



Traditional HMO — Standard PPP Addendum

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2011 Wisconsin Public Employers Group Health Insurance Program

Participating Local Government
Employees & Annuitants



ET-2157 (Rev. 11/2010)

Keep this as a reference
throughout the year
with the *It's Your Choice* guides.

2011 Monthly Local Employee Rates: Traditional HMO Option—Standard PPP

Plan Name	Tier	Non-Medicare Rates		Medicare Rates		
		Single	Family	Single	Medicare 1 Eligible*	Medicare 2 Eligible**
Anthem Blue Northeast	1	930.70	2,322.90	635.80	1,563.90	1,269.00
Anthem Blue Northwest	1	948.90	2,368.40	644.90	1,591.20	1,287.20
Anthem Blue Southeast	1	1,101.10	2,748.90	721.00	1,819.50	1,439.40
Arise Health Plan	1	769.20	1,919.20	555.00	1,321.60	1,107.40
Dean Health Plan	1	538.20	1,341.70	434.10	969.70	865.60
GHC of Eau Claire	1	841.00	2,098.70	574.20	1,412.60	1,145.80
GHC of South Central Wisconsin	1	545.80	1,360.70	443.40	986.60	884.20
Gundersen Lutheran Health Plan	1	810.20	2,021.70	507.10	1,314.70	1,011.60
HealthPartners	1	864.90	2,158.40	582.20	1,444.50	1,161.80
Health Tradition Health Plan	1	723.50	1,804.90	532.10	1,253.00	1,061.60
Humana Eastern	1	1,114.10	2,781.40	432.70	1,544.20	862.80
Humana Western	1	1,114.10	2,781.40	432.70	1,544.20	862.80
Medical Associates Health Plan	1	597.90	1,490.90	396.40	991.70	790.20
MercyCare Health Plan	1	512.10	1,276.40	426.50	936.00	850.40
Network Health Plan	1	649.90	1,620.90	495.40	1,142.70	988.20
Physicians Plus—Meriter & UW Health	1	529.10	1,318.90	406.00	932.50	809.40
Security Health Plan	1	978.10	2,441.40	557.20	1,532.70	1,111.80
Standard Plan - Balance of State ¹	3	959.50	2,394.90	370.00	1,329.50	737.30
Standard Plan - PPP: Dane ²	3	891.20	2,224.20	370.00	1,261.20	737.30
Standard Plan - PPP: Milwaukee ³	3	1,037.00	2,588.70	370.00	1,407.00	737.30
Standard Plan - PPP: Waukesha ⁴	3	959.50	2,394.90	370.00	1,329.50	737.30
State Maintenance Plan	1	712.90	1,778.60	NA	NA	NA
UnitedHealthCare Northeast	1	725.00	1,808.70	533.00	1,255.40	1,063.40
UnitedHealthCare Southeast	1	760.30	1,896.90	550.60	1,308.30	1,098.60
Unity Community	1	514.00	1,281.20	405.90	917.30	809.20
Unity UW Health	1	514.50	1,282.40	406.10	918.00	809.60
WEA Trust PPP	1	769.50	1,919.90	555.20	1,322.10	1,107.80
WPS Metro Choice	1	1,043.20	2,604.20	692.10	1,732.70	1,381.60

Standard Plan Area Includes The Following:

- ¹ BALANCE OF STATE: All other Wisconsin counties
- ² DANE: Dane, Grant, Jefferson, LaCrosse, Polk, St. Croix
- ³ MILWAUKEE: Milwaukee County, and retirees and continuants living out of state
- ⁴ WAUKESHA: Kenosha, Ozaukee, Racine, Washington, Waukesha

N/A= "not applicable." Medicare eligible participants automatically receive Standard Plan benefits. Medicare premium rates apply only to subscribers who have terminated employment.

