



# It's Your Choice: 2010 Decision Guide

Group Health Insurance Plans

Participating Local Government Employees & Annuitants



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**Enrollment Period: October 5-23, 2009**



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Dear Members:

I am pleased to introduce the new *It's Your Choice: 2010 Decision Guide*. Choosing a health plan is a complex and personal decision based on many considerations, such as cost, quality of care, provider preferences and convenience. This guide contains important information to help you make a smart, informed decision about your health plan options during this year's *It's Your Choice* enrollment period.

The "Choose Wisely" section highlights important changes to your health benefits and health plans for 2010. The "Choose Your Health Plan" section provides information about premium rates, your benefits package, and health plan options. The "Choose Quality" section provides the quality score of each health plan to help you compare how each plan ranks on care delivery and customer service. Finally, the "Glossary" section clarifies and explains common health care terminology.

The *Decision Guide* is paired with a reference booklet that contains more technical information, such as your "Certificate of Coverage" and important state and federal notifications. Please keep the reference booklet for future use since we will only publish a new reference booklet during the years when there are major changes in health insurance law, coverage and plans.

The goal of the new design is to provide you with important information that is easy to find and understand. We are also trying to reduce costs and waste and be more efficient by trimming the size of the booklet, putting more information on our website, and distributing the booklet in an electronic format when possible.

Our mission at ETF is to provide high quality, affordable benefits for you and your family. We will continue to work with the Group Insurance Board to be a leader in improving the quality of our health care delivery system in a cost effective way.

Sincerely,

David A. Stella  
Secretary, Department of Employee Trust Funds

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

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Important Changes for 2010  
Frequently Asked Questions



# Important Changes for 2010



## EFFECTIVE JANUARY 1, 2010

The following plan and coverage changes take effect on January 1, 2010. If you have questions or concerns about any of these changes, contact your health plan using the information listed in the back of this booklet.

Types of Changes	Plan Name	Change
<p>New state and federal mandates on eligibility, benefits and review after grievance are effective January 1, 2010.</p>	<p>All Plans</p> <p>For more information, see the Frequently Asked Questions section.</p>	<p>State law has added or increased coverage for autism, cochlear implants and hearing aids, mental health care, domestic partners, dependents up to age 27, and review at an Independent Review Organization (IRO). See frequently asked questions 11 through 16 in this book, and question 2 in the <i>Reference Guide</i> for more information.</p>
		<p>Federal law has increased coverage for mental health and drug and alcohol abuse. See frequently asked question 13 in this book.</p>

# Important Changes for 2010

Types of Changes	Plan Name	Change
Health Plans newly available	HealthPartners	Health Partners is an HMO that offers providers in Wisconsin's Pierce, Polk and St. Croix Counties and a number of Minnesota counties in and around Minneapolis.
SMP Counties no longer available	SMP (State Maintenance Plan)	SMP will no longer be available in Buffalo and Pierce Counties. Subscribers using providers in these counties must consider selecting another plan or will be limited to the SMP providers remaining in other areas.
Significant Plan Provider Network Changes	For examples, see below:	Some plans have made significant changes by adding or terminating contracts with provider groups. Refer to the map on page 24 and call the health plan for more detail.
	Arise Health Plan	Added Agnesian providers.
	Health Tradition	Added providers in Pepin County.
	Humana Eastern and Western	Offering HMO Premier providers in more areas.

# Important Changes for 2010

Types of Changes	Plan Name	Change
Changes to Pharmacy out-of-pocket maximums	All except Standard Plan	The annual prescription drug out-of-pocket amount will increase to \$410 per individual and \$820 per family. See the Comparison of Benefit Options in the <i>Choose Your Health Plan</i> section for more information.
Changes to Dental Coverage	For examples, see below:	See the Health Plan Description pages in the <i>Choose Your Health Plan</i> section for more information.
	Health Tradition	Eliminating exclusions on dentures, bridges or replacement of appliance, crown, etc. Note, maximum benefit remains at \$500/person/year.
	Medical Associates	Clarification that fluoride treatments are only allowable for children age 19 and under.
Other Information on ETF's website	All	The <i>It's Your Choice: Decision Guide</i> and <i>Reference Guide</i> are available at <b>etf.wi.gov</b> . Any known printing discrepancies will be clarified on this site. Additional information about insurance programs including the complete Report Card on health plans, is available

## Important Changes for 2010

Types of Changes	Plan Name	Change
Online help	All	<p>Are you unsure where to start with the redesigned <i>It's Your Choice Decision Guide and Reference Guide</i>? Review ETF's newest online tutorial, <i>It's Your Choice: Your Health Insurance Benefits for 2010</i>. The program explains how the books are organized, where to find specific information and highlights important factors to consider when choosing a health plan for 2010. Find it on ETF's Internet site, under the Group Health Insurance menu, at <a href="http://etf.wi.gov/">http://etf.wi.gov/</a></p>

**Note:** If you plan to stay with your current plan for next year and you are not changing your coverage, you do not need to take any action during the It's Your Choice Enrollment period.

# Frequently Asked Questions

## IT'S YOUR CHOICE ENROLLMENT PERIOD

The “It’s Your Choice” enrollment period is the annual opportunity for our insured subscribers to select one of the many health plans offered by the Wisconsin Public Employers Group Health Insurance program. Today, eligible subscribers have over 17 different health plans from which to choose. In previous years, we have referred to this enrollment opportunity by its more technical name, “Dual-Choice”. Following are some of the most commonly asked questions about the enrollment period. You can also find information about key terms in the Glossary at the back of this booklet.

### 1. Is the It’s Your Choice enrollment available to everyone?

No, the It’s Your Choice enrollment period is offered only to subscribers presently insured under the Wisconsin Public Employers Group Health Insurance program.

### 2. May I change from single to family coverage during the It’s Your Choice enrollment period?

Yes, you have the opportunity to change from single to family coverage without a waiting period or exclusions for pre-existing medical conditions. Coverage will be effective January 1 of the following year to include all eligible dependents.

### 3. How do I change health plans during the It’s Your Choice enrollment period?

If you decide to change to a different plan, you need to follow these instructions by the last day of the enrollment period:

- Active employees should receive blank applications from your benefits/payroll/personnel office to complete and return to that office.
- Annuitants and continuants should complete the application found in the back of this booklet and submit it to ETF.

Applications received after the deadline will not be accepted.

**Note:** If you plan to stay with your current plan for next year and you are not changing your coverage, you do not need to take any action.

# Frequently Asked Questions

## 4. What is the effective date of changes made during the It's Your Choice enrollment period?

It's Your Choice coverage changes are effective January 1 of the following year.

## 5. What if I change my mind about the health plan I selected during the It's Your Choice enrollment period?

You may submit or change an application at any time during the It's Your Choice enrollment period. After that time, you may withdraw your application (and keep your current coverage) by following these instructions before December 31.

- Active employees should inform your benefits/payroll/personnel office.
- Annuitants and continuants should notify ETF.

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## 6. How do I select a health plan?

You will want to:

- Determine which plans have providers in your area by reviewing the Health Plan map on page 24.
- Contact the health plans directly for information regarding available physicians, medical facilities, and services.
- Review the Health Plan Report Card in the *Choose Quality* section in the book and at <http://etf.wi.gov>.
- Review the Plan Descriptions in the *Choose Your Health Plan* section.
- Compare the premium rates and contributions beginning on page 25.

## 7. Can family members covered under one policy choose different health plans?

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

SELECTING A  
HEALTH PLAN



## 8. Can I receive medical care outside of my health plan network?

This can be a concern for members who travel frequently, and those who have a covered dependent living elsewhere, such as a college student living away from home. When selecting a health plan you will want to consider the following:

- If you are covered through an HMO, you are required to obtain routine care from providers in the HMO's network. HMOs will cover emergency care outside of their service areas, but you must get any follow-up care to the emergency from providers in the HMO's network.
- If you are covered through a Preferred Provider Plan (PPP) such as WPS Metro Choice or the Standard Plan, you have the flexibility to seek care outside a particular service area. However, out-of-network care is subject to higher deductible and coinsurance amounts.

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

Contact the plan directly. Neither ETF nor your benefits/payroll/personnel office maintains a current list of this information.

## 10. If I change plans, what happens to any benefit maximums that may apply to services I've received?

When you change plans for any reason (for example, during the It's Your Choice enrollment period or due to a move from a plan's service area), any annual health insurance benefit maximums will start over at \$0 with your new plan, such as durable medical equipment, even if you change plans mid-year. 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.

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## 11. What are the new benefits for Autism Spectrum Disorder (ASD)?

Your insured dependents are eligible for both intensive-level and nonintensive-level services for the treatment of ASD if the treatment is prescribed by a physician and performed by a qualified provider as defined in Wis. Stat. § 632.895 (12m) (b). For detailed information, contact your health plan at the number found on the back cover of this book.



## 12. What are the new benefits for Cochlear Implants and Hearing Aids?

Your insured dependents under 18 years of age are eligible for coverage for the cost of cochlear implants, hearing aids, and related treatment. This is a new benefit for members in the Standard Plan. This is a benefit enhancement for members covered under Uniform Benefits, where previously these services were covered at 80% up to an out-of-pocket maximum.

## 13. What are the new Mental Health and AODA Benefits?

There are two changes to mental health benefits and one change to coverage of Alcohol and Drug Abuse (AODA) treatment due to changes in the law. They are:

- Federal mental health parity laws have eliminated the annual dollar maximums and day limits for mental health and AODA services. These services will be applied toward your lifetime policy maximum.
- State mandates now allow for coverage provided by a licensed mental health professional practicing within the scope of his or her license. This primarily includes independent psychologists and social workers. This results in making more providers available to members in the

Standard and SMP Plans. It's not expected to result in a significant change of providers to members in Uniform Benefits. Contact your health plan for more information.

#### 14. Who is eligible for Domestic Partner health insurance benefits?

Subscribers can enroll their Domestic Partner and their domestic partner's eligible dependents if they can attest to all of the following on the *ETF Affidavit of Domestic Partnership*.

The criteria are:

1. On the date the affidavit is signed, both domestic partners are at least 18 years of age and legally competent.
2. Neither domestic partner is married to or in a domestic partnership with another person, or has been divorced or terminated a domestic partnership within the past 6 months.
3. They are not related by blood in any way that would prohibit marriage under Wisconsin's laws.
4. They consider themselves to be members of each other's immediate family.
5. They agree to be responsible for each other's basic living expenses.
6. They share a common residence.

If the domestic partners attest to this on a notarized ETF affidavit, the health insurance coverage for the domestic partner of the employee or annuitant and their eligible dependents will be effective:

- January 1, 2010 for domestic partners whose completed affidavit is received by ETF on or before December 30, 2009. We encourage you to file your affidavit and health insurance application to add your domestic partner and his/her eligible dependents as soon as possible, starting during the It's Your Choice enrollment period in October.
- The date the completed affidavit is received by ETF after January 1, 2010.



**Note:** See Important Note following question 15 for information regarding how the fair market value of this benefit may impact your taxes.

### 15. What are the new Dependent Eligibility changes?

Effective January 1, 2010, adult children are now eligible for coverage up to the end of the month in which they turn the age of 27 as long as:

- They are not married, and
- They are not eligible for coverage under a group health benefit plan as defined in Wis. Stat. § 632.745 (9), that is offered by their employer and for which the amount of the premium contribution is not greater than the premium amount for their coverage as a dependent under this program.

#### **Important note for subscribers with domestic partners or other dependents who are not tax dependents:**

There are two important issues for subscribers.

First, the fair market value (FMV) of insurance coverage provided for a domestic partner and his/her eligible dependents, or for other individuals who do not qualify as dependents under Internal Revenue Code (IRC) Section 152, is taxable. Therefore, the FMV of the health insurance benefit will be calculated and added to an employee's earnings as imputed income.

Second, the employee's share of premium that is attributable to a non-qualifying dependent's coverage will be deducted on a post-tax basis. Employees may change from single to family coverage to add a newly eligible domestic partner or other dependent who does not qualify as a dependent under IRC Section 152 during the plan year, but the additional premium attributable to the non-qualified dependent will be taxable and deducted on a post-tax basis. It has not yet been determined if a person with family coverage can add a non-qualified dependent during the year.

The details have not been finalized as of the printing of this book. As more information becomes available, ETF will post it on their website and payroll/benefits/personnel offices will provide it to affected employees.



## 16. What is imputed income?

Imputed income is the non-cash benefit earned for items, such as health insurance for certain dependents, that is reported as income to the government on forms such as the W-2. Employees and annuitants may be taxed on the fair market value (FMV) of the health care coverage extended to their dependents who do not qualify as dependents for tax purposes.

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## 17. If I do not change from single to family coverage during the It's Your Choice enrollment period will I have other opportunities to change plans?

There are other opportunities for coverage to be changed from single to family without restrictions as described below:

1. If a *Health Insurance Application/Change* form (ET-2301) is received by your benefits/payroll/personnel office for active employees or ETF for annuitants, within 30 days of the following events, coverage becomes effective on the date of the following event:
  - Marriage or domestic partnership (Domestic partnership is effective on the date the affidavit is received by ETF. See question 14 for more information).
  - You or any of your eligible dependents involuntarily lose other medical coverage or lose the employer contribution for the other coverage.
  - Legal guardianship is granted.
  - An unmarried parent whose only eligible child becomes disabled and thus is again an eligible dependent. Coverage will be effective the date eligibility was regained.
2. If an application is received by your benefits/payroll/personnel office for active employees or ETF for annuitants, within 60 days of the following events, coverage becomes effective on the date of the following event:
  - Birth, adoption of a child or placement for adoption (timely application prevents claim payment delays).
  - 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 Services (or equivalent if the birth was outside of the state of Wisconsin). The effective date of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. If filed more than 60 days after the birth, coverage will be effective on the first of the month following receipt of application.

3. If an application is received by your benefits/payroll/ personnel office for active employees or ETF for annuitants, 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 application by the employer; or
  - The date specified on the Medical Support Notice.

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

#### 18. What if my spouse or domestic partner and I work for the same employer?

Your employer may determine whether married employees or domestic partners may elect single or family coverage, or if they are eligible only for family coverage through one of the spouses/domestic partners.

**Note:** For domestic partners, further information is available on our website, [etf.wi.gov](http://etf.wi.gov).

#### 19. What do I need to do when my spouse or domestic partner or I become eligible for Medicare?

Most people become eligible for Medicare at age 65. For some, it occurs earlier due to disability or End Stage Renal Disease. (See the Medicare Information in the *Reference Guide* for full details.)

**Active Employees and their dependents** may wish to enroll in Medicare Part A when you first become eligible at age 65. However, the requirement to enroll for



Medicare Part B coverage is deferred until the subscriber's termination of the WRS-covered employment through which active employee coverage is provided. Medicare Part D coverage is voluntary and enrollment can also be deferred without penalty, as with Part B, until the subscriber's termination.

***Subscribers and their dependents with End Stage Renal Disease (ESRD)*** will want to contact your local Social Security Office, health plan, provider, and Medicare to make sure you enroll in Medicare Parts A and B at the appropriate time. You will want to decide if it would be beneficial to enroll in Part B during your initial or general enrollment opportunities to avoid delayed Medicare enrollment and potential premium penalties after your 30-month coordination period ends

***Retired Wisconsin Public Employers Employees (Annuitants) and their dependents*** that are eligible for coverage under the federal Medicare program must immediately enroll in both Medicare Parts A and B. If you do not enroll for all available portions of Medicare upon retirement, you may be liable for the portion of your claims that Medicare would have paid on the date Medicare coverage would have become effective. For pharmacy benefit coverage, if you are eligible for Medicare when you retire, or obtain Medicare eligibility after retiring, you will be enrolled in the State's preferred Medicare Part D prescription drug plan (PDP). Your prescription drug coverage will no longer be managed by the State's PBM. It is important to provide ETF with a copy of your, and/or your dependents', Medicare card as soon as possible after receiving it. However, if you or your insured spouse or domestic partner is also insured as an active employee under a non-Wisconsin Public Employers group plan, enrollment in Medicare may be deferred until retirement from that job.

**Important Caution:** All health plans have coverage options that coordinate with Medicare and you will remain covered by the plan you selected after you are enrolled in Medicare Parts A and/or B.

***For those Annuitants enrolled in both Medicare Parts A and B*** the following exceptions apply:

- Members enrolled in the SMP Plan will be changed to the Standard Plan on the member's Medicare effective date.
- Members enrolled in Humana will be enrolled in their Medicare Advantage Private Fee-For-Service (MA-PFFS) plan after they enroll in Medicare Parts A and B through Social Security.

**20. What if I have a child who is disabled and I am changing health plans during It's Your Choice?**

You should consider that each health plan has the right to determine whether or not a newly enrolled disabled dependent meets the (new) plan's definition of disabled dependent. (See the Dependent Information contained in the *Reference Guide* for full details.)



# Choose Your Health Plan

Introduction to Health Plan Options

Health Plan Map

Health Plan Premium Rates

Comparison of Benefit Options

Health Plan Features - At a Glance

Health Plan Descriptions



# Introduction to Health Plan Options

As a participant in the Wisconsin Public Employers Group Health Insurance program, all the health plans listed in this booklet are available to you. This includes 17 different private insurers (also called the “Alternate Plans”), the “Standard Plan,” and “State Maintenance Plan” (SMP). All of these options are described in more detail below. You will want to choose the plan that works best for you based on the location of providers, the premium costs, and the quality of the care they deliver.

## Alternate Health Plans

Nearly 100% of current local employees chose coverage through the Alternate Health Plans. These include 17 Health Maintenance Organizations (HMOs)\* and 1 Preferred Provider Plan (PPP)\*\*. These health plans all administer a “Uniform Benefits” package, meaning you will receive the same package of covered benefits and services, regardless of your health plan selection. *Uniform Benefits* is described in detail in the *It’s Your Choice: Reference Guide*.

