
Traditional HMO - Standard PPP Addendum

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*Keep this as a reference throughout the year with the
It's Your Choice book, ET-2128.*

ET-2157 (Rev 9/2008)

Wisconsin Public Employers' Group Health Ins.
(Participating Local Government Employees & Annuitants)

2009

2009 MONTHLY LOCAL EMPLOYEE RATES: TRADITIONAL HMO OPTION--STANDARD PPP

MONTHLY LOCAL EMPLOYEE GROUP HEALTH INSURANCE RATES FOR 2009	NON-MEDICARE RATES RATES APPLY ONLY IF NO FAMILY MEMBERS ARE ELIGIBLE FOR MEDICARE		MEDICARE RATES RATES APPLY IF AT LEAST ONE INSURED FAMILY MEMBER IS ELIGIBLE FOR MEDICARE		
	SINGLE/NON-MEDICARE	FAMILY/NON-MEDICARE	SINGLE MEDICARE	FAMILY MEDICARE - 2*	FAMILY MEDICARE - 1**
STANDARD PLAN: DANE--PPP ¹	772.00	1926.20	384.50	766.40	1156.40
STANDARD PLAN: MILWAUKEE--PPP ²	898.40	2242.20	384.50	766.40	1282.80
STANDARD PLAN: WAUKESHA--PPP ³	831.20	2074.30	384.50	766.40	1215.70
STANDARD PLAN: BALANCE OF STATE--PPP ⁴	831.20	2074.30	384.50	766.40	1215.70
STATE MAINTENANCE PLAN	617.50	1540.20	NA	NA	NA
ANTHEM BCBS NORTHEAST	1039.60	2595.30	708.20	1413.90	1745.30
ANTHEM BCBS NORTHWEST	759.50	1895.00	568.10	1133.70	1325.10
ANTHEM BCBS SOUTHEAST	1039.60	2595.30	708.20	1413.90	1745.30
ARISE HEALTH PLAN	604.40	1507.30	490.50	978.50	1092.40
DEAN HEALTH PLAN	460.00	1146.30	418.40	834.30	875.90
GHC OF EAU CLAIRE	737.40	1839.80	542.40	1082.30	1277.30
GHC OF SOUTH CENTRAL WISCONSIN	474.40	1182.30	425.60	848.70	897.50
GUNDERSEN LUTHERAN HEALTH PLAN	658.30	1642.00	517.50	1032.50	1173.30
HEALTH TRADITION HEALTH PLAN	633.30	1579.50	504.90	1007.30	1135.70
HUMANA EASTERN	875.20	2184.30	418.80	835.10	1291.50
HUMANA WESTERN	760.20	1896.80	418.80	835.10	1176.50
MEDICAL ASSOCIATES HEALTH PLAN	512.10	1276.50	382.10	761.70	891.70
MERCYCARE HEALTH PLAN	460.80	1148.30	418.80	835.10	877.10
NETWORK HEALTH PLAN	547.20	1364.30	461.90	921.30	1006.60
PHYSICIANS PLUS--MERITER & UW HEALTH	466.90	1163.50	421.80	841.10	886.20
SECURITY HEALTH PLAN	930.80	2323.30	467.90	933.30	1396.20
UNITEDHEALTHCARE NE	585.10	1459.00	480.90	959.30	1063.50
UNITEDHEALTHCARE SE	636.50	1587.50	506.60	1010.70	1140.60
UNITY COMMUNITY	447.50	1115.00	403.50	804.50	848.50
UNITY UW HEALTH	451.50	1125.00	414.10	825.70	863.10
WPS METRO CHOICE	853.10	2129.00	614.90	1227.30	1465.50

Standard Plan rates are determined by the employer county or the retiree county of residence

STANDARD PLAN AREA INCLUDES THE FOLLOWING:	¹ DANE: Dane, Grant, Jefferson, LaCrosse, Polk, St. Croix
	² MILWAUKEE: Milwaukee county & <u>retirees and continuants living out of state</u>
	³ WAUKESHA: Kenosha, Ozaukee, Racine, Washington, Waukesha
	⁴ BALANCE OF STATE: All other Wisconsin counties

N/A = "not applicable". Medicare eligible participants automatically receive Standard Plan benefits.

*Medicare Family 2=Two or more family members enrolled in Medicare Parts A, B, & D.