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

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

Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN		STATE MAINTENANCE PLAN (SMP) if under Medicare age
		Preferred Provider	Non-Preferred Provider	
Annual Deductible ¹	No deductible ²	Non-Medicare \$250 individual/ \$500 family. Medicare \$150 individual/ \$300 family.	Non-Medicare \$500 individual/ \$1,000 family. Medicare \$300 individual/ \$600 family.	Major Medical* only \$200 single, \$400 family.
Annual Co-insurance ³	As described below ⁴	Non-Medicare 90%/10% Annual OOP maximum (includes deductible): \$1,000 individual/\$2,000 family. Medicare 100%	Non-Medicare 70%/30% Annual OOP maximum (includes deductible): \$2,000 individual/\$4,000 family. Medicare 100%	Major Medical*, only 80%/20%, to out-of-pocket maximum \$1,000 single/\$2,000 family.
Hospital Days	As medically necessary, plan providers only. No day limit.	90%/10% up to 365 per confinement	70%/30% up to 365 per confinement	100%, up to 365 days per confinement, then Major Medical*.
ER	\$60 copay per visit	90%/10%, no copay	90%/10%, subject to in-network deductible	100%, no copay on Base** Major Medical* deductible/ coinsurance, as applicable
Ambulance	100%	90%/10%	90%/10%, subject to in-network deductible	Plan pays first \$50 per trip, then applies Major Medical* deductible/ coinsurance.
Transplants (May cover these and others listed)	Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung	90%/10% Bone marrow, parathyroid, musculoskeletal, corneal, and kidney	70%/30% Bone marrow, parathyroid, musculoskeletal, corneal, and kidney	100% Bone marrow, parathyroid, musculoskeletal, corneal, and kidney
Mental Health/ Alcohol & Drug Abuse	Inpatient, Outpatient, and Transitional, 100%	Inpatient 90%/10%, up to 365 days. Outpatient and Transitional 90%/10%.	Inpatient 70%/30%, up to 365 days. Outpatient and Transitional 70%/30%.	Inpatient 100%, up to 365 days. Outpatient & Transitional portions can be covered under Base** and/or Major Medical* deductible/coinsurance.
Routine Physical	One per year	100% no deductible as required by federal law. Otherwise, 90%/10%.	70%/30%	100%
Hearing Exam	100%	Benefit for illness or disease 90%/10%	Benefit for illness or disease 70%/30%	100% Benefit for illness or disease
Hearing Aid (per ear)	Every 3 years: Adults, 80%/20%, up to \$1,000; dependents younger than 18 years, 100%, maximum does not apply	For dependents younger than 18 years only, every 3 years. 90%/10%	For dependents younger than 18 years only, every 3 years. 70%/30%	Only for dependents younger than 18 years, once every three years—subject to Major Medical* deductible/ coinsurance.

Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN		STATE MAINTENANCE PLAN (SMP) if under Medicare age
		Preferred Provider	Non-Preferred Provider	
Cochlear Implants	Adults, 80%/20% for device, surgery, follow-up sessions; 100% hospital charge for surgery. Dependents under 18, 100%.	Dependents under 18, 90%/10% device, surgery, follow-up sessions.	Dependents under 18, 70%/30% device, surgery, follow-up sessions.	Only for dependents younger than 18 years, once every three years--subject to Base** &/or Major Medical* deductible/ coinsurance.
Routine Vision Exam	One per year	No benefit for routine. Illness or disease only, 90%/10%.	No benefit for routine. Illness or disease only, 70%/30%.	Preventive 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	90%/10% of the lesser of 120 days per confinement or 2 days of confinement for each unused hospital day	70%/30% of the lesser of 120 days per confinement or 2 days of confinement for each unused hospital day	100% of the lesser of 120 days per confinement or 2 days of confinement for each unused hospital day
Home Health (non custodial)	50 per year; Plan may approve an additional 50.	90%/10% for 365 days less hospital days used	70%/30% for 365 days less hospital days used	100%, up to 365 days, less hospital days used
Physical/Speech /Occupational Therapy	50 per year; Plan may approve an additional 50.	90%/10%, no limit on visits or days	70%/30%, no limit on visits or days	Major Medical* deductible/ coinsurance, no limit on visits or days
Durable Medical Equipment	80%/20% co-insurance, \$500 OOP maximum	90%/10%	70%/30%	Major Medical* deductible/ coinsurance
Hospital Pre-Certification	Varies by plan	Medical Management Program for inpatient stays. Voluntary 2nd surgical opinion.	Medical Management Program for inpatient stays. Voluntary 2nd surgical opinion.	None required
Referrals	In-network varies by plan. Out-of-network required.	None required	None required	In-network none required. Out-of-network required.
Primary Care Provider/Clinic	Varies by plan	None required	None required	Any provider in network
Surgical Treatment for Morbid Obesity	Excluded	90%/10% at Center of Excellence in-network provider	70%/30%	Excluded
Oral Surgery	11 procedures	23 procedures. 90%/10%	23 procedures. 70%/30%	23 procedures. 100%
Dental Care	Varies by plan	No benefit	No benefit	Preventative up to age 12, 100%
Drug Copays and Out-of-Pocket Maximum OOPM ⁵	Level 1=\$5; 2=\$15; 3=\$35 ⁶ . OOPM \$410 individual/ \$820 family.	Level 1=\$5; 2=\$15; 3=\$35 ⁶ . OOPM No limit.	Level 1=\$5; 2=\$15; 3=\$35 ⁶ . OOPM No limit.	Level 1=\$5; 2=\$15; 3=\$35 ⁶ . No limit.

Footnotes appear on Page 4.

The Comparison of Benefit Options chart on the preceding pages is designed to compare Uniform Benefits, the Standard PPP and SMP. It is not intended to be a complete description of coverage. Differences might exist among the health plans in the administration of the benefits package.

FOOTNOTES FROM COMPARISON OF BENEFIT OPTIONS CHARTS

* 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.

¹ Deductible applies to all services, except prescription drugs.