You should be aware that there are some differences amongst the Alternate Health Plans and these can change annually. When choosing from these health plans, you should consider the following:

- **Premium:** As an employee, your total monthly premium contribution amount can vary. Your employer will provide information about each plan’s cost to you.
- **Provider Network:** The location, quantity, quality, and availability of the doctors, clinics, hospitals, and emergency/urgent care centers are different for each health plan.
- **Dental Benefits (if offered):** The location and availability of dental benefits and providers are different for each plan.
- **Benefit Determinations:** While all plans cover the Uniform Benefits package, this does not mean that all health plans will treat all illnesses or injuries in an identical manner. Treatment will vary depending on the needs of the patient, the preferred practices of the physicians, and the managed care policies and procedures of the health plan.
- **Administrative Requirements:** The health plans may require you to select a primary care provider (PCP), get a referral from your PCP before seeing a specialist, or get a prior authorization before obtaining certain services.

# Introduction to Health Plan Options

\*An **HMO** is an entity that provides health care through a group of hospitals, physicians, and other health professionals who contract or collectively agree to provide all medically necessary covered services to the HMO's participants in return for a pre-paid fee. Each HMO offers service only in specific areas of the State.

All insured members of an HMO are expected to receive their health care only through physicians, health professionals, and hospitals affiliated with that HMO. Do not expect to join an HMO and get a referral to a non-HMO physician. An HMO generally refers outside its network only if it is unable to provide needed care within the HMO.

\*\*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 will contribute more toward your health care costs. This arrangement can be attractive to our participants who are generally satisfied with the health plan's providers, but who may occasionally need to utilize a particular specialist or need additional options while traveling. Currently, the only available Alternate Health Plan that is a PPP is WPS Metro Choice.



# Introduction to Health Plan Options

## State Maintenance Plan (SMP)

The SMP is available only in counties that lack a qualified HMO. You can compare SMP to the Uniform Benefits package on pages 29 through 31.

## The Standard Plan

The Standard Plan is administered by WPS. The Standard Plan provides you with comprehensive freedom of choice among hospitals and physicians across Wisconsin and nationwide. You can compare the Standard Plan to the Uniform Benefits package on pages 29 through 31.



## Health Plans Available to Annuitants and Continuant

### **Medicare Coordinated Plans**

All health plans have coverage options which are coordinated with Medicare. You will remain covered by the plan you select after you are enrolled in Medicare Parts A and B. The following exceptions apply:

1. Members enrolled in the SMP Plan will be moved to the Standard Plan plan on the member's Medicare effective date.
2. Members enrolled in Humana will be enrolled in Humana's Medicare Advantage Private Fee-For-Service (MA-PFFS) plan after they enroll in Medicare Parts A and B.

The **Medicare Advantage Private Fee-For-Service Plan** (MA-PFFS) allows members to use any healthcare provider that participates with Medicare, accepts Medicare payments, and accepts the health plan. The MA-PFFS plan is modeled to replicate the Uniform Benefits package.



# Health Plan Premium Rates

This section lists the total monthly premium for each plan. Your employer will provide information about each plan's cost to you.

Employers determine the amount they will contribute toward the premium under one of the two methods described here.

1. Your employer pays between 50% and 105% of the premium rate of the lowest cost qualified plan in the employer's service area for either single or family coverage for employees who are participants under the Wisconsin Retirement System (WRS).

Note: Your employer may pay as little as 25% of the premium for either single or family coverage for an employee appointed to a position working less than 1044 hours per year and who is a participating employee under the WRS.

2. A Three-Tier health insurance premium option is also available to employers. The Group Insurance Board and their actuaries rank and assign each of the available health plan to one of three Tier categories, based its efficiency and quality of care. Your premium contribution is determined by the Tier ranking of your health plan. 2010 Health Plan Tiers appear on page 28

The employee's required contribution to the health insurance premium for coverage is generally the same dollar amount for all health plans in the same tier, regardless of the total premium.

**NOTE:** Your employer may contribute any amount toward the premium for retired employees who continue group coverage.

# LOCAL GOVERNMENT EMPLOYEES & ANNUITANTS RATES

## 2010 Traditional HMO Option - Classic Standard Plan

PLAN NAME	Plan code	Local Employees & Non-Medicare Annuitants		Local Medicare Annuitants		
		Single	Family	Single	Medicare 1*	Medicare 2**
ANTHEM BLUE NORTHEAST	AE	1524.10	3806.60	992.60	2514.20	1982.70
ANTHEM BLUE NORTHWEST	AW	1106.70	2763.10	784.00	1888.20	1565.50
ANTHEM BLUE SOUTHEAST	AS	1524.10	3806.60	992.60	2514.20	1982.70
ARISE HEALTH PLAN	A	664.30	1657.10	562.70	1224.50	1122.90
DEAN HEALTH PLAN	D	508.10	1266.60	479.70	985.30	956.90
GHC OF EAU CLAIRE	GEC	840.90	2098.60	634.30	1472.70	1266.10
GHC OF SOUTH CENTRAL WISCONSIN	GSC	510.60	1272.80	485.90	994.00	969.30
GUNDERSEN LUTHERAN HEALTH PLAN	GL	709.70	1770.60	585.50	1292.70	1168.50
HEALTHPARTNERS	HP	820.50	2047.60	621.30	1439.30	1240.10
HEALTH TRADITION HEALTH PLAN	HT	737.90	1841.10	599.50	1334.90	1196.50
HUMANA EASTERN	HE	1370.10	3421.60	543.80	1911.40	1085.10
HUMANA WESTERN	HW	1370.10	3421.60	543.80	1911.40	1085.10
MEDICAL ASSOCIATES HEALTH PLAN	MA	556.40	1387.30	441.70	995.60	880.90
MERCYCARE HEALTH PLAN	MC	506.40	1262.30	483.80	987.70	965.10
NETWORK HEALTH PLAN	N	601.90	1501.10	531.50	1130.90	1060.50
PHYSICIANS PLUS--MERITER & UW HEALTH	PP	506.70	1263.10	456.40	960.60	910.30
SECURITY HEALTH PLAN	S	978.00	2441.30	598.00	1573.50	1193.50
STANDARD PLAN: BALANCE OF STATE <sup>1</sup>	NA	1002.70	2502.90	427.10	1429.70	851.70
STANDARD PLAN: DANE <sup>2</sup>	NA	929.20	2319.30	427.10	1356.30	851.70
STANDARD PLAN: MILWAUKEE <sup>3</sup>	NA	1084.50	2707.50	427.10	1511.60	851.70
STANDARD PLAN: WAUKESHA <sup>4</sup>	NA	1002.70	2502.90	427.10	1429.70	851.70
STATE MAINTENANCE PLAN	SMP	666.90	1663.70	NA	NA	NA
UNITEDHEALTHCARE NE	UN	691.40	1724.80	576.30	1265.20	1150.10
UNITEDHEALTHCARE SE	US	699.80	1745.80	580.50	1277.80	1158.50
UNITY COMMUNITY	UC	487.50	1215.10	474.40	959.40	946.30
UNITY UW HEALTH	UU	488.00	1216.30	474.60	960.10	946.70
WPS METRO CHOICE	W	957.10	2389.10	709.20	1663.80	1415.90

Please refer to page 27 for footnoted information.

Note that single and family rates apply when no family members are eligible for Medicare. At least one insured family member must be eligible for Medicare in order for the Medicare rates to apply. Furthermore, Medicare premium rates apply only to subscribers who have terminated employment.

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Footnotes from page 26:

NA = "not applicable". Medicare eligible participants automatically receive Standard Plan benefits.

\*Medicare 1 = Family coverage with at least one insured family member enrolled in Medicare Parts A, B, & D.

\*\*Medicare 2 = Family coverage with all insured family members enrolled in Medicare Parts A, B, & D.

Standard Plan rates are determined by the employer county or the retiree county of residence. Counties are divided into the following rate categories:

<sup>1</sup>BALANCE OF STATE: All other Wisconsin counties not listed below

<sup>2</sup>DANE: Dane, Grant, Jefferson, La Crosse, Polk, St. Croix

<sup>3</sup>MILWAUKEE: Milwaukee county & retirees and continuants living out of state

<sup>4</sup>WAUKESHA: Kenosha, Ozaukee, Racine, Washington, Waukesha

# LOCAL HEALTH PLAN TIERS

2010 Health Plans by Tier for Local Employees
<b>TIER 1</b>
ARISE HEALTH PLAN
DEAN HEALTH PLAN
GHC OF EAU CLAIRE
GHC OF SOUTH CENTRAL WISCONSIN
GUNDERSEN LUTHERAN HEALTH PLAN
HEALTHPARTNERS
HEALTH TRADITION HEALTH PLAN
MEDICAL ASSOCIATES HEALTH PLAN
MERCYCARE HEALTH PLAN
NETWORK HEALTH PLAN
PHYSICIANS PLUS - MERITER & UW HEALTH
SECURITY HEALTH PLAN
STATE MAINTENANCE PLAN (SMP)
UNITEDHEALTHCARE NE
UNITEDHEALTHCARE SE
UNITY COMMUNITY
UNITY UW HEALTH
WPS METRO CHOICE
<b>TIER 2</b>
NO TIER 2 HEALTH PLANS
<b>TIER 3</b>
ANTHEM BLUE NORTHEAST
ANTHEM BLUE NORTHWEST
ANTHEM BLUE SOUTHEAST
HUMANA EASTERN
HUMANA WESTERN
STANDARD PLAN

# Comparison of Benefit Options

The chart on the following pages is designed to compare Uniform Benefits, the Standard Plan and the State Maintenance Plan (SMP).

This outline is not intended to be a complete description of coverage. The Uniform Benefits package is described in detail in your *It's Your Choice: Reference Guide*. Details for the other plans are found in the Standard Plan (ET-2131), and the State Maintenance Plan (ET-2165) benefit booklets.

All of the plans listed are substantially equivalent in the value of their benefits. However, there may be differences amongst the health plans in the administration of the benefits package. Health plans may have slight differences in benefits such as dental or wellness programs, and treatment may vary depending on the needs of the patient, the preferred practices of the physicians, and the managed care policies and procedures of the health plan.

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Note: Footnotes below refer to the chart on the following pages.

<sup>1</sup> Deductible applies to all Uniform Benefits medical services when employer selects deductible option. Deductible applies to only major medical\* Standard Plan and SMP services. Does not apply to prescription drugs.

<sup>2</sup> Coinsurance out-of-pocket maximum (OOPM) does not include deductible.

<sup>3</sup> This is separate from other out-of-pocket maximums, such as the medical.

<sup>4</sup> Level 3 copays don't apply to the OOPM.

# Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN	STATE MAINTENANCE PLAN (SMP)
Annual Deductible <sup>1</sup>	No deductible (OR option of \$500 single / \$1000 family)	Major Medical* only Non-Medicare: \$250 single, \$500 family Medicare: \$150 single, \$300 family	Major Medical* only \$200 single, \$400 family
Annual Co-insurance <sup>2</sup>	As described below	Major Medical* only 80%/20% to out-of-pocket maximum \$1,000 single/\$2,000 family	Major Medical* only 80%/20% to out-of-pocket maximum \$1,000 single/\$2,000 family
Maximum	\$2 Million	Major Medical* only \$250,000	Major Medical* only \$250,000
Hospital Days	As medically necessary, plan providers only	100% up to 365 per admission, then Major Medical*	100% up to 365 days per admission, then Major Medical*
Emergency Room	\$60 copay per visit	100%, no copay on Base** Major Medical* deductible/coinsurance as applicable	100%, no copay on Base** Major Medical* deductible/coinsurance as applicable
Ambulance	100%	Plan pays first \$50 per trip, then applies Major Medical* deductible/ coinsurance	Plan pays first \$50 per trip, then applies Major Medical* deductible/ coinsurance
Transplants (May cover these and others listed)	Lifetime benefit of \$1,000,000. <i>Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung</i>	100% <i>Bone marrow, parathyroid, musculoskeletal, corneal, and kidney</i>	100% <i>Bone marrow, parathyroid, musculoskeletal, corneal, and kidney</i>
Mental Health/ Alcohol & Drug Abuse	Inpatient, Outpatient, & Transitional 100%	Inpatient 100% 120 days; Outpatient & Transitional- portions can be covered under base** &/or major medical* deductible/ coinsurance.	Inpatient 100% 120 days; Outpatient & Transitional- portions can be covered under base** &/or major medical* deductible/ coinsurance.
Routine Physical	One per year	Major Medical* deductible/ coinsurance applies to the office visit	100%
Hearing Exam	100%	Benefit for illness or disease, Major Medical* deductible/ coinsurance applies	Benefit for illness or disease, 100%
Hearing Aid (per ear)	Every 3 years: Adults, 80%/ 20% up to \$1,000; Dependents under 18, 100%, maximum does not apply.	For dependents under 18 only, every 3 years- 100%- subject to major medical* deductible/ coinsurance	For dependents under 18 only, every 3 years- subject to major medical* deductible/ coinsurance

# Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN	STATE MAINTENANCE PLAN (SMP)
Cochlear Implants	Adults 80% / 20% for device, surgery, follow-up sessions; 100% hospital charge for surgery. Dependents under 18, 100%	Dependents under 18, portions can be covered under base** &/or major medical* deductible/ coinsurance.	Dependents under 18, portions can be covered under base** &/or major medical* deductible/ coinsurance.
Routine Vision Exam	One per year	No Benefit for routine. Illness or disease only, Major Medical* deductible/ coinsurance applies	Preventative up to age 18, 100% one per year. Age 18 and older, illness or disease only, 100%
Skilled Nursing Facility (non custodial care)	120 days per benefit period	100% up to a max of 120 per confinement less hospital days used	100% up to a maximum of 120 days per admission less hospital days used
Home Health (non custodial)	50 per year; Plan may authorize an additional 50	100% up to 365 days less hospital days used	100% up to 365 days less hospital days used
Physical/Speech /Occupational Therapy	50 per year; Plan may prior-authorize an additional 50	Major Medical* deductible/ coinsurance, no limit on visits or days	Major Medical* deductible/ coinsurance, no limit on visits or days
Durable Medical Equipment	20% co-insurance, \$500 OOP maximum	Major Medical* deductible/ coinsurance	Major Medical* deductible/ coinsurance
Referrals	In network varies by plan. Out of network required.	Not required	In network none required. Out of network required.
Primary Care Provider/Clinic	Varies by plan	Not required	Any provider in network
Surgical Treatment for Morbid Obesity	Excluded	100% Base** benefits, Major Medical* services to deductible/ coinsurance	Excluded
Oral Surgery	11 procedures	23 procedures. 100%	23 procedures. 100%
Dental Care	Varies by plan	No benefit	Preventative up to age 12, 100%
Drug Copays and Out-of-Pocket Maximum OOPM <sup>3</sup>	Level 1=\$5; 2=\$15; 3=\$35 <sup>4</sup> . OOPM \$410 individual / \$820 family	Level 1=\$5; 2=\$15; 3=\$35 <sup>4</sup> . No limit	Level 1=\$5; 2=\$15; 3=\$35 <sup>4</sup> . No limit

\* Common Major Medical services comprise durable medical equipment, physical/speech/occupational therapy, medical services and supplies, cardiac rehabilitation, and total extraction and replacement of teeth.

\*\*Base benefits are hospital inpatient services and most professional services such as surgery and anesthesia. Note that professional services have an aggregate maximum payment of \$10,000 per participant per illness or injury. Professional charges after \$10,000 may be payable under major medical services.

# Health Plan Features - At a Glance

## Evaluate Your Health Plan Features and Take Charge of Your Health

On the surface, you may think that there is not much difference amongst the health plan options available to you. However, benefits and services can vary from plan to plan. The chart on the following pages was developed to assist you in comparing the health plans on key benefits and services.

### Dental Benefits

The Uniform Benefits package does not include coverage for routine dental care, but the health plans have the option to offer dental coverage to members. The comparison chart highlights the plans that have elected to provide some level of dental coverage. Members who place a high value on dental services should refer to the additional information in the Plan Descriptions that appear later in this section, or contact the health plan directly if you have specific questions regarding dental coverage or dental provider availability.

### Quality

Each year, participating health plans are evaluated based on care delivery, in areas such as wellness and prevention, disease management, and consumer satisfaction. The chart lists how the various health plans rated on overall quality and how many of our members would recommend their plan to family and friends. We encourage you to also look at the more comprehensive quality ratings in the *Report Card* section of this book.

### Health & Wellness Plan Services

Your daily decisions and actions can have a positive or negative impact on your overall health. The chart lists which plans offer the following services.

Selecting a Primary Care Physician (PCP) or clinic location is required by some health plans.

Health Risk Assessments (HRA) are a great 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

# Health Plan Features - At a Glance

osteoporosis. Once you have completed your questionnaire, the health plan will provide you with personalized information to help you take charge of your health.

Wellness Classes and Education may be offered by the health plans. These services may be in the form of online education tools, classes through providers, and/or discounts to participate in various wellness activities.

24-Hour Nurseline is 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. This is a useful resource in determining if you need to seek emergency or urgent care services, or if you have a medical question and can't reach your primary care physician.

## Online Services

If you have internet access, some health plans offer online information and services on their websites. The chart lists some of the services the various plans offer, such as searchable provider directories and access to your medical information.

