or any dependents. If medical records are needed, my health plan and/or ETF will provide me with an authorization form.

5. Any children, as defined, listed on this application are unmarried and dependent on me, or the other parent, for at least 50% of support and maintenance. Provided these conditions are met, children may be covered through the end of the year in which they turn 19; or if they are full-time students, coverage continues through the end of the year in which they cease to be a full-time student or turn age 25. Children may also be covered beyond age 19 if they have a disability of long standing duration and are incapable of self-support.

6. I understand it is my responsibility to notify the employer, or if I am an annuitant or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce or marriage, or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims and/or loss of continuation rights. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependents.

7. I understand that if there is a qualifying event in which a qualified beneficiary (me, my spouse or any dependents) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 36 months from the date of the qualifying event or the date of the notice to my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial 36 months of continuation coverage. I understand that notification of these events must be made to ETF in order to take advantage of the maximum 36 months.

8. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the ***It's Your Choice*** booklet.

STATE OF WISCONSIN ANNUITANT OR CONTINUANT ONLY

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Name: _____ Insurance Co. _____

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Applicant						N/A	N/A		
Spouse						N/A	N/A		
Eligible Dependent(s)									

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☐ I am on continuation (eligible for a maximum of 36 months' coverage)

DATE SIGNED (MM/DD/CCYY)

APPLICANT SIGNATURE

SIGN HERE

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8. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the ***It's Your Choice*** booklet.

How to Contact the 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
24-hour 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 Metro 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