

Deductible HMO — Deductible Standard PPP Addendum

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2011 Wisconsin Public Employers Group Health Insurance Program

Participating Local Government
Employees & Annuitants

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



ET-2159 (Rev. 11/2010)

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

Plan Name	Tier	Non Medicare Rates		Medicare Rates		
		Single	Family	Single	Medicare 1 Eligible*	Medicare 2 Eligible**
Anthem Blue Northeast	1	828.90	2,068.40	584.90	1,411.20	1,167.20
Anthem Blue Northwest	1	844.90	2,108.40	592.90	1,435.20	1,183.20
Anthem Blue Southeast	1	978.90	2,443.40	659.90	1,636.20	1,317.20
Arise Health Plan	1	700.20	1,746.70	520.50	1,218.10	1,038.40
Dean Health Plan	1	488.40	1,217.20	409.80	895.60	817.00
GHC of Eau Claire	1	772.70	1,927.90	541.60	1,311.70	1,080.60
GHC of South Central Wisconsin	1	513.40	1,279.70	427.20	938.00	851.80
Gundersen Lutheran Health Plan	1	759.20	1,894.20	470.20	1,226.80	937.80
HealthPartners	1	810.10	2,021.40	556.20	1,363.70	1,109.80
Health Tradition Health Plan	1	678.70	1,692.90	507.80	1,183.90	1,013.00
Humana Eastern	1	1,029.50	2,569.90	378.70	1,405.60	754.80
Humana Western	1	1,029.50	2,569.90	378.70	1,405.60	754.80
Medical Associates Health Plan	1	536.00	1,336.20	368.60	902.00	734.60
MercyCare Health Plan	1	469.10	1,168.90	405.00	871.50	807.40
Network Health Plan	1	581.70	1,450.40	461.30	1,040.40	920.00
Physicians Plus—Meriter & UW Health	1	484.50	1,207.40	392.30	874.20	782.00
Security Health Plan	1	888.50	2,217.40	539.90	1,425.80	1,077.20
Standard Plan: Balance of State ¹	3	902.80	2,253.00	349.20	1,251.90	695.80
Standard Plan - PPP: Dane ²	3	839.40	2,094.50	349.20	1,188.60	695.80
Standard Plan - PPP: Milwaukee ³	3	973.30	2,429.40	349.20	1,322.50	695.80
Standard Plan - PPP: Waukesha ⁴	3	902.80	2,253.00	349.20	1,251.90	695.80
State Maintenance Plan	1	651.90	1,626.00	NA	NA	NA
UnitedHealthCare Northeast	1	660.20	1,646.70	500.60	1,158.20	998.60
UnitedHealthCare Southeast	1	689.20	1,719.20	515.10	1,201.70	1,027.60
Unity Community	1	483.80	1,205.70	392.30	873.50	782.00
Unity UW Health	1	484.30	1,206.90	392.50	874.20	782.40
WEA Trust PPP	1	714.50	1,782.40	527.70	1,239.60	1,052.80
WPS Metro Choice	1	947.10	2,363.90	644.00	1,588.50	1,285.40
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

This chart is designed to compare Uniform Benefits, the Standard Plan 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.