# Health Plan Features – At a Glance

Stars: ★ 1-4, one being lowest

• Indicates a “Yes” response. This means the Health Plan either offers the service or has a requirement that applies.	Quality Information			Dental Benefits			
	Overall Quality Score	% That Would Recommend Plan to Family or Friends	NCQA Accreditation	Deductible Applies	Orthodontic Benefits	Annual Benefit Maximum per Member	Separate Dental ID Card Required
ANTHEM BLUE NORTHEAST	★	Not Available	●	No Dental Coverage Available			
ANTHEM BLUE NORTHWEST	★	73%	●	No Dental Coverage Available			
ANTHEM BLUE SOUTHEAST	★	89%	●	No Dental Coverage Available			
ARISE HEALTH PLAN	★★★★	93%	●	●	●	●	●
DEAN HEALTH PLAN	★★★★	95%	●	No Dental Coverage Available			
GHC OF EAU CLAIRE	★★★★★	98%		No Dental Coverage Available			
GHC OF SOUTH CENTRAL WISCONSIN	★★★★★	97%	●		●		
GUNDERSEN LUTHERAN HEALTH PLAN	★★★★	99%		●		●	
HEALTHPARTNERS	Not Available	Not Available	●	No Dental Coverage Available			
HEALTH TRADITION HEALTH PLAN	★★★★	93%		●		●	
HUMANA EASTERN	★	93%	●	●	●		●
HUMANA WESTERN	★	70%	●	●	●		●
MEDICAL ASSOCIATES	★★★★★	97%	●	●	●	●	
MERCYCARE	★★	92%	●	No Dental Coverage Available			
NETWORK HEALTH PLAN	★★★★	97%	●	●	●	●	●
PHYSICIANS PLUS--MERITER & UW HEALTH	★★★★	97%		No Dental Coverage Available			
SECURITY HEALTH PLAN	★★★★★	97%	●	No Dental Coverage Available			
UNITEDHEALTHCARE NE	★	92%	●	●	●	●	●
UNITEDHEALTHCARE SE	★	91%	●	●	●	●	●
UNITY COMMUNITY	★★★★	93%	●	No Dental Coverage Available			
UNITY UW HEALTH	★★★★	96%	●	No Dental Coverage Available			
WPS METRO CHOICE	Not Available	87%		No Dental Coverage Available			

# Health Plan Features – At a Glance

Health Plan Services				Online Services			
Primary Care Physician or Clinic Required	Health Risk Assessments (HRA)	Wellness Classes & Education	24-Hour Nurseline	Searchable Provider Directory	Communicate with Member Services Through a Message Center	Request and View Appointments	Review Preventive Test Results and/or Electronic Health Records
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## Anthem Blue Preferred Northeast Network

(800) 490-6201 (Non-members select "1", "0#", "0#" from menu)

[www.anthem.com](http://www.anthem.com)



Overall Quality Rating

See Report Card section

- **What's New for 2010**

Anthem 360° Health gives you a variety of tools to help you enhance your well-being every day. You can access online tools to calculate your personal health index, keep a record of your children's shots, listen to recorded messages on hundreds of health topics and more.

- **Provider Directory**

Go to [www.anthem.com/shared/wi/f4/s1/t0/pw\\_ad093378.pdf](http://www.anthem.com/shared/wi/f4/s1/t0/pw_ad093378.pdf). To search for a provider, go to [www.anthem.com](http://www.anthem.com) and enter the site by selecting "Wisconsin." Click "Find a Doctor," select "Wisconsin" and click "Next." Under the "Plan Information" pull down menu, select "Blue Preferred HMO Northeast – State of Wisconsin." Or call Anthem Customer Service to request a paper copy of the directory.

- **Referrals and Prior Authorizations**

You do not need a referral from your primary care physician (PCP) to see any of the 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. 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. Anthem will provide a written response to requests to both you and your PCP.

- **Care Outside Service Area**

Emergency Care: 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: Call your primary care physician (PCP) for advice about appropriate treatment.

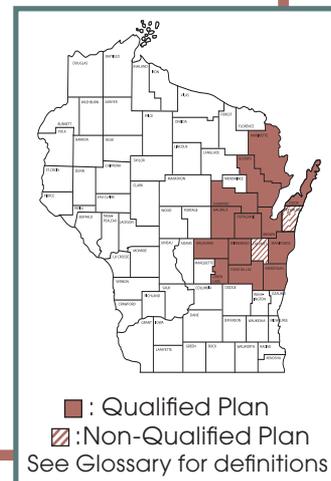
All Other Care: You must receive prior authorization from Anthem for all other care outside the Northeast Network as explained above. .

- **Mental & Behavioral Health Services**

You do not need a referral to see a Northeast Network mental health provider. Precertification is required for inpatient care.

- **Dental Benefits**

No routine dental coverage provided.





## Anthem Blue Preferred Northwest Network

(800) 490-6201 (Non-members select "1", "0#", "0#" from menu)  
www.anthem.com

### • What's New for 2010

Provider network now includes Mayo (Luther Midelfort in Eau Claire and Red Cedar) and Lakeview Hospital in Stillwater, Minnesota. Anthem 360° Health gives you online tools to calculate your personal health index, keep a record of your children's shots, listen to recorded messages on hundreds of health topics and more.

### • Provider Directory

Go to [www.anthem.com/shared/noapplication/f4/s2/t0/pw\\_ad088213.pdf](http://www.anthem.com/shared/noapplication/f4/s2/t0/pw_ad088213.pdf). To search for a provider, go to [www.anthem.com](http://www.anthem.com) and enter the site by selecting "Wisconsin." Click "Find a Doctor," select "Wisconsin" and click "Next." Under the "Plan Information" pull down menu, select "Blue Preferred HMO Northwest – State of Wisconsin." Or call Anthem Customer Service to request a paper copy of the directory.

### • Referrals and Prior Authorizations

You do not need a referral from your primary care physician (PCP) to see any of the 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. 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. Anthem will provide a written response to requests to both you and your PCP.

### • Care Outside Service Area

**Emergency Care:** 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:** Call your primary care physician (PCP) for advice about appropriate treatment.

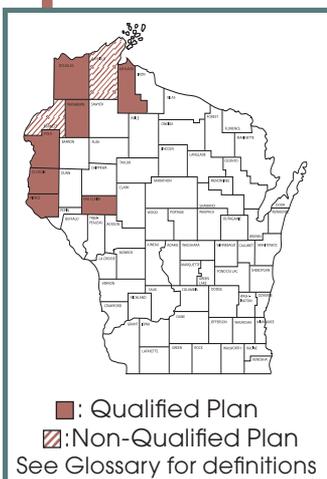
**All Other Care:** You must receive prior authorization from Anthem for all other care outside the Northwest Network as explained above.

### • Mental & Behavioral Health Services

You do not need a referral to see a Northwest Network mental health provider. Precertification is required for inpatient care.

### • Dental Benefits

No routine dental coverage provided.



## Anthem Blue Preferred Southeast Network

(800) 490-6201 (Non-members select "1", "0#", "0#" from menu)

[www.anthem.com](http://www.anthem.com)



Overall Quality Rating

See Report Card section

- **What's New for 2010**

Anthem 360° Health gives you a variety of tools to help you enhance your well-being every day. You can access online tools to calculate your personal health index, keep a record of your children's shots, listen to recorded messages on hundreds of health topics and more.

- **Provider Directory**

Go to [www.anthem.com/shared/noapplication/f4/s2/t0/pw\\_ad088214.pdf](http://www.anthem.com/shared/noapplication/f4/s2/t0/pw_ad088214.pdf). To search for a provider, go to [www.anthem.com](http://www.anthem.com) and enter the site by selecting "Wisconsin." Click "Find a Doctor," select "Wisconsin" and click "Next." Under the "Plan Information" pull down menu, select "Blue Preferred HMO Southeast – State of Wisconsin." Or call Anthem Customer Service to request a paper copy of the directory.

- **Referrals and Prior Authorizations**

You do not need a referral from your primary care physician (PCP) to see any of the 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. 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. Anthem will provide a written response to requests to both you and your PCP.

- **Care Outside Service Area**

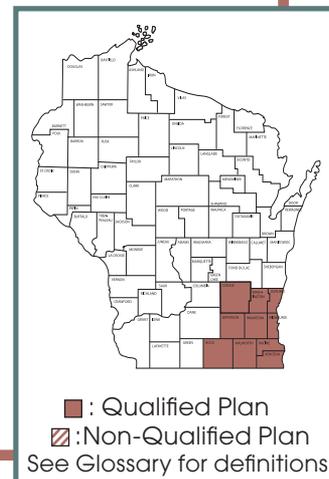
Emergency Care: Go to the nearest health care facility for treatment, and contact your primary care physician (PCP) and Anthem within 24 hours or as soon as reasonably possible. Urgent Care: Call your primary care physician (PCP) for advice about appropriate treatment. All Other Care: You must receive prior authorization from Anthem for all other care outside the Southeast Network as explained above.

- **Mental & Behavioral Health Services**

You do not need a referral to see a Southeast Network mental health provider. Precertification is required for inpatient care.

- **Dental Benefits**

No routine dental coverage provided.



## Arise Health Plan

(888) 711-1444 toll free or (920) 490-6900

[www.WeCareForWisconsin.com](http://www.WeCareForWisconsin.com)



Overall Quality Rating  
See Report Card section

### • What's New for 2010

Our provider network now includes Agnesian Network providers, including the following hospitals: St Agnes Hospital (Fond du Lac County) and Waupun Memorial Hospital (Dodge County). These providers join our already robust provider network in northeast and north central Wisconsin featuring groups such as Prevea Health, Bellin Health, ThedaCare, Aspirus Network, Holy Family Memorial Network, Door County Memorial, and Bay Area Medical Center/NorthShore Health Network.

### • Provider Directory

Go to [www.WeCareForWisconsin.com](http://www.WeCareForWisconsin.com), select "Members" and then "Find A Doc." Enter group number "087889." Or call 1-888-711-1444 to request a directory.

### • Referrals and Prior Authorizations

No written referrals are required when receiving necessary care from participating providers. Pre-service authorization is required for all non-participating providers and tertiary care specialists. We will send written notification of approval or denial to you and your provider requesting the pre-service authorization. Please refer to your Arise handbook (*When Do I need a Pre-Service Authorization?*).

### • Care Outside Service Area

Emergency care is covered. If you are admitted to the hospital, you must notify us within 48 hours. If you are out of area and need urgent care, go to the nearest appropriate facility, unless you can safely return to the service area to receive care from a participating provider. For follow-up care, contact your PCP for instructions. Please refer to your Arise handbook (*Emergency, Urgent, Out Of Area Care*).

### • Mental & Behavioral Health Services

Participating providers must be used for all mental health and alcohol and other drug abuse (AODA) services. Pre-service authorization is required for inpatient services and transitional care; however, it is not required for outpatient care.

### • Dental Benefits (*This is a brief summary. Contact plan for details.*)

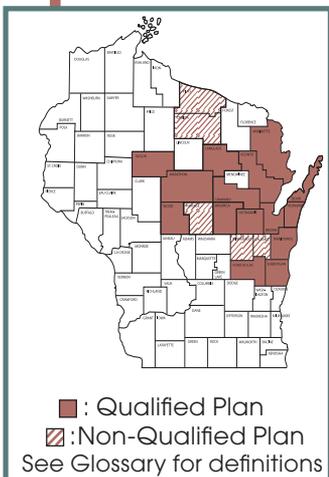
Preventive Services: Covered at 100%: Exams, cleanings, fluoride treatments, x-rays, space maintainers. Limited to 6 month intervals. Full mouth x-rays.

Restorative Services: Covered at 80%, subject to deductible (\$25 individual / \$75 family): Sealants (up to age 14, one per tooth per lifetime), fillings, & emergency treatment to relieve pain.

Annual Benefit Maximum: Individual maximum is \$1,000.

Orthodontics: 50% for eligible dependent children up to a lifetime maximum of \$1,500.

Dental Network: Go to [www.deltadentalwi.com](http://www.deltadentalwi.com). Select Premier or PPO as your dental plan. Call 1-800-236-3712 with questions.





- **What's New for 2010**

Online Health Risk Assessment (HRA) - A thorough wellness-based health assessment addressing all major lifestyle factors. HRA is available through DeanConnect on our website at [www.deancare.com](http://www.deancare.com).

- **Provider Directory**

Go to [www.deancare.com](http://www.deancare.com) to view the provider directory and/or search for a provider. Select "Members", then select "State of Wisconsin Members", then choose from the menu options. You may also call Customer Service to request a hard copy.

- **Referrals and Prior Authorizations**

Referrals are not needed when getting care from plan providers. Prior authorizations are required for certain services and for care from all non-plan providers. If you are not sure if a service or procedure requires prior authorization, you may contact our Customer Service Department. You must inform your provider to contact Dean Health Plan to obtain the prior authorization before getting care. Dean Health Plan will notify you and your provider in writing of the decision.

- **Care Outside Service Area**

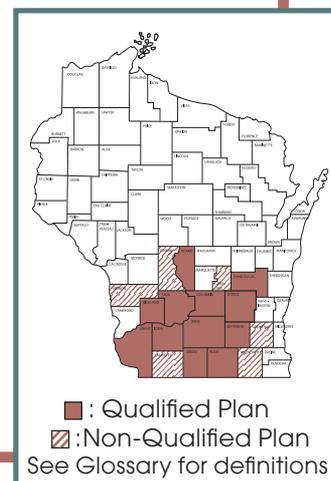
For emergency and/or urgent care outside our network; call us at the number on your ID card by the next business day or as soon as possible regarding the care received. Non-emergent/urgent care is not covered unless an approved prior authorization is obtained prior to services being received as explained above.

- **Mental & Behavioral Health Services**

You can see any plan provider. Inpatient mental health must be prior authorized

- **Dental Benefits**

No routine dental coverage provided.





## Group Health Cooperative of Eau Claire

(888) 203-7770 or (715) 552-4300

[www.group-health.com](http://www.group-health.com)

- **What's New for 2010**

Group Health Cooperative of Eau Claire (GHC) has added more dentists and chiropractors in the Eau Claire area.

- **Provider Directory**

Go to [www.group-health.com/docs/GHCProviderDirectory.pdf](http://www.group-health.com/docs/GHCProviderDirectory.pdf). To search for a provider, go to [www.group-health.com](http://www.group-health.com) and select "Find a Provider". To request a paper copy, please contact a Member Services Advocate at (888) 203-7770.

- **Referrals and Prior Authorizations**

Referrals are not required for in-network providers. Prior to receiving care from an out-of-network provider, you must get a referral event authorization. Event authorization is required for all admissions, selected outpatient services and all out-of-network care. GHC will send written notification to you and the ordering physician of approval or denial of the event authorization request. For further information regarding Authorization Guidelines, please contact a Member Services Advocate at (888) 203-7770.

- **Care Outside Service Area**

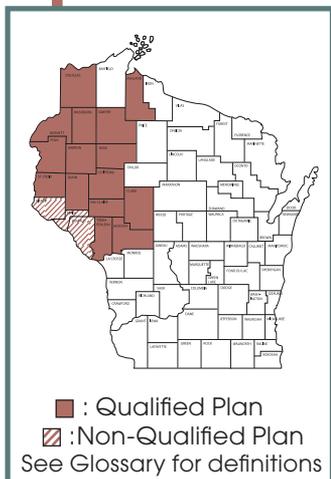
Emergency and urgent care do not require a referral. The FirstCare Nurseline, listed on your ID card, can help you determine the appropriate level of care. GHC has the right to review for medical necessity. Follow up care must be received by an in-network provider.

- **Mental & Behavioral Health Services**

No referral is needed to see a provider in GHC's network. Please refer to the GHC Provider Directory for a listing of mental health providers in the network.

- **Dental Benefits**

No routine dental coverage provided.





- **What's New for 2010**

- Access Community Health Center Clinics have been added to the GHC-SCW Provider Network.
- Check out GHC-SCW mobile on your Smart Phone device.

- **Provider Directory**

Visit [https://ghcscw.com/page\\_flip\\_prod/Default.htm](https://ghcscw.com/page_flip_prod/Default.htm). To search for providers and to view their professional qualifications, go to **ghcscw.com** and click on "Find a Provider." Members may request a Provider Directory by contacting GHC-SCW Member Services at (800) 605-4327.

- **Referrals and Prior Authorizations**

Your PCP will submit a referral request to a certified GHC-SCW Case Manager when you need to receive services outside of a GHC-SCW Clinic or through a specialty care area. You will receive a letter from GHC-SCW, as well as notification in your GHCMYChart online account, letting you know if the referral request has been approved.

- **Care Outside Service Area**

Call us at (800) 605-4327, ext. 4514 within 48 hours after receiving emergency or urgent care outside the GHC-SCW network. All other care requires a referral as described above. This phone number is also located on the member ID card.

- **Mental & Behavioral Health Services**

When you need mental health services, contact a GHC-SCW staff outpatient mental health provider directly. Please refer to the GHC-SCW Provider Directory. A referral is *not* required for services provided in a GHC-SCW Clinic. A referral *is* needed for transitional and/or inpatient care.

- **Dental Benefits (*This is a brief summary. See plan for details.*)**

Preventive Services: Covered at 100%: Exams, x-rays, cleanings, every 6 months.

Restorative Services: Covered at 100%: Amalgam fillings, composite fillings for anterior teeth, stainless steel crowns for primary teeth and simple and surgical extractions.

Annual Benefit Maximum: None

Orthodontics: 50% of the first \$3,500 in billed charges for dependent children through age 18.

Dental Network: All dental services must be obtained from Dental Health Associates in Madison.





Overall Quality Rating  
See Report Card section

### • What's New for 2010

Gundersen Lutheran Health Plan (GLHP) is pleased to announce the availability of our new member web portal. Visit [www.glhealthplan.org](http://www.glhealthplan.org) to set up your account where you can view claims information, order ID cards, and submit questions directly to our Customer Service Representatives.

### • Provider Directory

To see or print a copy of the provider directory go to [www.glhealthplan.org/etf](http://www.glhealthplan.org/etf). A searchable provider directory is also available by clicking on the "Find A Doctor" tab and selecting "Provider Directory." Select "Gundersen Lutheran Health Plan Employer Group" as the network and select the fields that you would like to include in your search. Or call Customer Service at 800-897-1923 to request a directory.