² PPPs have out-of-network deductibles. See Uniform Benefits PPP Plan Descriptions in the *It's Your Choice: Decision Guide* for details.

³ Coinsurance applies to all services up to the listed out-of-pocket maximum, then all services are covered at 100%.

⁴ PPPs have out-of-network coinsurance. See Uniform Benefits PPP Plan Descriptions in the *It's Your Choice: Decision Guide* for details.

⁵ This is separate from other out-of-pocket maximums, such as the medical.

⁶ Level 3 copays do not apply to the OOPM.

FREQUENTLY ASKED QUESTIONS AND THEIR ANSWERS

Standard Preferred Provider Plan (PPP)

WHAT IS THIS CHANGE TO A PPP ALL ABOUT?

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

This arrangement can be attractive to members who, for the most part, are comfortable with the plan's providers but occasionally feel the need to utilize a particular specialist or desire coverage for routine care while traveling. In addition, members who have students away at college may choose the plan to offer comprehensive coverage to all family members, regardless of where they live. The provider network is nationwide, so covered members who receive care out-of-state will have improved access to providers.

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

HOW DO I KNOW WHICH PROVIDERS ARE IN-NETWORK PROVIDERS?

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

HOW IS THE STANDARD PPP WITH A PREFERRED PROVIDER NETWORK DIFFERENT FROM THE CLASSIC STANDARD PLAN?

Under the Standard PPP, when you receive services from providers, you will need to meet up-front deductible and coinsurance amounts with the exception of in-network federally mandated preventive care services, that are paid for in full. You will not have to pay the old major medical deductible and coinsurance. If you use in-network providers, you will have lower deductible and coinsurance costs.

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

A hospital pre-certification program is included. This program requires at least 48 hours prior notice of non-emergency hospital admissions, or notice with 48 hours after an emergency admission. If you do not notify WPS, their payment for your claim will be reduced by \$100. You will be responsible to pay that amount in addition to your deductible. This program does not apply if Medicare pays for your claims first, for example, if you are an annuitant older than 65 years old.

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

HOW DOES THE APPLICATION OF THE PREFERRED PROVIDER NETWORK INTO THE STANDARD PLAN SAVE MONEY AND IMPROVE SERVICES?

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

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

WHY IS THE STANDARD PLAN WITH THE PREFERRED PROVIDER NETWORK BEING IMPLEMENTED NOW?

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

CAN MY EMPLOYER PAY FOR MY OUT-OF-POCKET COSTS FOR MEDICAL SERVICES AND PRESCRIPTION DRUG COPAYS, DEDUCTIBLES AND/OR COINSURANCE?

No, however, if your employer offers you a medical Flexible Spending Account (FSA), you may be able to lower the amount you pay for certain medical out-of-pocket costs.

A medical FSA program allows you to reduce your taxable income by an agreed-upon amount each pay period and to have these amounts set aside to pay certain medical expenses. Contributions are made on a pre-tax basis to your account as established by you annually. These contributions are returned to you by submitting receipts and other required documentation to your employer's FSA administrator.

A medical reimbursement account is used to pay medical expenses for you, your spouse and dependents that are not paid by insurance. This would include deductibles and coinsurance amounts; drugs; dental, vision and hearing care; orthodontia; and other uncovered medical procedures or supplies.

Standard PPP Plan

Administered by WPS Health Insurance

800-634-6448 www.wpsic.com/state

- **What's New for 2011**

Federally mandated preventive care services performed by in-network providers will be payable without deductible or coinsurance being assessed. In addition, the \$2,000,000 lifetime maximum has been eliminated.

Visit the Health Center at 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 Preferred Provider Plan (PPP). It provides you with freedom of choice among hospitals and physicians in Wisconsin and nationwide. A higher level of benefits is available by using a preferred or in-network provider which are available nationwide. For detailed information, see the Health Care Benefit Plan booklet at <http://etf.wi.gov/publications/et2160.pdf>.

- **Provider Directory**

Go to www.wpsic.com/state/pdf/dir2011_statewide_eastern.pdf or www.wpsic.com/state/pdf/dir2011_statewide_western.pdf to search for a provider within Wisconsin and bordering areas. You can also visit www.wpsic.com/state/fad2010_state_national.shtml to search for providers within Wisconsin, as well as nationwide. You may also contact WPS Member Services to request a copy.

- **Other: Pre-Certification**

To avoid a \$100 inpatient benefit reduction, you, a family member or a provider must notify WPS of any inpatient hospitalization to request pre-certification.

- **Referrals and Prior Authorizations**

Referrals are not needed.

WPS recommends that members or providers request prior authorization for services when there is concern if the services will be payable and at what cost. Without an approved prior authorization, WPS may deny payment. Please visit www.wpsic.com/state and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form or contact WPS Member Services.

- **Mental & Behavioral Health Services**

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license. Inpatient services will be limited to 365 days.

- **Dental Benefits**

No dental coverage provided.