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN		DEDUCTIBLE STATE MAINTENANCE PLAN (SMP)
		Preferred Provider	Non-Preferred Provider	
Annual Deductible ¹	\$500 individual/ \$1,000 family ²	Non-Medicare & Medicare \$500 individual/ \$1,000 family.	Non-Medicare & Medicare \$1,000 individual/ \$2,000 family.	\$500 individual/\$1,000 family
Annual Co-insurance ³	As described below ⁴	Non-Medicare 80%/20% Annual OOP maximum (includes deductible): \$2,000 individual/\$4,000 family. Medicare 100%	Non-Medicare 70%/30% Annual OOP maximum (includes deductible): \$4,000 individual/\$8,000 family. Medicare 100%	100%
Hospital Days	As medically necessary, plan providers only	80%/20% up to 365 per confinement	70%/30% up to 365 per confinement	100% up to 365 days per confinement
ER	\$60 copay per visit	80%/20%	80%/20%, subject to in-network deductible	100%, no copay
Ambulance	100%	80%/20%	80%/20%, subject to in-network deductible	100%
Transplants (May cover these and others listed)	Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung	80%/20% 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 80%/20%, up to 365 days. Outpatient and Transitional 80%/20%.	Inpatient 70%/30%, up to 365 days. Outpatient and Transitional 70%/30%.	Inpatient 100%, up to 365 days. Outpatient and Transitional 100%.
Routine Physical	One per year	100% no deductible as required by federal law. Otherwise, 80%/20%.	70%/30%	100% no deductible as required by federal law. Otherwise deductible applies.
Hearing Exam	100%	Benefit for illness or disease 80%/20%	Benefit for illness or disease 70%/30%	Benefit for illness or disease 100%
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. 80%/20%	For dependents younger than 18 years only, every 3 years. 70%/30%	100% only for dependents younger than 18 years, once every three years

Footnotes appear on Page 4.

Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS	STANDARD PLAN		DEDUCTIBLE STATE MAINTENANCE PLAN (SMP)
		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, 80%/20% device, surgery, follow-up sessions.	Dependents under 18, 70%/30% device, surgery, follow-up sessions.	100% only for dependents younger than 18 years, once every three years.
Routine Vision Exam	One per year	No benefit for routine. Illness or disease only, 80%/20%.	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	80%/20% 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 visits per year; Plan may add 50 visits.	80%/20% 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 visits per year; Plan may prior authorize an additional 50 visits.	80%/20%, no limit on visits or days	70%/30%, no limit on visits or days	100%, no limit on visits or days
Durable Medical Equipment	20% co-insurance, \$500 OOP maximum	80%/20%	70%/30%	100%
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.	Medical Management Program for inpatient stays. Voluntary 2nd surgical opinion.
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	80%/20% at Center of Excellence in-network provider	70%/30%	Excluded
Oral Surgery	11 procedures	23 procedures. 80%/20%	23 procedures. 70%/30%	23 procedures, 100%
Dental Care	Varies by plan	No benefit	No benefit	Preventive 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.

Comparison of Benefit Options Footnotes

- ¹ Deductible applies to all services, except certain preventive services and prescription drugs.
- ² PPPs like WEA Trust PPP and WPS Metro Choice have out-of-network deductibles. See PPP Plan Descriptions in *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 like WEA Trust PPP and WPS Metro Choice have out-of-network coinsurance. See PPP Plan Descriptions in *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 don't apply to the OOPM.

FREQUENTLY ASKED QUESTIONS AND THEIR ANSWERS

General Information

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.

Deductible HMO

HOW IS THE DEDUCTIBLE HMO OPTION DIFFERENT FROM UNIFORM BENEFITS, THE TRADITIONAL HMO OPTION?

Under the Deductible HMO option, you have an upfront deductible per calendar year of \$500 per individual, \$1,000 per family for medical services with the exception of federally mandated preventive care services, that are paid for in full. That is, you usually pay the first \$500 in services per individual or \$1,000 per family. Once the deductible is met, you receive benefits as described in Uniform Benefits, for example, copayment on emergency room visits, coinsurance on durable medical equipment (DME), etc.

ARE THERE ANY SERVICES THAT DO NOT APPLY TO THE UPFRONT DEDUCTIBLE?

The deductible does not apply to federally mandated preventive care services. In addition, pharmacy claims do not apply and continue to be subject to existing prescription drug copays.

HOW WILL I KNOW WHEN MY DEDUCTIBLE IS MET?

Until you meet your deductible, your HMO will send you an Explanation of Benefits (EOB) each time it processes a claim. The EOB will identify information about the claim, including the provider name, the amount billed, and the amount applying to your deductible, which you are responsible for paying the provider. Typically you would pay your provider after you receive the EOB from your health plan. The EOB will allow you to track when your deductible is met.