### • Referrals and Prior Authorizations

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 network, he/she will complete a referral request form and submit it to GLHP for review. Selected medical procedures and services covered by GLHP require prior authorization. Your provider should submit a written prior authorization request to GLHP for review. GLHP will respond in writing to you and your provider after reviewing the referral or prior authorization request.

### • Care Outside Service Area

In the case of an emergency or urgent medical condition, you should seek care from the nearest provider equipped to handle your condition. You must receive urgent care from a plan provider if you are in the plan service area, unless it is not reasonably possible. Please notify GLHP within 24 hours if admitted to a hospital. All other care must be with a plan provider, unless GLHP has approved a referral as described above.

### • Mental & Behavioral Health Services

Referrals are not required for services received from a GLHP behavioral health provider. Prior authorization is required for transitional services.

### • Dental Benefits (*This is a brief summary. See plan for details.*)

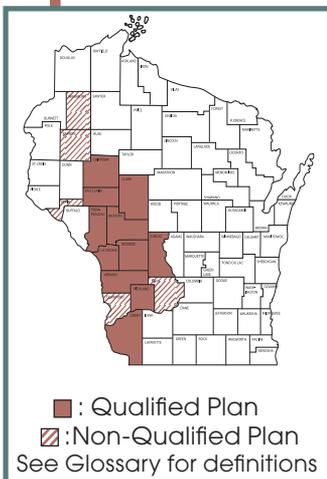
Preventive Services: Covered at 100%: Exams, prophylaxis, fluoride (to age 18), sealants (to age 18) and x-rays, 2 per year.

Restorative Services: Covered at 80%: Bridgework, implants, dentures, crowns and root canals.

Annual Benefit Maximum: \$500 per person per calendar year.

Orthodontics: None

Dental Network: You can go to any dental provider and the services are not subject to a Usual and Customary fee schedule.



## HealthPartners Health Plan

(800) 883-2177 or (952) 883-5000

[www.healthpartners.com/stateofwis](http://www.healthpartners.com/stateofwis)

Not Available  
Overall Quality Rating  
See Report Card section

- **What's New for 2010**

HealthPartners! We are your new medical and dental plan with great network coverage throughout Minnesota and Western Wisconsin. You will benefit from award-winning customer service, convenient online tools, wellness reimbursements/discounts and more.

- **Provider Directory**

Go to [www.healthpartners.com/stateofwis](http://www.healthpartners.com/stateofwis) and click on the search for providers link. Members can also register here to view claims. (For help registering, please call our Web support team at 1-877-726-0203.) Call 1-800-883-2177 to request a directory or for assistance in finding a provider.

- **Referrals and Prior Authorizations**

No referrals are necessary to see in-network providers. Certain services will require a prior authorization. Call Member Services at (800) 833-2177 for more information or see complete listing at [www.healthpartners.com/stateofwis](http://www.healthpartners.com/stateofwis). Your doctor will request the authorization and HealthPartners will notify you in writing of the coverage decision.

- **Care Outside Service Area**

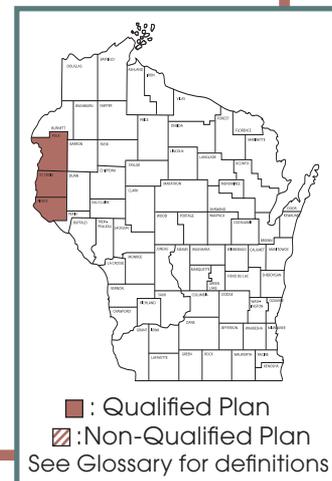
Members are covered for emergency and urgently needed care outside of the HealthPartners plan service area when medically necessary. Call 1-800-316-9807 within 48 hours if an admission occurs.

- **Mental & Behavioral Health Services**

No referrals are necessary to see in-network behavioral health providers.

- **Dental Benefits**

No routine dental coverage provided.



## Health Tradition Health Plan

(877) 832-1823 or (888) 459-0230

[www.healthtradition.com](http://www.healthtradition.com)



Overall Quality Rating  
See Report Card section

### • What's New for 2010

Health Tradition Health Plan (HTHP) now has a comprehensive provider network in Pepin County and is offering a wellness reimbursement program. Visit our website for more details.

### • Provider Directory

Go to [www.healthtradition.com](http://www.healthtradition.com). Under "Quick Links" select "Choosing a Provider." Scroll down to "State of Wisconsin Members" and select the directory. You can also contact us at (888) 459-0230 to request one.

### • Referrals and Prior Authorizations

You can see any provider in the HTHP network (primary care or specialist) without a referral. You must get a referral approved by HTHP before you see providers outside the HTHP network (including Mayo Clinic). Your doctor must submit a referral request. Prior authorization is required for certain services. Contact HTHP to request a prior authorization. HTHP will notify you and your provider in writing as to whether the request has been approved or denied. For more information, see our website or call us at (877) 832-1823.

### • Care Outside Service Area

Call us at (888) 758-7848 within 48 hours after receiving emergency or urgent care outside of our network. All other care requires HTHP approval as described above.

### • Mental & Behavioral Health Services

You must use a provider within our network for mental/behavioral health services. Prior authorization is required for inpatient care, transitional services, group therapy and psychiatric testing.

### • Dental Benefits *(This is a brief summary. Contact plan for details.)*

Preventive Services: Covered at 100% up to annual benefit maximum: exams, cleanings, fluoride treatments, xrays and sealants.

Restorative Services: Covered at 80% up to annual benefit maximum: services such as fillings, bridges, crowns and root canals.

Annual Benefit Maximum: \$500 per person per year on all services.

Orthodontics: None

Dental Network: You can see any dentist. Benefits subject to Usual and Customary charges unless you use the Health Tradition Preferred Dental Network. See instructions above to view the dental directory.



# Health Plans

## Humana – Eastern

(800)-4humana or Enrollment Hotline (888) 393-6765

www.humana.com



- **What's New for 2010**

Network: The network name has changed to "HMO Premier." HMO Premier is a national network; you will now have access to providers within WI on both sides of the state and outside of WI. You MUST select a WI based PCP regardless of your address. Providers outside of WI may require a referral in addition to those required by Humana (see handbook). If you are traveling outside of WI, check the website for providers in the area. ID Card: You will receive a new medical ID card this year with a different phone number for mental/behavioral health services.

- **Provider Directory**

Go to <http://apps.humana.com/egroups/Wisconsin/home.asp> for the 2010 directory. Or go to [www.humana.com](http://www.humana.com) to search for a provider. Click on "Enter Member Site" and select the type of provider under "Provider Search." Enter your zip code and select "HMO Premier." Call 1-800-4humana to request a directory.

- **How Humana is Unique for Members on Medicare**

If you are retired and enrolled in Medicare Parts A&B, Humana will automatically enroll you in a Humana Medicare Advantage Private Fee-For-Service Plan. Medicare Advantage has all the coverage of Uniform Benefits and more, including all benefits of Original Medicare plus extra services outlined in the Humana Group Medicare Guidebook. Flexibility to access virtually any provider around the country - you are not limited to any specific network provider. Just confirm your provider participates in Medicare, accepts the terms, conditions & administration of Humana, which is based on original Medicare payment calculations. Questions? Call **Humana Group Medicare Enrollment: 1-866-396-8810**.

- **Referrals and Prior Authorizations**

Referrals are required to see some network providers and all providers outside the HMO Premier network. Prior authorizations are required for certain services. See your Humana handbook. Your PCP must contact Humana at 1-800-626-2698 to make the request. Verify the status of the request by logging into your MyHumana web page or calling 1-800-4humana.

- **Care Outside Service Area**

Call Humana at 1-888-555-1234 within 48 hours after receiving emergency or urgent care outside our network.

- **Mental & Behavioral Health Services**

Before seeking any mental or behavioral health services, call 1-800-4humana between 8:00 a.m. - 5:30 p.m. and follow the prompts; a behavioral health specialist will assist you.

- **Dental Benefits (This is a brief summary. Contact plan for details.)**

Preventive Services: 100% - Exams, cleanings, fluoride, xrays.

Restorative Services: 50% after deductible (\$25 per individual /\$75 per family) - Emergency care, surgery, amalgam.

Annual Benefit Maximum: None

Orthodontics: 50% - dependents under age 18. Lifetime Max \$1,200.

Dental Network: Go to [www.humanadental.com](http://www.humanadental.com). Follow the instructions above and select "Dentists" as the type of provider.





- **What's New for 2010**

Network: The network name has changed to "HMO Premier." HMO Premier is a national network; you will now have access to providers within WI on both sides of the state and outside of WI. You MUST select a WI based PCP regardless of your address. Providers outside of WI may require a referral in addition to those required by Humana (see handbook). If you are traveling outside of WI, check the website for providers in the area. Note that Chippewa Valley Hospital and affiliated physicians, and Lakeview Medical Center of Rice Lake are no longer in the network. ID Card: You will receive a new medical ID card this year with a different phone number for mental/behavioral health services.

- **Provider Directory**

Go to <http://apps.humana.com/egroups/Wisconsin/home.asp> for the 2010 directory. Or go to [www.humana.com](http://www.humana.com) to search for a provider. Click on "Enter Member Site" and select the type of provider under "Provider Search." Enter your zip code and select "HMO Premier." Call 1-800-4humana to request a directory.

- **How Humana is Unique for Members on Medicare**

If you are retired and enrolled in Medicare Parts A&B, Humana will automatically enroll you in a Humana Medicare Advantage Private Fee-For-Service Plan. Medicare Advantage has all the coverage of Uniform Benefits and more, including all benefits of Original Medicare plus extra services outlined in the Humana Group Medicare Guidebook. Flexibility to access virtually any provider around the country - you are not limited to any specific network provider. Just confirm your provider participates in Medicare, accepts the terms, conditions & administration of Humana, which is based on original Medicare payment calculations. Questions? Call **Humana Group Medicare Enrollment: 1-866-396-8810.**

- **Referrals and Prior Authorizations**

Referrals are required to see some network providers and all providers outside the HMO Premier network. Prior authorizations are required for certain services. See your Humana handbook. Your PCP must contact Humana at 1-800-626-2698 to make the request. Verify the status of the request by logging into your MyHumana web page or calling 1-800-4humana.

- **Care Outside Service Area**

Care Outside Service Area – Call Humana at 1-888-555-1234 within 48 hours after receiving emergency or urgent care outside our network.

- **Mental & Behavioral Health Services**

Before seeking any mental or behavioral health services, call 1-800-4humana between 8:00 a.m. - 5:30 p.m. and follow the prompts; a behavioral health specialist will assist you.

- **Dental Benefits (This is a brief summary. Contact plan for details.)**

Preventive Services: 100% - Exams, cleanings, fluoride, xrays.

Restorative Services: 50% after deductible (\$25 per individual /\$75 per family) - Emergency care, surgery, amalgam.

Annual Benefit Maximum: None

Orthodontics: : 50% - dependents under age 18. Lifetime Max \$1,200.

Dental Network: Go to [www.humanadental.com](http://www.humanadental.com). Follow the instructions above and select "Dentists" as the type of provider.



## Medical Associates Health Plans

1 (800) 747-8900

[www.mahealthcare.com](http://www.mahealthcare.com)



Overall Quality Rating  
See Report Card section

- **What's New for 2010**

There are no significant changes for 2010. You may see any primary care doctor or specialist in the Medical Associates Health Plan (MAHP) network without a referral. You may continue to see the dental provider of your choice.

- **Provider Directory**

Go to [www.mahealthcare.com/OnlineDirectories/EmpGroup.aspx](http://www.mahealthcare.com/OnlineDirectories/EmpGroup.aspx) or visit MAHP's website at [www.mahealthcare.com](http://www.mahealthcare.com) to view an online provider directory. Call MAHP at 800-747-8900 to request a directory.

- **Referrals and Prior Authorization**

Members do not need to obtain referrals to get care within the MAHP network. However, members must obtain written authorization from the MAHP Medical Director prior to receiving services from a provider outside of the MAHP network. If services cannot be provided by a physician within the MAHP network, your physician will initiate the request for prior authorization. MAHP will review the request and respond in writing to you and your physician. Call MAHP to confirm the status of your authorization request before receiving services.

- **Care Outside Service Area**

If you need urgent or emergent care when you are outside of the MAHP service area, contact MAHP Health Care Services at 800-325-7442 (number shown on the back of your MAHP ID card) prior to receiving care or as soon as reasonably possible. Present your MAHP ID card to the facility for proper billing. All other care should be obtained from a MAHP participating physician or provider unless it is prior authorized as explained above.

- **Mental & Behavioral Health Services**

Services must be obtained from a physician or provider in the MAHP network. No referral or prior authorization is needed.

- **Dental Benefits (This is a brief summary. Contact plan for details.)**

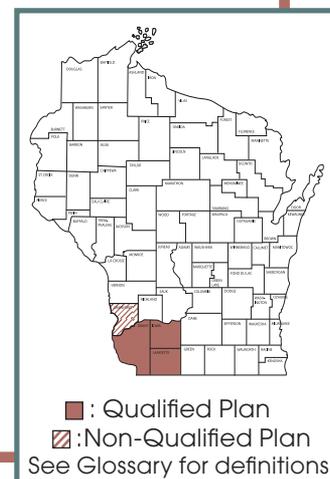
Preventive Services: Covered at 100%: Exams & cleanings, 2 per calendar year; Fluoride (under age 19), 2 per calendar year; Sealants (under age 14); Bitewing x-ray, 1 per calendar year; Full mouth x-ray in a 3 year period.

Restorative Services: Covered at 80% up to the annual benefit maximum: Amalgams (silver) and restorative compositions (tooth colored-front teeth only).

Annual Benefit Maximum: \$1,000 per member

Orthodontics: 50% coverage, up to \$1,500 lifetime maximum (up to age 19).

Dental Network: You can see the dentist of your choice. Benefits are not subject to Usual and Customary charges.





Overall Quality Rating  
See Report Card section

- **What's New for 2010**

We are implementing a web portal for members and providers to access their claims, eligibility, communicate with us about ID cards, change a primary care provider (PCP), and ask questions.

- **Provider Directory**

Go to [www.mercycarehealthplans.com](http://www.mercycarehealthplans.com). Under "For Members," click on "State of Wisconsin Members" and click on the link to the provider directory. To search for a provider, from our home page click on "Find a Provider" and select "WI – HMO" or enter your group number. You may search by provider type or facility type. Contact Customer Service at 800-895-2421 to request a paper copy.

- **Referrals and Prior Authorizations**

You have open access to providers and specialists in MercyCare's network. If the care is not available in our network, your PCP must request a prior authorization from MercyCare. MercyCare will notify you in writing if authorization is approved or denied. Prior authorization is also required for specific services. If you have questions, contact Customer Service at 800-895-2421.

- **Care Outside Service Area**

If you require emergency care, you should seek care from the nearest physician, hospital or clinic. Contact Customer Service at 800-895-2421 for all emergency or out-of-state inpatient admissions within 48 hours or as soon as reasonably possible.

- **Mental & Behavioral Health Services**

Mental health and substance abuse services must be provided by a provider in MercyCare's network. Outpatient visits do not require prior authorization. Inpatient and transitional care require prior authorization. Contact Customer Service at 800-895-2421 with any questions.

- **Dental Benefits**

No routine dental coverage provided.



■: Qualified Plan  
▨: Non-Qualified Plan  
See Glossary for definitions

## Network Health Plan

(800) 826-0940

[www.networkhealth.com](http://www.networkhealth.com)



Overall Quality Rating  
See Report Card section

- **What's New for 2010**

Visit WebMD on Network Health Plan's (NHP) website to complete an on-line HRA and access other wellness information and tools.

- **Provider Directory**

Go to <http://www.networkhealth.com/page/network-members-doctors>. Then scroll down and click on "State of Wisconsin Fox Valley Network Provider Directory". Or call 1-800-826-0940 to request a copy.

- **Referrals and Prior Authorizations**

You do not need a referral to see providers participating in NHP's network. However, prior authorization is required to see a provider that is not in NHP's network. Prior authorizations are also required for certain services. Members should contact NHP's Customer Service for information on specific health care services that require prior authorization. Your doctor must submit the prior authorization request and NHP will notify you in writing of approval or denial.

- **Care Outside Service Area**

Emergency and urgent care outside the service area is covered when medically necessary. Call us at 1-800-236-0208 within 48 hours of going to an emergency room or a non-participating hospital. All other care, including follow-up care, must be obtained from participating providers unless it is authorized by NHP as explained above.

- **Mental & Behavioral Health Services**

Prior authorization is required for all behavioral health services. For assistance, please contact NHP's Care Management Behavioral Health Department at 1-800-555-3616. After hours, call your provider or *NurseDirect* at 1-800-362-9900.

- **Dental Benefits (This is a brief summary. Contact plan for details.)**

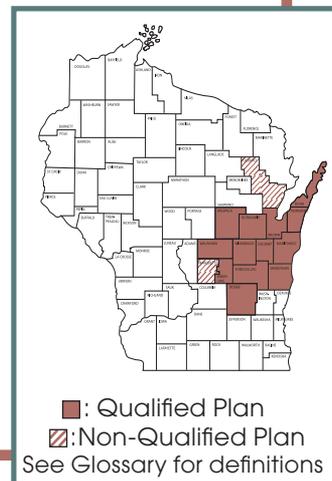
Preventive Services: Covered at 100%: exams, cleanings, fluoride treatments, x-rays, and space maintainers.

Restorative Services: Covered at 80%, subject to deductible: sealants, emergency treatment to relieve pain, and fillings.

Annual Benefit Max: \$1,000/ind Deductible: \$25 ind/\$75 fam

Orthodontics: Covered at 50%, subject to deductible. Lifetime maximum is \$1,500. No adult orthodontics.