**Medicare Family 1=One family member enrolled in Medicare Parts A, B, & D.

Medicare premium rates apply only to subscribers who have terminated employment.

FREQUENTLY ASKED QUESTIONS AND THEIR ANSWERS

Standard Preferred Provider Plan (PPP)

What is this change to a PPP all about?

The redesign of the Wisconsin Public Employer's Classic Standard Plan into a preferred provider plan (PPP) with a network will be effective on the date selected by your employer. This PPP network offers participants the choice to see any provider, but there are differences in reimbursements depending on whether you go to an in-network or an out-of-network provider. If you receive services from an in-network provider you will have lower out-of-pocket costs. If you choose an out-of-network provider, you contribute more toward your health care costs by incurring additional deductible and coinsurance costs.

This arrangement can be attractive to members 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. In addition, members who have students away at college may choose the plan to offer comprehensive coverage to all family members, regardless of where they live. The provider network is nationwide, so covered members who receive care out-of-state will have improved access to providers.

Note that the Standard PPP uses elements of the Classic Standard Plan, and is separate from Uniform Benefits offered by the alternate plans (HMOs and WPS Metro Choice's PPP). All eligible employees and annuitants have the option to enroll in this plan.

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

You can get this information from WPS Health Insurance (WPS) over the Internet at www.wpsic.com/state. See the plan description page for more information. Or you can call WPS at (800) 634-6448 for information or to request a printed provider directory.

How is the Standard PPP with a preferred provider network different from the Classic Standard Plan?

Under the Standard PPP, when you receive services from providers, you will need to meet up-front deductible and coinsurance amounts. You will not have to pay the old major medical deductible and coinsurance. If you use in-network providers, you will have lower deductible and coinsurance costs.

Please note that in- and out-of-network deductibles and coinsurance out-of-pocket *amounts accumulate separately*. Your in-network costs do not apply to the out-of-network deductible and coinsurance, and vice versa. Therefore, if you use both in- and out-of-network providers, you will pay more for your care.

A few other benefits have been adjusted to keep the overall benefit level comparable. The lifetime maximum benefit will increase to an overall \$2,000,000 from \$250,000 major medical only, to more closely match Uniform Benefits.

A hospital pre-certification program is included. This program requires at least 48 hours prior notice of non-emergency hospital admissions, or notice within 48 hours after an emergency admission. If you do not notify WPS, their payment for your claim will be reduced by \$100. You will be responsible to pay that

amount in addition to your deductible. This program does not apply if Medicare pays for your claims first, for example, if you are an annuitant over 65 years old.

Refer to the plan description page for more details. After the effective date your employer has chosen, the Classic Standard Plan will no longer be available to you.

How does the application of the preferred provider network into the Standard Plan save money and improve services?

When using a preferred provider network, claim charges are discounted by in-network providers to a greater extent than those of out-of-network providers. As members utilize in-network services, the plan saves money and future increases would reflect the savings.

The Classic Standard Plan was implemented in the 1970s. Health insurance has changed dramatically since that time, and the Classic Standard Plan had become one of the few of its type remaining in the marketplace. With this change in applying a preferred provider network, we hope our plan will become easier to understand and use, for members and providers, as it becomes more similar to other plans in the marketplace. Also, this change helps to keep the cost of administration down.

Why is the Standard Plan with the Preferred Provider Network being implemented now?

Over the past few years the Group Insurance Board has been studying alternatives for our plans. One of the goals was to make the plan more cost-effective and affordable. Your employer is also concerned about this, and has selected this option to meet these goals.

Can my employer pay for my out-of-pocket costs for medical services and prescription drug copays, deductibles and/or coinsurance?

No, however, if your employer offers you a Section 125 Cafeteria Plan, you may be able to lower the amount you pay for certain medical out-of-pocket costs by having dollars deducted on a pre-tax basis from your payroll, for reimbursement through a medical reimbursement Employee Reimbursement Account (ERA).

If your employer offers you a medical reimbursement ERA program you should know that ERA's allow you to reduce your taxable income by an agreed-upon amount each pay period and to have these amounts set aside to pay certain medical expenses. Contributions are made on a pre-tax basis to your account as established by you annually. These contributions are returned to you by submitting receipts and other required documentation to your employer's ERA vendor.

A medical reimbursement account is used to pay medical expenses for you, your spouse and dependents that are not paid by insurance. This would include deductibles and co-insurance amounts; drugs; dental, vision and hearing care; orthodontia; and other uncovered medical procedures or supplies. Certain over-the-counter drugs such as antacids, allergy, pain and cold remedies, may also be paid.