Deductible Standard Preferred Provider Plan (PPP)

WHAT IS THIS CHANGE TO THE DEDUCTIBLE STANDARD PLAN 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. The 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 provider or an out-of-network provider. If you receive services from an in-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 Deductible Standard Plan 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 get this information from WPS Health Insurance (WPS) over the Internet at www.wpsic.com/state. See the plan description page for more information. Or you can call WPS at (800) 634-6448 for information or to request a printed provider directory.

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

Under the Deductible Standard Plan, when you receive services from providers, you will need to meet up-front deductible and coinsurance amounts annually, with the exception of 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 keep in mind 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.

Deductible Standard Maintenance Plan (SMP)

HOW ARE THE DEDUCTIBLE SMP BENEFITS DIFFERENT FROM THE OLD SMP?

Like the Classic Standard Plan, SMP was a program with major medical deductible and coinsurance amounts based on a benefit design from the 1970s. Under the Deductible SMP option, you'll have an upfront deductible per calendar year of \$500 per individual, \$1,000 per family for medical services with the exception of in-network federally mandated preventive care services, that are paid for in full. Once met, care is covered at 100% except for pharmacy claims that are subject to prescription drug copays. This change should make the plan easier to understand and less expensive to administer.

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 Health Insurance (WPS), their payment for your claim will be reduced by \$100. You will be responsible to pay that amount in addition to your deductible.

HAS SMP'S NETWORK OR ELIGIBILITY REQUIREMENTS CHANGED WITH THIS REDESIGN TO THE DEDUCTIBLE SMP?

No. The Deductible SMP's network is identical to SMP's.

Deductible Standard PPP Plan

Administered by WPS Health Insurance
800-634-6448 www.wpsic.com/state

- **What's New for 2010**

Federally mandated preventive care services 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 more information, see the booklet at <http://etf.wi.gov/publications/et2162.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 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 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 and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form or contact 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.

Deductible SMP-State Maintenance Plan

Administered by WPS Health Insurance

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

- **What's New for 2011**

SMP is no longer available in Crawford County. Subscribers using providers in this county must consider selecting another plan or will be limited to the SMP providers remaining in other areas.

SMP will be newly available in Buffalo and Vilas counties.

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

- **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 chart starting on Page 2 for more information and view the Health Care Benefit Plan booklet at <http://etf.wi.gov/publications/et2163.pdf>.

- **Provider Directory**

Please visit www.wpsic.com/state/pdf/dir2011_state_smp.pdf to search for a provider or 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 of services.

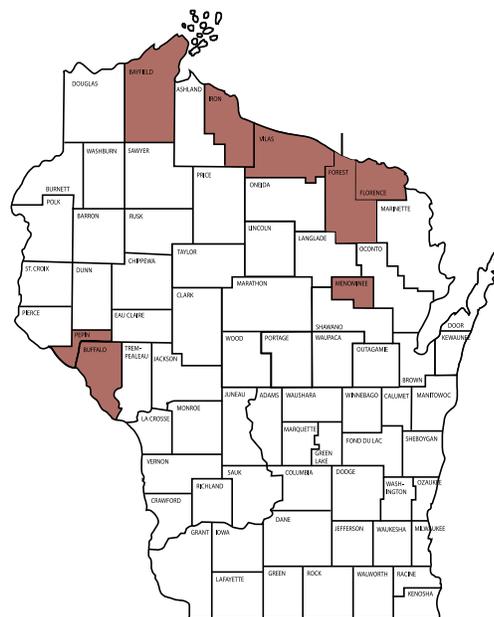
- **Referrals and Prior Authorizations**

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 and follow the Member Materials link to obtain a copy of a Medical Preauthorization Request Form or call 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**

After overall/medical deductible of \$500 individual/\$1,000 family, 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.