Dental Network: Go to [www.deltadentalwi.com](http://www.deltadentalwi.com) and choose Delta Dental Premier or Delta Dental PPO as your Dental Plan. Or call Delta Dental at 1-800-236-3712.





## Physicians Plus – Meriter & UW Health

(608) 282-8900 or (800) 545-5015

[www.HealthyChoicesBigRewards.com](http://www.HealthyChoicesBigRewards.com)

### • What's New for 2010

- Primary care access to the new downtown-Madison Meriter Medical Clinic, opening early-fall 2009 at 345 W. Washington Avenue.
- GO-TO Healthy Choices personal health manager adds four new health improvement programs: insomnia, depression, binge eating and physical activity.

### • Provider Directory

Go to [HealthyChoicesBigRewards.com](http://HealthyChoicesBigRewards.com) and click on "Find a Provider." To print the provider listing, select "State Directory." To search for a provider, select "State of Wisconsin/Wisconsin Public Employee (State/WPE) group plan member." Call Member Service at (608) 282-8900 for a printed copy.

### • Referrals and Prior Authorizations

Written referrals are not required to visit most network specialty care providers. Before receiving care from non-network providers, members must have their primary care physician submit a referral to Physicians Plus. Prior authorizations are required for certain services; consult the member handbook. Your doctor must submit the request, and we will notify you in writing of our decision on all requests.

### • Care Outside Service Area

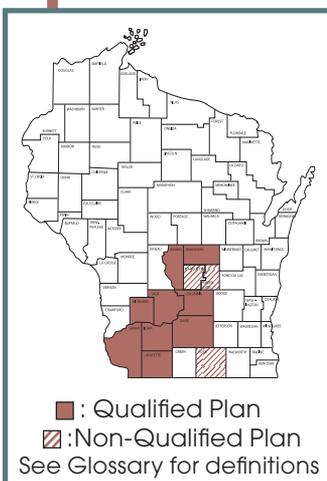
Emergency and urgent care outside the service area is covered when medically necessary. Call Physicians Plus at (800) 545-5015 within 72 hours after receiving emergency or urgent care outside our network. All other care, including follow-up care, should be obtained from network providers unless approved by Physicians Plus as described above.

### • Mental & Behavioral Health Services

Contact UWMF Behavioral Health Consultation System at (608) 282-8960 or (800) 683-2300 for prior authorization Monday–Friday, 8:00 a.m.–5:00 p.m. For emergencies, please contact your therapist. If you do not currently have a therapist, call a Physicians Plus participating emergency room. A mental health professional will assess your situation and refer you to the appropriate provider.

### • Dental Benefits

No routine dental coverage provided.



## Security Health Plan

(800) 472-2363 or (715) 221-9555

[www.securityhealth.org/state](http://www.securityhealth.org/state)



Overall Quality Rating  
See Report Card section

- **What's New for 2010**

Provider network now includes CareNorth, a network of specialists based in Duluth and also serving northwestern Wisconsin.

- **Provider Directory**

Visit [www.securityhealth.org/state](http://www.securityhealth.org/state) and click on "Provider Directory." For a printed copy, contact Customer Service at 1-800-472-2363.

- **Referrals and Prior Authorizations**

Referrals: are required prior to seeing providers outside of the network.

Prior authorizations: are required for certain services. See our Member Handbook or call Customer Service for more information. You or your doctor must submit the request; Security Health Plan will notify you in writing of our decision.

- **Care Outside Service Area**

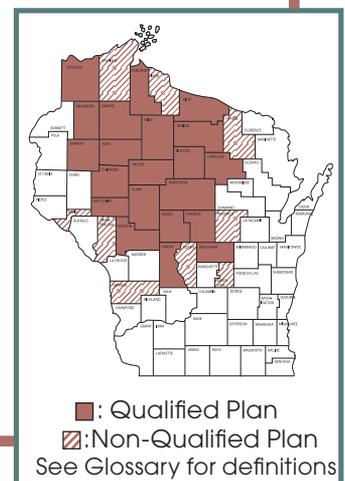
For emergency and urgent care outside of the network, you must notify Security Health Plan by the next business day or as soon as possible to ensure appropriate claim payment. All other care provided by providers outside of the network will not be covered unless a referral has been approved by Security Health Plan, as explained above.

- **Mental & Behavioral Health Services**

You may see any provider in the network for mental/behavioral health care. You do not need a referral or authorization.

- **Dental Benefits**

No routine dental coverage provided.



Not Available  
Overall Quality Rating  
See Report Card section

Administered by WPS Health Insurance  
800-634-6448 [www.wpsic.com/state](http://www.wpsic.com/state)

- **What's New for 2010**

Visit the Health Center at [www.wpsic.com/healthcenter](http://www.wpsic.com/healthcenter), an online resource designed to help you make good health decisions, whether you're looking for advice on treating a chronic condition, or for tips on leading a healthy lifestyle.

- **General Information**

The Standard Plan is a comprehensive health plan that provides you with freedom of choice among hospitals and physicians in Wisconsin and across the nation.

See the Comparison of Benefit Options section on pages 29, 30 and 31 for more information or view the booklet at <http://efw.wi.gov/publications/ef2131.pdf>

- **Provider Directory**

You may see any provider, but if you see providers from the participating directory, they will accept WPS' fee schedule and not balance bill you for Usual Customary & Reasonable (UCR) disputed charges. Go to [www.wpsic.com/state/pdf/dir2010\\_par.pdf](http://www.wpsic.com/state/pdf/dir2010_par.pdf) to search for a provider or contact WPS member services to request a copy.

- **Referrals and Prior Authorizations**

Referrals are not needed.

WPS recommends that members or providers request prior authorization for services when you are concerned if they will be payable and at what cost. Without an approved prior authorization, WPS may deny payment. Please visit [www.wpsic.com/state](http://www.wpsic.com/state) and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form or call Member Services.

- **Mental & Behavioral Health Services**

Based on recent changes to the State of Wisconsin mandates, a broader base of providers is now available to you. Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license. Additionally, mental health and AODA services are no longer limited to certain dollar maximums based on changes from the new Federal Mental Health Parity law. Inpatient services will be limited to 365 days.

- **Dental Benefits**

No dental coverage provided.

# Health Plans

## SMP - State Maintenance Plan

Administered by WPS Health Insurance  
(800) 634.6448 [www.wpsic.com/state](http://www.wpsic.com/state)

Not Available  
Overall Quality Rating  
See Report Card section

- **What's New for 2010**

SMP is no longer available in Buffalo and Pierce Counties. Subscribers using providers in these counties should consider selecting another plan or will be limited to the SMP providers remaining in other areas.

SMP will be newly available in (insert counties) Counties

- **General Information**

The SMP program provides maximum health care coverage over a broad range of benefits in a managed care environment. See the Comparison of Benefit Options section on pages 29, 30 and 31 for more information or view the booklet at <http://etf.wi.gov/publications/et2165.pdf>.

- **Provider Directory**

Please visit [www.wpsic.com/state/pdf/dir2010\\_state\\_smp.pdf](http://www.wpsic.com/state/pdf/dir2010_state_smp.pdf) to search for a provider or contact WPS member services.

- **Referrals and Prior Authorizations**

You must get a referral approved by WPS before getting care outside the WPS SMP network. *Your provider must request the referral.* Retroactive referrals are *not* allowed. It is ultimately the member's responsibility to make sure the referral is submitted and approved prior to receiving services.

WPS recommends that members or providers request prior authorization for services when you are concerned if they will be payable and at what cost. Without an approved prior authorization, WPS may deny payment. Please visit [www.wpsic.com/state](http://www.wpsic.com/state) and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form or call Member Services.

- **Mental & Behavioral Health Services**

Based on recent changes to the State of Wisconsin mandates, a broader base of providers is now available to you. Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license. Additionally, mental health and AODA services are no longer limited to certain dollar maximums based on changes from the new Federal Mental Health Parity law. Inpatient services will be limited to 365 days.

- **Dental Benefits**

Members under the age of 12 are eligible to receive preventive care limited to routine exam, prophylaxis and topical fluoride, but not more than once in any 180 consecutive day period.





## UnitedHealthcare of Wisconsin Northeast

(800) 357-0974 or (866) 873-3903 during the Enrollment Period

[www.myuhc.com](http://www.myuhc.com)

- **What's New for 2010**

There are no significant network changes for 2010.

- **Provider Directory**

Go to [www.myuhc.com/groups/state](http://www.myuhc.com/groups/state) and click on "Find Physicians & Facilities" and then on "Wisconsin Northeast." To request a directory, call customer service at 800-357-0974 and request directory #FWOAH20WI-608.

- **Referrals and Prior Authorizations**

You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception". In addition, you are responsible for notifying UHC's Care Coordination before obtaining services for dental/oral surgery or within 24 hours (or as soon as possible) of an emergency admission to a non-network hospital. You and your physician will be notified in writing of UHC's decision and coverage determination.

- **Care Outside Service Area**

For emergency or urgent care, please contact UHC's customer service at 800-357-0974 as soon as possible. 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.

- **Mental & Behavioral Health Services**

Members must call United Behavioral Health (UBH) at 800-851-5188 for an initial assessment and for authorization for any and all services with network providers. *Please note: After standard business hours, UBH can only manage inpatient benefits and authorizations.*

- **Dental Benefits (*This is a brief summary. Contact plan for details.*)**

Preventive Services: Covered at 100%: exams 2 times per calendar year, bitewing x-rays, cleanings, fluoride treatments and sealants, complete series or panorex x-rays.

Restorative Services: Covered at 50% after deductible (\$50 per individual / \$100 per family, per calendar year): amalgam and composite resin restorations, general anesthesia and space retainers. No coverage for major restorative services.

Annual Benefit Maximum: \$1,000 per person per calendar year.

Orthodontics: Covered at 50% for dependents under age 19, up to an individual ortho lifetime maximum of \$1,200.

Dental Network: Open dental network to allow members to go to a dentist of their choice. Charges are payable up to UHC's maximum allowable fee schedule.



## UnitedHealthcare of Wisconsin Southeast

(800) 357-0974 or (866) 873-3903 during the Enrollment Period

[www.myuhc.com](http://www.myuhc.com)



- **What's New for 2010**

There are no significant network changes for 2010.

- **Provider Directory**

Go to [www.myuhc.com/groups/state](http://www.myuhc.com/groups/state) and click on "Find Physicians & Facilities" and then on "Wisconsin Southeast." To request a directory, call customer service at 800-357-0974 and request directory #FWOAH20WI-606.

- **Referrals and Prior Authorizations**

You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception". In addition, you are responsible for notifying UHC's Care Coordination before obtaining services for dental/oral surgery or within 24 hours (or as soon as possible) of an emergency admission to a non-network hospital. You and your physician will be notified in writing of UHC's decision and coverage determination.

- **Care Outside Service Area**

For emergency or urgent care, please contact UHC's customer service at 800-357-0974 as soon as possible. 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.

- **Mental & Behavioral Health Services**

Members must call United Behavioral Health (UBH) at 800-851-5188 for an initial assessment and for authorization for any and all services with network providers. *Please note: After standard business hours, UBH can only manage inpatient benefits and authorizations.*

- **Dental Benefits (This is a brief summary. Contact plan for details.)**

Preventive Services: Covered at 100%: exams 2 times per calendar year, bitewing x-rays, cleanings, fluoride treatments and sealants, complete series or panorex x-rays.

Restorative Services: Covered at 50% after deductible (\$50 per individual / \$100 per family, per calendar year): amalgam and composite resin restorations, general anesthesia and space retainers. No coverage for major restorative services.

Annual Benefit Maximum: \$1,000 per person per calendar year.

Orthodontics: Covered at 50% for dependents under age 19, up to an individual ortho lifetime maximum of \$1,200.

Dental Network: Open dental network to allow members to go to a dentist of their choice. Charges are payable up to UHC's maximum allowable fee schedule.





### • What's New for 2010

We have implemented an enhanced online Message Center that offers a convenient and secure way for you to communicate with us. You will also find improved information when you register or sign-in to **MyUnity**.

### • Provider Directory

Go to [unityhealth.com/state/community2010](http://unityhealth.com/state/community2010) to view the complete provider directory. To search for a provider, go to [chooseunityhealth.com](http://chooseunityhealth.com) and select the Community Network in *Find A Doctor*. Or call 800-362-3310 to request a copy.

### • Referrals and Prior Authorizations

Written referral requests are required to see providers outside of the Community Network. Prior Authorizations are required for certain services. See the Community Network Provider Directory for more information. Your doctor must submit the request and we will notify you in writing of our decision.

### • Care Outside Service Area

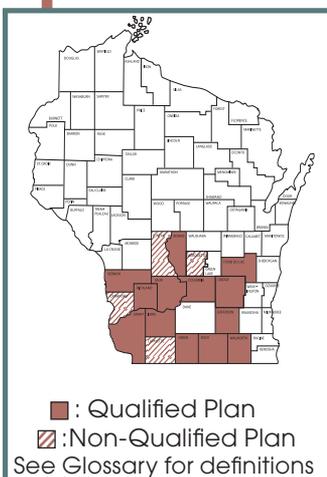
Call us at 800-362-3310 within three (3) business days after receiving emergency or urgent care services from a non-participating provider. All other care from non-participating providers requires a written referral request as described above.

### • Mental & Behavioral Health Services

Before getting services, you must call UW Behavioral Health at 800-683-2300. Assistance is available 24 hours a day.

### • Dental Benefits

No routine dental coverage provided.



## Unity Health Insurance – UW Health

(800) 362-3310

chooseunityhealth.com



Overall Quality Rating

See Report Card section

- **What's New for 2010**

We have implemented an enhanced online Message Center that offers a convenient and secure way for you to communicate with us. You will also find improved information when you register or sign-in to **MyUnity**.

- **Provider Directory**

Go to [unityhealth.com/state/uwhealth2010](http://unityhealth.com/state/uwhealth2010) to view the complete provider directory. To search for a provider, go to [chooseunityhealth.com](http://chooseunityhealth.com) and select the Community Network in *Find A Doctor*. Or call 800-362-3310 to request a copy.

- **Referrals and Prior Authorizations**

Written referral requests are required to see providers outside of the UW Health Network. Prior Authorizations are required for certain services. See the UW Health Network Provider Directory for more information. Your doctor must submit the request and we will notify you in writing of our decision.

- **Care Outside Service Area**

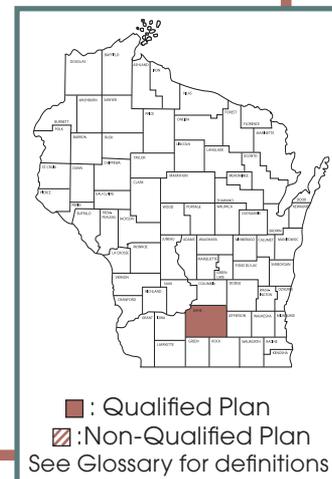
Call us at 800-362-3310 within three (3) business days after receiving emergency or urgent care services from a non-participating provider. All other care from non-participating providers requires a written referral request as described above.

- **Mental & Behavioral Health Services**

Before getting services, you must call UW Behavioral Health at 608-282-8960. For alcohol and other drug abuse (AODA) needs, call UW Health Gateway Recovery at 608-278-8200. Assistance is available 24 hours a day.

- **Dental Benefits**

No routine dental coverage provided.



Not Available  
Overall Quality Rating  
See Report Card section

- **What's New for 2010**

Visit the Health Center at [www.wpsic.com/healthcenter](http://www.wpsic.com/healthcenter), an online resource designed to help you make good health decisions, whether you're looking for advice on treating a chronic condition, or for tips on leading a healthy lifestyle.

- **Provider Directory**

Go to [www.wpsic.com/state/pdf/dir2010\\_metro\\_choice.pdf](http://www.wpsic.com/state/pdf/dir2010_metro_choice.pdf) to search for a provider or contact WPS member services at 1-800-634-6448 to request a copy.

- **How Metro Choice is Unique**

Metro Choice is an attractive alternative to HMO plans, with coverage for medical services received outside of your Network at a lesser benefit level (see below).

- **Referrals and Prior Authorizations**

Referrals are not necessary under this plan. 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%.**

Prior Authorization is recommended for any of the below 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

Members may also request prior authorization for any service to ensure coverage. WPS will notify you and your provider in writing of its decision on the authorization request.

- **Care Outside Service Area**

In-network hospital emergency rooms or urgent care facilities should be used whenever possible. Should you be unable to reach an in-network provider and cannot safely postpone the care until you are able to return to the service area, go to the nearest appropriate medical facility and contact WPS Member Services as soon as possible.

- **Mental & Behavioral Health Services**

Based on recent changes to Wisconsin mandated benefits, a broader base of providers are now available to you. Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license. **Note:** If you utilize providers that are not in the WPS Metro Choice network, services are subject to the deductible, then payable at 70%.

- **Dental Benefits**

No routine dental coverage provided.





Health Plan Report Card

Grievances & Complaints Information

Other Quality Information Resources



# Health Plan Report Card

PLEASE NOTE:  
ETF'S WEBSITE  
CONTAINS  
MORE DETAILED  
QUALITY  
INFORMATION  
<http://etf.wi.gov/>

## Health Plan Report Card

This section provides the results of two important annual evaluations of our health plans -- the member satisfaction survey and quality performance measures. We encourage you to review this information and see how your health plan compares with other plans available to you.

\*The **Quality Composite** provides a summary of the health plans' quality scores in an overall composite and in the following four areas of care: Wellness and Prevention, Behavioral and Mental Health, Disease Management, and Consumer Satisfaction and Experiences.

\*The Consumer Assessment of Healthcare Providers and Systems (**CAHPS®**) is our annual member survey. The survey reveals how members rate their health plan and the health care services they receive. The survey focuses on areas where the people enrolled in the health plans are really the experts about how well their plan is working. *The Department of Employee Trust Funds (ETF) would like to thank the 6,655 members who participated in this year's successful survey.* This important study was administered by Synovate, an independent research firm on the behalf of ETF.