Standard Preferred Provider Plan (PPP)

Administered by WPS Health Insurance



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

Standard Preferred Provider Plan (PPP)

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

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
- Surgery
- Extended Care Facility (except custodial care)
- Routine physical exams (See Exclusions)

Prior Authorizations

To ensure that services are covered, WPS recommends that members or treating 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
- Pain management injections
- 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.

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 **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. It is not intended to be a complete description of coverage/exclusions and does not serve as a legal document. For a complete listing of benefits, limitations, and exclusions, please refer to the Benefit Handbook available through your personnel representative or call at WPS.

Service Centers

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

Appleton

1500 N. Casaloma Drive, Suite 202
Appleton WI 54912-7216

Wausau

1800 W. Bridge Street, Suite 200
Wausau WI 54401

Madison

1751 W. Broadway
Madison WI 53713
(800) 634-6448

Milwaukee

111 W. Pleasant Street, Suite 110
Milwaukee WI 53212

Eau Claire

2519 N. Hillcrest Parkway, Suite 200
Eau Claire WI 54702

Standard Preferred Provider Plan (PPP)

Administered by WPS Health Insurance

Non-Medicare: *In-network* deductible is \$250 individual, not to exceed \$500 family, then you pay 10% until your out-of-pocket limit has been reached at \$1,000 individual, not to exceed \$2,000 family, per calendar year. *Out-of-network* deductible is \$500 individual, not to exceed \$1,000 family, then you pay 30% until your out-of-pocket limit has been reached at \$2,000 individual, not to exceed \$4,000 family, per calendar year. **Medicare:** *In-network* deductible is \$150 individual, not to exceed \$300 family. *Out-of-network* deductible is \$300 individual, not to exceed \$600 family. Thereafter care both in- and out-of-network is covered at 100%. **All members:** \$2,000,000 lifetime maximum.

Health Benefits	In- /Out-of-Network	Plan Pays	Limitations
Physician & Chiropractic Care	In	90%	Subject to in-network deductible.
	Out	70%	Subject to out-of-network deductible.
Hospital	In	90%	365 days semi-private room. Subject to in-network deductible. Pre-admission certification required.
	Out	70%	365 days semi-private room. Subject to out-of-network deductible. Pre-admission certification required.
Lab and X-rays	In & Out	90%	Subject to in-network deductible.
Behavioral Health (Combined w/Alcohol & Drug Abuse)	In & Out	100%	<i>In 2009, annual dollar maximums for Behavioral Health services are suspended.</i> INPATIENT—Of the first \$6,300 per calendar year or 120 days, whichever is less.
		90%	OUTPATIENT*—of the first \$2,000 per calendar year.
		90%	TRANSITIONAL—of the first \$3,000 per calendar year.
Alcohol & Drug Abuse (Combined w/Behavioral Health)	In & Out	100%	<i>Total benefits payable shall not exceed \$7,000 per participant per calendar year.</i> INPATIENT—Of the first \$6,300 per calendar year, or 30 days whichever is less.
		90%	OUTPATIENT*—of the first \$2,000 per calendar year.
		90%	TRANSITIONAL—of first \$3,000 per calendar years.
Emergency Room	In & Out	90%	Subject to in-network deductible.
Extended Care Facility	In	90%	120 days per admission less hospital days used. In-network deductible applies. Excludes custodial care.
	Out	70%	120 days per admission less hospital days used. Out-of-network deductible applies. Excludes custodial care.
Vision Care	In	90%	For illness/disease. Subject to in-network deductible.
	Out	70%	For illness/disease. Subject to out-of-network deductible.
Prescribed Medical Services/Supplies	In	90%	Subject to deductible.
	Out	70%	Subject to deductible.
Transplants	In	90%	Kidney, cornea, bone marrow, parathyroid, musculoskeletal. Subject to in-network deductible. Excludes all services related to non-covered transplants.
	Out	70%	Out-of-network deductible applies; transplants listed above.
Ambulance	In & Out	90%	Subject to in-network deductible.
Hearing Aids		0%	Not a covered benefit.
Prescription Drugs			Separate PBM administration through Navitus. Annual out-of-pocket maximums do not apply

*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 Preferred Provider Plan (PPP) 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 collection attempts in a court-of-law. 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.