\*The Healthcare Effectiveness Data and Information Set (**HEDIS®**) demonstrates health plan performance from a clinical perspective. The measures evaluate whether the health plan delivers the recommended care based on medical evidence to prevent or manage illness. HEDIS measures address health care issues that are meaningful to consumers and purchasers. They measure performance in areas of care where improvements can make a meaningful difference in member's lives and areas that health care systems can take action to improve.

### Example of the types of information gathered:

CAHPS: How often did you get care as soon as you thought you needed it?

HEDIS: What percentage of women age 42 to 69 had a mammogram within the last two years?

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 Plans Included in this Report Card

Note the following about the health plans that were included in this report card:

- CAHPS results were collected by health plan for active state and retiree membership. The survey only includes health plans that were available to state employees and retirees starting on January 1, 2008, therefore no data was collected for Anthem Blue Northeast, a health plan that was offered beginning in January 1, 2009, or for HealthPartners, a new health plan available beginning January 1, 2010. Although data was collected for the State Maintenance Plan (SMP), the results were not included in this report card due to the low number of respondents.
- HEDIS scores include all the HMO insurers that were available to ETF members in 2009. HEDIS data is collected by each insurer for their entire commercial population and is not reported separately by service area or for state employee and retiree membership. No HEDIS data is available for SMP, the Standard Plan or WPS Metro Choice. HEDIS data for HealthPartners was not included in this report card but scores by measure are available on ETF's Website.
- The Quality Composite Rating Chart includes all HMO health plans that were available in 2009 and for which HEDIS and CAHPS data was available. Anthem Blue Northeast was assigned CAHPS scores that were imputed between the other two available Anthem plans for the purpose of calculating the composite scores.



# Quality Composite Rating Chart

## Quality Composite

The following are descriptions of the rankings displayed in the chart on page 65.

### **Overall Quality Score**

The overall score is based on a comprehensive set of CAHPS and HEDIS measures. All the measures that are included in the four areas of focus described below are included in the overall quality score.

### **Wellness and Prevention Score**

This score includes HEDIS measures such as childhood immunizations, well child visits, prenatal and postpartum care, the appropriate use of antibiotics for children and adults, and breast, cervical, and colorectal cancer screenings. This composite also includes questions surveying our members about whether or not wellness information is provided by their doctor.

### **Behavioral and Mental Health**

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

### **Disease Management**

This score 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 addresses monitoring members who are on persistent medications of interest.

### **Consumer Satisfaction and Experiences**

This composite includes CAHPS scores that measure member satisfaction with their health plan and the health care they receive and whether or not they believed their health plan improved from the previous year. The composite also includes questions about member experiences such as getting needed care, getting care quickly, health plan customer service, finding and understanding information, ease of paperwork, and how claims were processed.

# Quality Composite Rating Chart

Understanding the Scores for the Health Plans:

- ★★★★★ 4 stars: **well above** the average of all health plans (by **more than** one standard deviation)\*
- ★★★★ 3 stars: **above** the average of all health plans (by **less than** one standard deviation)\*
- ★★★ 2 stars: **below** the average of all health plans (by **less than** one standard deviation)\*
- ★ 1 star: **well below** the average of all health plans (by **more than** one standard deviation)\*

Please see previous page for descriptions of the Quality Composite Ratings.

PLAN NAME	Overall Quality	Wellness & Prevention	Behavioral & Mental Health	Disease Management	Consumer Satisfaction & Experiences
ANTHEM BLUE NORTHEAST	★	★	★★	★	★
ANTHEM BLUE NORTHWEST	★	★	★★	★	★
ANTHEM BLUE SOUTHEAST	★	★	★★★★	★	★
ARISE HEALTH PLAN	★★★★	★★	★★★★	★★★★	★★★★
DEAN HEALTH PLAN	★★★★	★★	★★★★	★★★★	★★★★
GHC OF EAU CLAIRE	★★★★★	★★★★	★★★★★	★★★★★	★★★★
GHC OF SCW	★★★★★	★★★★★	★★	★★★★	★★★★★
GUNDERSEN LUTHERAN	★★★★	★★★★	★★★★	★★★★	★★★★★
HEALTH TRADITION	★★★★	★★★★	★	★★★★	★★★★
HUMANA EASTERN	★	★★	★	★	★★
HUMANA WESTERN	★	★★	★	★	★
MEDICAL ASSOCIATES	★★★★★	★★	★★	★★★★★	★★★★★
MERCYCARE	★★	★★	★★★★	★★	★★
NETWORK HEALTH PLAN	★★★★	★★★★★	★★★★	★★★★	★★★★
PHYSICIANS PLUS	★★★★	★★★★	★★	★★	★★★★
SECURITY HEALTH PLAN	★★★★★	★★★★	★★★★★	★★★★★	★★★★
UNITEDHEALTHCARE NE	★	★★	★★★★	★	★★
UNITEDHEALTHCARE SE	★	★★	★★★★	★	★
UNITY COMMUNITY	★★★★	★★★★	★★	★★	★★★★
UNITY UW HEALTH	★★★★	★★★★	★★	★★	★★★★

\*The standard deviation measures the difference between an individual health plan's score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

# CAHPS Overall Rating Chart

Understanding the Scores for the Health Plans:

- ★★★★ 4 stars: **well above** the average of all health plans (by **more than** 1.96 standard deviations)\*
- ★★★ 3 stars: **above** the average of all health plans (by **less than** 1.96 standard deviations)\*
- ★★ 2 stars: **below** the average of all health plans (by **less than** 1.96 standard deviations)\*
- ★ 1 star: **well below** the average of all health plans (by **more than** 1.96 standard deviations)\*

This chart shows results for individual survey questions for which members were asked to rate their health plan, health care, primary doctor and specialists. 10 is the “best possible” rating and 0 is the “worst possible” rating. Health plan scores were adjusted for age, education level, and self-reported health status.

↗ means that a health plan had a statistically significant improvement in their score from 2008 to 2009.

↘ means that a health plan had a statistically significant decline in their score from 2008 to 2009.

PLAN NAME	How people rated their HEALTH PLAN	How people rated their HEALTH CARE	How people rated their PRIMARY DOCTOR	How people rated their SPECIALIST
<b>AVERAGE - All Health Plans</b>	8.10	8.40	8.68	8.23
ANTHEM BCBS NORTHWEST	★	★★	★★★	★★
ANTHEM BCBS SOUTHEAST	★	★	★★	★★
ARISE HEALTH PLAN	★★★	★★★	★★★	★★★
DEAN HEALTH PLAN	★★★★	★★★	★★★	★★
GHC OF EAU CLAIRE	★★★★	★★★★	★★★	★★★
GHC OF SCW	★★★★↗	★★★★	★★	★★★
GUNDERSEN LUTHERAN	★★★★	★★★★	★★★★	★★★
HEALTH TRADITION	★★★★	★★★	★★★	★★★
HUMANA EASTERN	★★	★★★★↗	★★	★★★
HUMANA WESTERN	★↗	★↗	★★	★★
MEDICAL ASSOCIATES	★★★★	★★★★	★★★★	★★★
MERCYCARE	★★	★★	★★	★★★
NETWORK HEALTH PLAN	★★★★↗	★★	★	★★★
PHYSICIANS PLUS	★★★★	★★★	★★	★★★
SECURITY HEALTH PLAN	★★★★	★★★	★★	★★↘
STANDARD PLAN	★★★★	★★★	★★	★★↘
UNITEDHEALTHCARE NE	★★	★★★	★★	★★
UNITEDHEALTHCARE SE	★	★★	★★	★★↘
UNITY COMMUNITY	★★★	★★	★★★	★★
UNITY UW HEALTH	★★★★	★★	★	★★★
WPS METRO CHOICE	★	★	★★★	★★

\*The standard deviation measures the difference between an individual health plan’s score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

# CAHPS Composite Rating Chart

Understanding the Scores for the Health Plans:

- ★★★★ 4 stars: **well above** the average of all health plans (by **more than** 1.96 standard deviations)\*
- ★★★ 3 stars: **above** the average of all health plans (by **less than** 1.96 standard deviations)\*
- ★★ 2 stars: **below** the average of all health plans (by **less than** 1.96 standard deviations)\*
- ★ 1 star: **well below** the average of all health plans (by **more than** 1.96 standard deviations)\*

This chart shows results for a composite of survey questions that asked members how often something occurred ("Always", "Sometimes", "Usually" or "Never") regarding Customer Service, Claims Processing, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Shared Decision Making (between the member and the doctor). Health plan scores were adjusted for age, education level, and self reported health status.

↗ means that a health plan had a statistically significant improvement in their score from 2008 to 2009.

↘ means that a health plan had a statistically significant decline in their score from 2008 to 2009.

PLAN NAME	Customer Service	Claims Processing	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Shared Decision Making
<b>AVERAGE - All Health Plans</b>	3.37	3.42	3.35	3.50	3.64	3.47
ANTHEM BCBS NORTHWEST	★	★	★★	★★	★★	★★
ANTHEM BCBS SOUTHEAST	★	★	★★★★	★★	★★	★★
ARISE HEALTH PLAN	★★★★★	★★★★★	★★★★★	★★★★	★★★★	★★★★
DEAN HEALTH PLAN	★★	★★★	★★	★★	★★	★★
GHC OF EAU CLAIRE	★★★★★	★★★★★	★★★★	★★★★	★★★★★	★★★★★
GHC OF SCW	★★★★★	★★★★★	★★★★↗	★★★★★	★★★★	★★★★★
GUNDERSEN LUTHERAN	★★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★★★
HEALTH TRADITION	★★★★★	★★★	★★★★	★★★★★	★★★★	★★★★
HUMANA EASTERN	★	★	★★★★	★★★★	★★★★	★★
HUMANA WESTERN	★↗	★	★	★★★★↗	★	★
MEDICAL ASSOCIATES	★★★★★	★★★	★★★★★	★★★★★	★★★★	★★↘
MERCYCARE	★★	★★★★	★★	★	★★★★	★★★★
NETWORK HEALTH PLAN	★★★★★	★★★★★	★★★★	★★	★	★★
PHYSICIANS PLUS	★★★	★★★★★	★★	★★	★★	★★★★
SECURITY HEALTH PLAN	★★★★★	★★★★★↗	★★★★	★★★★	★★★★	★★
STANDARD PLAN	★★★	★★	★★★★★	★★★★	★	★★★★
UNITEDHEALTHCARE NE	★	★	★★★★	★★★★	★★	★★
UNITEDHEALTHCARE SE	★	★	★★★★	★★★★↘	★★	★★
UNITY COMMUNITY	★★★★★	★★★	★★	★★★★	★★★★	★★★★
UNITY UW HEALTH	★★★★★	★★★★★	★★	★	★★★★	★★★★
WPS METRO CHOICE	★★	★	★	★★★★	★★	★★

\*The standard deviation measures the difference between an individual health plan's score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

# HEDIS Composite Chart

**This chart displays the following quality measures:**

- \* **Cancer Screenings:** This score includes the following HEDIS measures: Colorectal, Breast and Cervical Cancer Screenings.
- \* **Appropriate Use of Antibiotics:** This score includes the following HEDIS measures: Appropriate Treatment for Children with Upper Respiratory Infection, Appropriate Testing for Children with Pharyngitis, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.
- \* **Diabetes Care:** This score includes the following HEDIS measures: HbA1c Control, Cholesterol Screening and Control, Medical Attention for Kidney Disease, Eye Exam, and Blood Pressure Control.
- \* **Controlling High Blood Pressure:** This score examines the percentage of eligible members with high blood pressure who had their blood pressure controlled.
- \* **Cholesterol Management for Patients with Cardiovascular Conditions:** This score includes the following HEDIS measures: Cholesterol Screening and Control.
- \* **Annual Monitoring for Patients with Persistent Medications:** This single score examines monitoring for the following drugs of interest: Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxins, Diuretics, Anticonvulsants.

PLAN NAME	Cancer Screenings	Appropriate Use of Antibiotics	Diabetes Care	Controlling High Blood Pressure	Cholesterol Management for Patients with Cardiovascular Conditions	Annual Monitoring for Patient with Persistent Medications
ANTHEM BLUE	★	★★	★	★	★★	★★
ARISE HEALTH PLAN	★★★	★	★★★★	★★★★	★★★★	★★★★
DEAN HEALTH PLAN	★★	★★	★★★★	★★★★	★★	★★★★
GHC OF EAU CLAIRE	★★★	★★★★	★★★★★	★★★★	★★★★★	★★
GHC OF SCW	★★★★	★★★★★	★★	★★★★	★★	★★★★★
GUNDERSEN LUTHERAN	★★★★	★★★★	★★★★	★★★★	★★	★
HEALTH TRADITION	★★★	★★	★★★★	★★★★★	★★	★★★★
HUMANA	★★	★★	★	★★	★★	★★★★
MEDICAL ASSOCIATES	★★	★★	★★★★★	★★★★★	★★★★★	★★
MERCYCARE	★★	★★★★★	★★	★	★	★★
NETWORK HEALTH PLAN	★★★★	★★★★	★★★★	★★	★★★★★	★★★★
PHYSICIANS PLUS	★★	★★★★	★★★★	★★★★	★★★★	★
SECURITY HEALTH PLAN	★★★	★★	★★★★	★★★★★	★★★★★	★★★★★
UNITEDHEALTHCARE	★	★★	★	★★★★	★	★★★★
UNITY HEALTH INSURANCE	★★★	★★	★★	★★	★★	★★

Please see page 67 for a description of the star rating system that was used for this chart.

# Grievances and Complaints Information

The Grievance process is a health plan's internal process for resolving member complaints. Each health plan is required to have a Grievance process in place for members to seek a change to an unfavorable decision.

A Complaint occurs when a member contacts ETF about an issue for input or investigation. The Complaint process is the initial, optional step involved in the Administrative Review process, which allows members to appeal a health plan decision to ETF and subsequently to the Group Insurance Board.

The most frequent types of Complaints filed by members in 2008 were related to:

- Billing and claim processing
- Enrollment and eligibility
- General program provision or design

The most frequent types of Grievances filed by members in 2008 were related to:

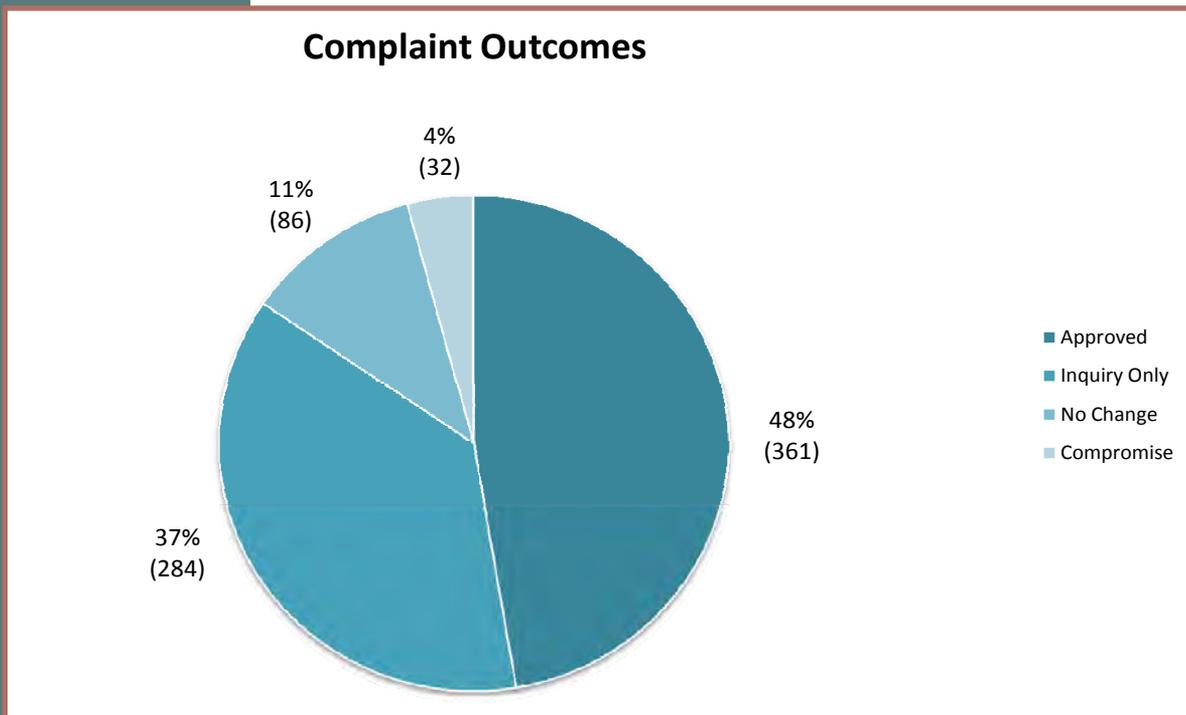
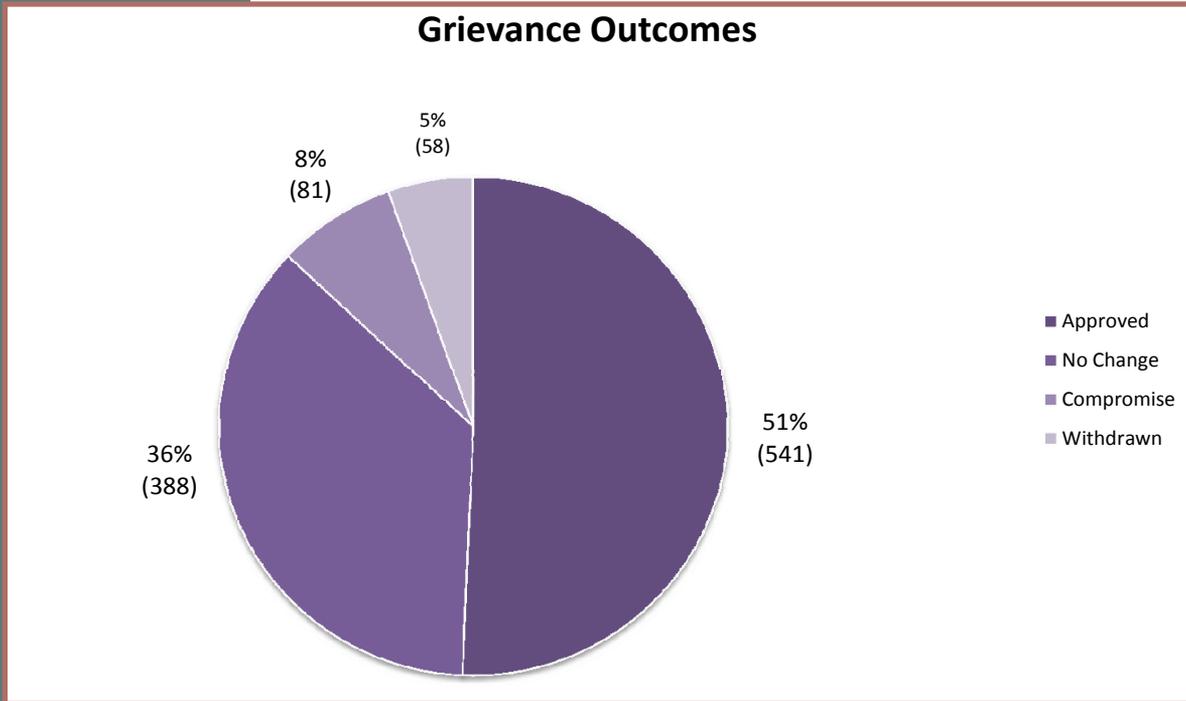
- Non-covered or excluded benefits
- Plan administration
- Prior authorizations

In 2008, 1,079 members filed Grievances with their health plan and 1,284 filed Complaints with ETF.

The following pie charts show how often Complaints and Grievances were resolved in favor of the member. Approximately one half of Complaints and Grievances filed by members were ultimately approved (the health plan's original decision was overturned).



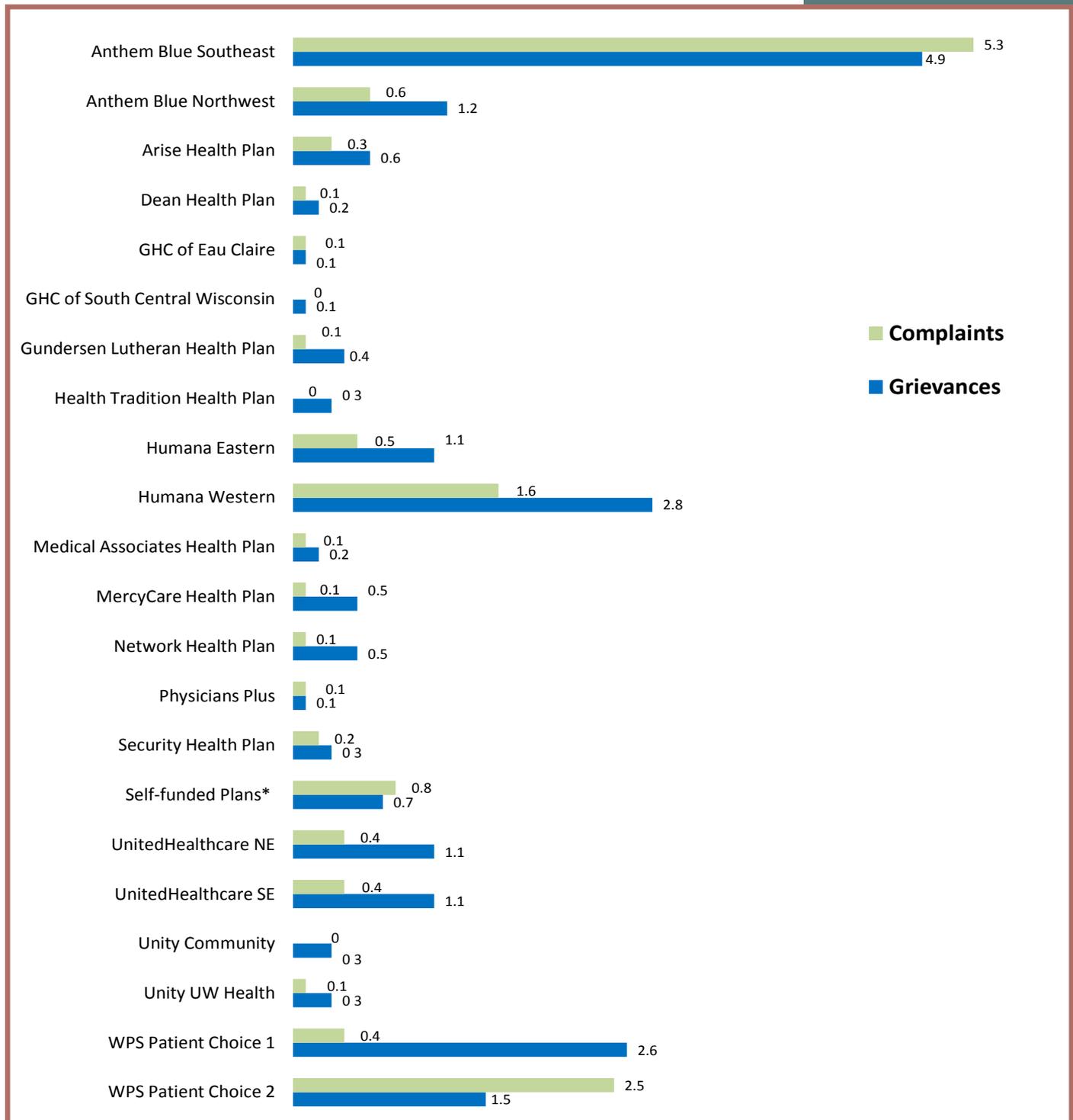
# Grievances & Complaints Chart



**Note:** *Approved* defined as: health plan's original decision was overturned.

# Grievances & Complaints Charts by Health Plan

This chart shows the number of Complaints and Grievances filed by member per 100 Plan Members during the 2008 calendar year.



\*Includes the Standard Plan, SMP and Medicare Plus \$1,000,000

## Other Quality Information Resources

There are several organizations that provide useful information about health care quality. We encourage you to look into the following resources.

**Leapfrog** is a nationwide effort to address patient safety in hospitals, focusing on hospital quality and safety practices that are proven to reduce medical errors and save lives.

The Leapfrog web site provides consumers with the ability to select hospitals and compare their performance on patient safety ratings. [www.leapfroggroup.org](http://www.leapfroggroup.org)

**Checkpoint** is a program sponsored by the Wisconsin Hospital Association that provides a snapshot of hospital performance in key areas. You can use this information to compare how well hospitals administer recommended care. The 128 hospitals that currently participate in Checkpoint provide care to 99% of Wisconsin's patient population. [www.wicheckpoint.org](http://www.wicheckpoint.org)

**The Wisconsin Collaborative for Healthcare Quality (WCHQ)** provides links to a variety of performance measures that compare 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. [www.wchq.org](http://www.wchq.org)

**The Hospital Compare** tool provides information about how well hospitals care for patients with specific medical conditions or surgical procedures, and survey results from patients about the quality of care they received during a recent hospital stay. The site was created through the joint efforts of the Centers for Medicare & Medicaid Services, the U.S. Department of Health and Human Services, and other members of the Hospital Quality Alliance. [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)



Pharmacy Benefits  
Life Insurance



- **What's New for 2010**

The out-of-pocket maximum for 2010 is \$410 per individual and \$820 per family for all participants. EXCEPTION: There is no out-of-pocket maximum for Wisconsin Public Employer Participants enrolled in the Standard Plan or State Maintenance Plan (SMP), effective January 1, 2010.

- **Formulary Information**

The three-level formulary requires co-payments of \$5 (Level 1), \$15 (Level 2) and \$35 (Level 3). Level 3 co-payments are not applied against the out-of-pocket maximum. Detailed and updated formulary information is available on the Navitus Web site under the "Members" section (*State of WI and WI Public Employers (administered through ETF) Formulary*). You can also call Navitus Customer Care to receive a copy.

- **90-Day-At-Retail Program**

A 90-day supply of most maintenance medications can be purchased at your retail pharmacy. Some restrictions do apply and three copayments are still required. More information can be found on Navitus' web site or by calling Navitus Customer Care.

- **Mail Order Program**

Up to a 90-day supply can be purchased for only two copayments for Level 1 and Level 2 medications through our mail order service. To register for mail order service call Prescription Solutions Customer Service at 1-800-908-9097, 24 hours a day seven days a week. If you are hearing impaired, you can call 1-800-947-8642. More detailed information can be found on Navitus' web site; the Prescription Solutions Web site, [www.rxsolutions.com](http://www.rxsolutions.com); or by calling Navitus Customer Care.

- **RxCENTS Tablet-Splitting Program**

By splitting a higher-strength tablet in half to provide the needed dose, you will receive the same medication and dosage while purchasing fewer tablets and saving on your copayment. Medications included in the program are marked with "¢" in the Navitus Formulary. Members may obtain tablet splitting devices at no cost by calling Navitus Customer Care.

- **Generic Copay Waiver Program**

Your first fill of a sample medication through this program is free. Medications included in the Generic Copay Waiver Program are marked with "GW" in the Navitus Formulary. To use this program, your doctor needs to write a prescription for one of the program medications. If it is your first time filling this prescription, you get the medication at no cost.

- **Specialty Drug Program (Self-injectables & 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

*continued*

your self-injectable and other specialty medications from the specialty pharmacy, please contact Navitus SpecialtyRX toll-free at 1-800-218-1488.

- **Prior Authorization (PA) Requirements**

**A 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. Medications that require prior authorization for coverage can be identified on the Navitus Drug Formulary by a notation of "PA".

- **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 through coordination of benefits.

- **Medicare Part B**

Claims for certain drugs/supplies such as test strips, lancets, inhalation drugs and IV drugs requiring a pump need to be submitted to Medicare Part B first for primary coverage. Navitus may cover the remaining cost up to the allowed amount under your policy as secondary coverage. 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 may submit a Direct Member Reimbursement Form, accompanied with your Medicare Summary Notice, to be reimbursed by your Navitus secondary coverage. This form is available on the Navitus Web site or by calling Navitus Customer Care.

- **Medicare Part D**

When you become eligible for coverage under Medicare Part D, you must voluntarily enroll in a Medicare Part D Prescription Drug Plan (PDP). Navitus will no longer provide coverage for you. If you take no action you will be automatically enrolled in the DeanCare Rx PDP, provided by Dean Health Insurance (DHI). You will need to complete enrollment information forms that DHI will send to you. In addition, you will also be automatically enrolled in secondary coverage with a "Wrap" product from DHI. This will ensure that you have coverage during the Medicare Part D coverage gap referred to as the "donut hole". If you decide to enroll in a PDP other than the DeanCare Rx plan, you will still be covered by the Wrap benefit once you reach the "donut hole".

- **Coordination of Benefits**

Coordination of benefits applies when, as determined by the order of benefit determination rules, you have primary coverage under another policy and Navitus is your secondary coverage. All claims need to be submitted to your other policy first. Navitus covers the remaining cost of any covered prescriptions up to the allowed amount under your policies. COB does not guarantee that all of your out of pocket costs will be covered.

## Minnesota Life Insurance Company

(866) 295-8690

etf.wi.gov

- **Wisconsin Public Employers (WPE) Group Life Insurance**

The life insurance program offers employees coverage of up to five times annual earnings. Five levels of insurance are available to state employees, and these are described in more detail below. The amount of coverage available to local government employees depends on which plans are offered by your employer. The program is administered by Minnesota Life Insurance Company (MLIC).

- The **Basic Plan** provides coverage equal to your previous year's earnings, rounded up to the next thousand. Basic coverage will continue in a reduced amount for life, without cost, for eligible retirees over age 65.
- The **Supplemental Plan** provides coverage equal to your previous year's earnings, rounded up to the next thousand.
- The **Additional Plan** provides up to three units of coverage. Each unit of coverage equals your previous year's earnings, rounded up to the next thousand. Depending on how many levels of coverage are offered by your employer, you may choose 1, 2, or 3 units of Additional coverage.
- The **Age 70 and Over Additional Plan** provides up to three units of coverage for active employees over the age of 70. Each unit provides coverage equal to your previous year's earnings, rounded to the next thousand. Depending on how many levels of coverage are offered by your employer, you may choose 1, 2, or 3 units of coverage.
- The **Spouse & Dependent Plan** provides up to two units of coverage for your spouse or domestic partner and all dependent(s). Each unit of coverage provides \$10,000 in spouse coverage and \$5,000 coverage for each dependent (regardless of the number).
- **Conversion of Life Insurance to Pay Health Insurance Premiums**

Retirees who have WPE life insurance and have reached age 66 may be eligible to convert the present value of their life insurance to pay ETF-sponsored health insurance premiums. See *Converting Your Group Life Insurance to Pay Health Insurance Premiums* (ET-2325) for more information.

*continued on next page*

*continued*

- **Living Benefits**

Insured persons may apply to receive all or part of the value of their life insurance while still living, if they are diagnosed with a terminal condition caused by illness or injury and have a life expectancy of 12 months or less. See the *Living Benefits (ET-2327)* brochure for more information.

- **Eligibility and Enrollment**

You have an open enrollment opportunity for life insurance coverage if you:

- Are under age 70, and
- have worked six or more months in service covered by the WRS, and
- you apply within 30 days of your first eligibility.

For Spouse and Dependent coverage only, you may apply when you have either a spouse or domestic partner or dependent to insure for the first time. If you do not enroll for all available coverage when you are first eligible, you may apply for future coverage only through *Evidence of Insurability (ET -2305)*.

See the *Wisconsin Public Employers Group Life Insurance Program (ET-2101)* brochure for complete program details.



# Group Health Insurance Applications

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.

## GROUP HEALTH INSURANCE APPLICATION/CHANGE FORM

State of Wisconsin Employees and Annuityants

Wisconsin Public Employees and Annuityants

UW Graduate Assistants, Employees in Training, Short-Term Academic Staff, Fellows and Scholars

Wis. Stat. § 40.51

You must submit this application to your employer if you are actively employed, or to the Department of Employee Trust Funds if you are an annuityant or on continuation. Use this form when electing, declining, or canceling health insurance coverage; making changes; and adding or deleting a dependent. For complete enrollment and program information, read the *It's Your Choice* booklets. Your initial enrollment period is as follows:

- a) Within 30 days of your date of hire to be effective the first of the month on or following receipt of application by the employer; or
- b) **(State employees only)** Before becoming eligible for state contribution (completion of two months of state service under the Wisconsin Retirement System (WRS) for permanent/project employees; six months of state service for state limited term employees or completion of 1000 hours of service for WISCRAFT employees. This does not apply to UW unclassified faculty/academic staff.
- c) **(Wisconsin Public Employers' participants only)** Within 30 days prior to becoming eligible for employer contribution.
- d) **(Graduate Assistants only)** When you are notified of your appointment, immediately contact your benefits/payroll/personnel office for health insurance enrollment information and an application. If eligible, you may enroll for single or family coverage in any of the available health plans without restriction or waiting periods for pre-existing medical conditions. Your benefits/payroll/personnel office must receive your application within 30 days of the date of your first eligible appointment. Your health insurance coverage will be effective the first day of the month on or following receipt of your application by your employer.

If this is not your first eligible appointment, you may still be eligible for the initial 30-day enrollment period if you had a 30-day employment break between appointments. If you are currently an active participant under the WRS, you are not eligible for coverage under the graduate assistant program.

If you choose to enroll within your initial enrollment period, we recommend that you submit this application to your employer immediately upon employment. If you missed your enrollment opportunity there may be other enrollment periods available to enroll without limitations or waiting periods. For complete enrollment and program information, read the *It's Your Choice* booklets.

There are no interim effective dates, except as required by Federal HIPAA law. If your application is submitted after these enrollment periods, you will be subject to waiting periods as described in the *It's Your Choice* booklets.

# INSTRUCTIONS FOR COMPLETING HEALTH INSURANCE APPLICATION/CHANGE FORM

## SECTION 1 – APPLICANT INFORMATION

1. *Print* your responses *clearly* and *legibly*.
2. Enter your complete name (including your previous name, if applicable), your Social Security Number (SSN), your home address, including the county, and your home and daytime telephone numbers in the spaces provided.

NOTE: If you choose not to enroll, go to Section 7.

3. Marital or Domestic Partnership Status: Check the box that applies to you. If you indicate that you are Married, Divorced, Widowed, or in a Domestic Partnership, list the date in the space provided. *Note the effective date of a Domestic Partnership is the date that ETF receives the Affidavit of Domestic Partnership form (ET 2371).* If married or in a domestic partnership, you must provide your spouse/domestic partner name, SSN and birth date, even if you are applying for single coverage.
4. Eligibility Status: Check one box which describes your status as an applicant.
5. For initial enrollment only, indicate if you want immediate health insurance coverage or coverage when you become eligible for the employer contribution toward the health insurance premium. Indicate It's Your Choice enrollment for coverage changes during the annual enrollment period.
6. Coverage Desired: Indicate level of coverage desired by checking either single or family.
7. Health Plan Selected: Indicate the name of the Health Plan that you want to provide your health insurance.

## SECTION 2 – REASON FOR APPLICATION

### Subsections A and B

1. Indicate the reason for submitting this application by checking the box(es) that apply.
2. If checking boxes in Subsection A only or both A and B, go to Section 3 and complete all enrollment information.
3. If checking boxes in Subsection B only, go to Section 7 to complete the application except, if you are updating Other Insurance Coverage complete Section 6 & 7.

### Changes To Dependent Coverage

#### Subsection C

Complete this Subsection when deleting a dependent. Check the reason and list all dependents to be deleted from your Health Insurance Contract. Go to Section 7 to complete the application.

#### Subsection D

Complete this Subsection when adding a dependent. Check the reason for adding a dependent(s) and indicate the event date. Go to Section 3 and list all family members who are being added to your Health Insurance Contract. Also, complete Sections 4, 5, 6 and 7.

## SECTION 3 – ENROLLMENT INFORMATION

Provide all information requested in this Section for yourself, when applying for single coverage; when applying for family coverage, list yourself and all eligible dependents.

If the SSN is not known because it was just applied for, write —APPLIED FOR” in that field.

For —Re Code,” use the following codes to describe the relationship of dependents to you:

01=Spouse	24=Dependent of Your Minor Child
15=Legal Ward	53=Domestic Partner
17=Stepchild	38=Dependent of Domestic Partner
19=Child	

Completion of the Student Status column is required only if the dependent child(ren) is between the ages of 19 and 27:

F=Full-Time, P=Part-Time, and N=Not a Student.

Indicate —~~s~~” or —N”if the dependent is disabled.

Indicate —~~s~~” or —N”if your domestic partner and/or dependent child is considered a —~~ax~~ dependent” under federal law. You do not need to complete this box for your spouse. *Note there may be tax consequences to you when you cover dependents (i.e., domestic partners and children) who are not dependent on you for at least 50% of their support.*

For yourself and all eligible dependents, provide the name of the physician or clinic. If you have selected the Standard Plan, please indicate —NONE”.

## SECTION 4 – ADDITIONAL INFORMATION

Indicate —~~s~~” or “No” for all three questions, and list names as applicable.

## SECTION 5 – MEDICARE INFORMATION

Indicate whether any of your dependents (including your spouse/domestic partner) are covered by Medicare, and list the names of those covered. Provide the Health Insurance Claim number (HIC#) and effective date from the Medicare card for any individuals covered by Medicare.

## SECTION 6 – “OTHER COVERAGE”

Provide information regarding any other group *health insurance* under which you or your dependents (including your spouse/domestic partner) are covered. NOTE: —~~Other~~ coverage” does not include supplemental insurance (for example, EPIC or DentalBlue).

## SECTION 7 – SIGNATURE

Read the **TERMS AND CONDITIONS** on the reverse side of this page.

1. If applying for health insurance coverage, check the box that you are applying for coverage, sign and date the application, indicating agreement with the terms and conditions. Submit the application to your payroll representative or to ETF if you are an annuitant/continuant.
2. If declining health insurance coverage, check the box indicating you do not wish to enroll, sign and date the application, and submit to your payroll representative.
3. Your employer will complete Section 8 and provide a copy of the application to you. For annuitants/continuant, ETF will complete section 8 and provide a copy of the application to you.
4. If submitting during the annual It's Your Choice enrollment period, make a copy for your records.

ETF Use Only

State of Wisconsin
Department of Employee Trust Funds
HEALTH INSURANCE APPLICATION/CHANGE FORM

Employer Notes

1. APPLICANT INFORMATION

Applicant - Last Name, First, Middle, Previous Name, Social Security Number
Address - Street and No., City, State, Zip Code
County, Country (if not USA), Home Telephone No., Daytime Telephone No.

MARITAL OR DOMESTIC PARTNERSHIP STATUS: Single, Married\* (date), Divorced (date), Widowed (date), Domestic Partnership\* (date)
\*Spouse/Domestic Partner (DP) Name, SSN, Birth Date

ELIGIBILITY STATUS (check one) Employee, Survivor, Continuant (COBRA), Annuitant, Graduate Assistant
I WANT MY COVERAGE TO BE EFFECTIVE: As soon as possible, When employer contributes premium, It's Your Choice (January 1)

COVERAGE DESIRED Single, Family
HEALTH PLAN SELECTED

2. REASON FOR APPLICATION

A. Check all boxes that apply. Go to Section 3.
Initial Enrollment - 02, Moved from Service Area - 41, Change to Family Coverage - 43, Change to Single Coverage - 44 or 45, Spouse/DP to Spouse/DP Transfer - 31, Transfer from One State Agency to Another - 04, COBRA (or continuation) - 63, It's Your Choice - 40, Other
B. Check all boxes that apply. Complete event date.
Event Date, Cancellation - 09, Name Change, former name, Address Change, Telephone Number Change, Social Security Number Correction, Update Other Insurance Coverage

C. Complete the following for deleting a dependent. List only dependents affected by this change below.
Reason: Divorce/DP terminated, Age\*\*, Dependent Married, Other

\*\*Dependent turned 27 or is over 18 and is eligible for health insurance through employer; grandchild of a dependent that turned 18.

Table with columns: Last Name, First, Middle, Birthdate (Mo, Day, Yr), Gender (M/F), Social Security Number, Event Date, Dependent's Address, and a note about COBRA continuation coverage.

D. Complete the following when adding a dependent. List only dependents affected by this change in Section 3.
Reason: Marriage, Birth, Legal Ward\*\*\*, Adoption\*\*\*, Domestic Partner\*\*\*, Disabled, Other, Event Date

\*\*\*Please attach documentation for additions due to legal ward or adoption status; ETF affidavit required for domestic partnership.

Dependents include spouse or domestic partner and unmarried children. Children include those who are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, children of your domestic partner, or grandchildren until the grandchildren's parent (your child) reaches age 18.

Applicant Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

3. ENROLLMENT INFORMATION					Gender (M/F)	Social Security Number	Rel. Code	Student Status	Disabled? (Y/N)	Tax Dep? (Y/N)	Select Physician or Clinic
Last Name	First	Middle	Previous	Birthdate							
				Mo	Day	Yr					
Applicant											
Spouse/Domestic Partner											
Dependent Children											

**4. ADDITIONAL INFORMATION**

a. Are the dependent children listed above married?  Yes  No If yes, name(s) \_\_\_\_\_

b. Are any of the dependents listed above your grandchild?  Yes  No If yes, name of parent \_\_\_\_\_

**5. MEDICARE INFORMATION**

Are you or any insured dependent covered under Medicare?  Yes  No If yes, list names of insured and Medicare dates.

Name: \_\_\_\_\_ Dates: Part A \_\_\_\_\_ Part B \_\_\_\_\_ HIC # \_\_\_\_\_

Name: \_\_\_\_\_ Dates: Part A \_\_\_\_\_ Part B \_\_\_\_\_ HIC # \_\_\_\_\_

**6. OTHER COVERAGE**

a. Other health insurance coverage?  Yes  No If yes, name of other Insurance Company \_\_\_\_\_  
Name(s) of Insured(s) \_\_\_\_\_

b. Is your spouse/domestic partner a State of Wisconsin employee (including University of Wisconsin)?  Yes  No

**7. SIGNATURE** (read the **Terms and Conditions** on the attached page, check one box and sign)

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and have read and agree to the **TERMS AND CONDITIONS**. A copy of this application is to be considered as valid as the original.

I do not wish to enroll at this time.

I wish to cancel my current coverage. Reason \_\_\_\_\_

To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.

<b>SIGN HERE &amp; Return to Employer</b> →	Date Signed (MM/DD/CCYY)	Applicant Signature

**8. EMPLOYER COMPLETES** (Coding Instructions are in the *Employer Health Insurance Administration Manual*)

Employer Number <b>69-036-</b>	Name of Employer	Program Option Code	Surcharge Code
Group Number	Enrollment Type	Employee Type	Coverage Type Code
Carrier Suffix		Standard Plan Waiting Period	Participant County Code
<b>Previous Service – Complete Information</b>		Date Application Received by Employer (MM/DD/CCYY)	Date WRS Eligible Employment Began or Graduate Assistant Appointment Began (MM/DD/CCYY)
1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. Source of previous service check: <input type="checkbox"/> Online Network for Employers(ONE) <input type="checkbox"/> ETF			
Monthly Employee Share \$	Monthly Employer Share \$	Event Date (MM/DD/CCYY)	Prospective Date of Coverage (MM/DD/CCYY)
Payroll Representative Signature		Telephone ( )	

**COPY AND DISTRIBUTE:**  ETF ADVANCE  EMPLOYEE  EMPLOYER

## HEALTH INSURANCE APPLICATION/CHANGE FORM 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 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 in the contract, listed on this application are not married and not eligible for coverage under a group health insurance plan that is offered by their employer for which the amount of their premium contribution is not greater than the premium amount for their coverage under this program. Children may be covered through the end of the month in which they turn 27. Children may also be covered beyond age 27 if they:
  - have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or
  - are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.
6. I understand that if my insured domestic partner and/or dependent children are not considered ~~tax~~ dependents" under federal law, my income will include the fair market value of the health insurance benefits provided to my domestic partner and/or dependent children. Furthermore, I understand this may affect my taxable income and increase my tax liability.
7. I understand that 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, marriage or domestic partnership, a change in the ~~tax dependent~~" status of my domestic partner and/or dependent children, 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, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependents.
8. I understand that if there is a qualifying event in which a qualified beneficiary (me 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.
9. I understand that if I am declining enrollment for myself or my dependents (including spouse or domestic partner) because of other health insurance coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents if I request enrollment within 30 days after the marriage or effective date of the domestic partnership, or within 60 days after the birth, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am an annuitant or continuant).
10. 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*** booklets.







**Alternate Health Plans:** The insurance plans in the Wisconsin Public Employers Program that offer Uniform Benefits. Examples of this are HMOs (Health Maintenance Organizations) and Preferred Provider Plans (PPPs).

**Annuitant:** A retiree, beneficiary, or survivor of the retiree or beneficiary receiving benefits under the Wisconsin Retirement System (WRS).

**CAHPS (Consumer Assessment of Healthcare Providers & Systems):** A survey used to measure satisfaction based on consumer experiences.

**Checkpoint:** A program that provides data from Wisconsin hospitals showing their performance on interventions that medical experts agree should be taken to treat major diseases.

**COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986):** An option that allows an insured member to continue his/her employer sponsored group health insurance coverage for a limited period of time under certain circumstances after losing eligibility for their health insurance. The member is responsible for paying the entire premium.

**Complaint:** When a member contacts the Department of Employee Trust Funds (ETF) to appeal an insurance decision that is not favorable to the member.

**Coinsurance:** A specific percentage of the cost of an item or service that the member pays. For example, under Uniform Benefits, members pay 20% of the cost of purchasing most durable medical equipment (up to an out-of-pocket maximum cost of \$500 per member per year).

**Copayment:** The set dollar amount a member pays when he/she receives a covered service or prescription, for example, emergency room visits and prescription drugs.

**Deductible:** The amount you pay for your health care before the health plan begins to pay claims.

**Dependent:** A person who meets the specific eligibility criteria for coverage under the Wisconsin Public Employers Program rules.

**Dual Choice (It's Your Choice enrollment period):** The annual opportunity for currently insured members to change from one health plan to another, or to change from single to family coverage for the upcoming year without restrictions.

**Effective Date:** The date on which the member becomes enrolled and entitled to benefits.

**Emergency Care:** Medical Services to treat an injury or illness that could result in death or serious harm if not immediately treated.

**Formulary:** A list of covered prescription drugs. The State Group Health Insurance Program's formulary is available on Navitus Health Solutions' web site at <https://www.navitus.com/Pages/ETFFormulary.aspx>.

**Graduate Assistants:** This group consists of graduate student assistants, employees-in-training, short-term academic staff and some visiting appointees. Members in this group are not enrolled in the Wisconsin Retirement System (WRS).

**HEDIS (Healthcare Effectiveness Data & Information Set):** Compares the performance of health plans with regard to the delivery of care and service.

**HMO (Health Maintenance Organization):** A health plan that uses a specific network of doctors, clinics, hospitals, and other medical providers located in a specific geographic area. Members of HMOs are expected to receive services within that network.

**Grievance:** A written complaint filed with the health plan, PBM or ETF following a decision made by the health plan or PBM that was not favorable to the member.

**Group Insurance Board:** The governing body that sets policy and oversees the administration of the Group Health Insurance Programs for the State of Wisconsin and participating Wisconsin Public Employers.



**Leapfrog:** A nationwide program that encourages easy access to health care information and places high importance on health care safety, quality and consumer value.

**Mandated Benefits:** Benefits that are required by either federal or state law.

**MA-PFFS (Medicare Advantage Private Fee For Service) Plan:** Medicare coverage that is provided through a private insurance company under a contract with the federal government. State Group Health Insurance Program members that are enrolled in Humana and Medicare will automatically be enrolled in a MA-PFFS plan.

**Medicare:** The federal health insurance program for those who are eligible for coverage due to age, disability, or blindness. The original federal Medicare program provides coverage under Medicare Part A and Part B.

**Medicare Family 1 Premium Rate:** The rate for a family plan where at least one member is enrolled in Medicare Parts A and B (and Medicare is the primary (first) payer) and at least one family member is not.

**Medicare Family 2 Premium Rate:** The rate for a family plan where all members are enrolled in Medicare Parts A and B and Medicare is the primary (first) payer.

**Network:** A grouping of doctors, clinics, hospitals and other health care providers who contract with a specific health plan to provide services under that plan's benefit package.

**Non-Plan Provider:** A provider who is not in a health plan's network.

**Non-Qualified Plan:** Health plans that offer a limited amount of providers in a county.

**Out-of-Pocket Maximum:** The maximum amount of money a health plan member has to pay for services during a year.

**PBM (Pharmacy Benefit Manager):** The TPA that the Group Insurance Board contracts with to administer prescription drug benefits.

**PCP (Primary Care Physician/Provider):** The PCP coordinates access to your health plan's coverage and services. Your PCP works with you and other medical providers to provide, prescribe, approve and coordinate medical care.

**PDP (Prescription Drug Plan):** A prescription drug plan that provides Medicare Part D coverage. The State Group Health Insurance Program's preferred PDP is DeanCare Rx.

**Plan Benefits:** Comprehensive health care services and prescription drug benefits that your health plan provides to its members in accordance with the contract language.

**Plan Service Area:** The geographic area in which a health plan provides coverage through its network.

**Plan Provider:** A medical provider that is in a health plan's network.

**PPP (Preferred Provider Plan):** A health plan that uses a network of doctors, clinics, hospitals, and other medical providers in a specific geographic area, and also provides coverage outside of that network (at a higher out-of-pocket cost to the member).

**Prior Authorization:** A process for requesting the health plan's approval before receiving certain medical services to determine if they are covered under the policy.

**Qualified Plan:** In order for a health plan to be called qualified in a county, it must meet minimum provider availability requirements. The minimum requirements are five primary care providers, a hospital if one exists in the county, a chiropractor, and a dental provider if the plan offers dental coverage. A health plan that is non-qualified is missing one or more of these types of providers, but is still an available option in the county.

**Referral:** When your doctor recommends that you see another provider or specialist for care. The process for approving referrals varies by health plan so it is important to find out your health plan's requirements.

**Schedule of Benefits:** A document that details the specific benefits provided by your health plan including copays, deductibles and coinsurance, if any.



**Self-Funded Plans:** A self-funded plan is one where the State of Wisconsin is responsible for funding the payment of claims in addition to paying a hired TPA that administers the plan. Administration by a TPA means that they create networks, pay claims, etc. The Standard, SMP and Medicare Plus \$1,000,000 plans and Navitus Health Solutions are self-funded.

**Subscriber:** The employee, annuitant or continuant who is eligible to participate in the Group Health Insurance Program and is allowed to select one of the available health plans for their coverage. This person's dependents are also eligible for coverage.

**TPA (Third-Party Administrator):** A company that the Group Insurance Board contracts with to provide administrative services for self-funded plans. Administration by a TPA means that they review for medical necessity, create networks, pay claims, etc.

**Uniform Benefits:** The standardized level of benefits offered to State Group Health Insurance members through the HMOs and WPS Metro Choice.

**Urgent Care:** Care given in a non-emergency situation due to an accident or illness when a member needs to see a doctor more quickly than a routine clinic visit.

**Wisconsin Public Employer:** Employers who have voluntarily chosen to participate in the Wisconsin Public Employers Group Health Insurance Program. This includes some villages, towns, cities, counties and some school districts.



## Health Plan Contact Information

### **Anthem Blue**

P.O. Box 34210  
Louisville, KY 40233-4210  
Tele: (800) 490-6201  
NurseAssist: (888) 854-0618  
Web site: [www.anthem.com](http://www.anthem.com)

### **Arise 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](http://www.WeCareForWisconsin.com)

### **Dean Health Insurance (DHI) (Prescription drug coverage for Medicare eligible retirees)**

1277 Deming Way  
Madison, WI 53717  
Tele: (608) 827-4372  
(888) 422-3326  
Fax: (608) 827-4212  
Web site:  
[www.deancare/deancarerx](http://www.deancare/deancarerx)

### **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](http://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](http://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.ghcscw.com](http://www.ghcscw.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](http://www.glhealthplan.org)

### **HealthPartners Health Plan**

P.O. Box 1309  
Minneapolis, MN 55440-1309  
Tele: (800) 883-2177  
(952) 883-5000  
Fax: (952) 883-5666  
Careline: (800) 551-0859  
Web site:  
[www.healthpartners.com/stateofwis](http://www.healthpartners.com/stateofwis)

### **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](http://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](http://www.humana.com)  
or direct at  
<http://apps.humana.com/egroups/wisconsin/home.asp>

### **Medical Associates Health Plans**

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](http://www.mahealthcare.com)

### **MercyCare Health Plans**

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](http://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](http://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](http://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](http://www.HealthyChoicesBigRewards.com)

### **Security Health Plan**

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](http://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](http://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](http://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.chooseunityhealth.com](http://www.chooseunityhealth.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](http://www.wpsic.com/state)