

COMPARISON OF BENEFIT OPTIONS



The charts on the following pages are designed to compare Uniform Benefits, the Standard Plan and the Medicare Plus plan. There are differences in coinsurance between the Uniform Benefits for participants for whom Medicare is the primary payor and Uniform Benefits for non-Medicare plans.

The outlines are 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 *Medicare Plus* (ET-4113) and *Standard Plan* (ET-2112) benefit booklets.

Differences might exist among the health plans in the administration of the Uniform Benefits packages. Treatment may vary depending on patient needs, the physicians' preferred practices, and the managed care policies and procedures of the health plan.

Federally required *Summaries of Benefits and Coverage* (SBCs) and the *Uniform Glossary* are available through eff.wi.gov/members/health-plan-summaries.htm. If you need printed copies sent to you, please call the Department of Employee Trust Funds (ETF) at 1-877-533-5020 to let us know which plan's *Summary of Benefits and Coverage* you want.

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

¹ Deductible applies to all services, except prescription drugs.

² PPOs have out-of-network deductibles. See PPO Plan Descriptions (WEA Trust PPOs and WPS Metro Choice) for details.

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

⁴ PPOs have out-of-network coinsurance. See *Health Plan Descriptions* for detail.

⁵ As required by federal law, see list at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>. Note: coinsurance may vary by age.

⁶ This is separate from other out-of-pocket limits (OOP), such as the medical.

⁷ Level 3 copays do not apply to the OOP.

⁸ Medicare Plus coordinates with Medicare's payment up to 100% coverage. If Medicare denies, this plan also denies except as stated.

Choose Your Health Plan

2014 State—Comparison of Benefit Options

| BENEFIT | UNIFORM BENEFITS FOR ELIGIBLE PARTICIPANTS WHO ARE NOT ELIGIBLE FOR NOR ENROLLED IN MEDICARE AS THE PRIMARY PAYOR | UNIFORM BENEFITS FOR RETIRED PARTICIPANTS FOR WHOM MEDICARE IS THE PRIMARY PAYOR |
|--|--|--|
| Annual Deductible ¹ | No deductible ² | No deductible ² |
| Annual Coinsurance ³ & Out-of-Pocket Limit (OOPL) | 90%/10% to annual OOPL \$500 individual/\$1,000 family except as described ⁴ | As described in this grid and the one on the following page |
| Routine Preventive | 100% ⁵ | 100% |
| Hospital Days | 90%/10% coinsurance to OOPL as medically necessary, plan providers only. No day limit. | 100% as medically necessary, plan providers only. No day limit. |
| Emergency Room | \$75 copay per visit, 90%/10% coinsurance thereafter to OOPL | \$60 copay per visit |
| Ambulance | 90%/10% coinsurance to OOPL | 100% |
| Transplants (May cover these and others listed) | 90%/10% coinsurance to OOPL. <i>Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung</i> | 100% <i>Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung</i> |
| Mental Health/Alcohol & Drug Abuse | 90%/10% coinsurance to OOPL Inpatient, Outpatient and Transitional | 100% Inpatient, Outpatient and Transitional |
| Hearing Exam | 90%/10% coinsurance to OOPL | 100% |
| Hearing Aid (per ear) | Every three years: Adults, 80%/20%, up to plan paid \$1,000 (not to OOPL); dependents younger than 18 years, 90%/10% to OOPL | Every three years: Adults, 80%/20%, up to plan paid \$1,000; dependents younger than 18 years, 100% |
| Cochlear Implants | Adults, 80%/20% for device, surgery for implantation, follow-up sessions (not to OOPL); 90%/10% hospital charge for surgery. Dependents under 18, 90%/10% coinsurance up to OOPL for all services. | Adults, 80%/20% for device, surgery for implantation, follow-up sessions; 100% hospital charge. Dependents under 18, 100%. |

Footnotes explained on the preceding page.

Choose Your Health Plan

2014 State—Comparison of Benefit Options

| BENEFIT | UNIFORM BENEFITS FOR ELIGIBLE PARTICIPANTS WHO ARE NOT ELIGIBLE FOR NOR ENROLLED IN MEDICARE AS THE PRIMARY PAYOR | UNIFORM BENEFITS FOR RETIRED PARTICIPANTS FOR WHOM MEDICARE IS THE PRIMARY PAYOR |
|--|---|---|
| Routine Vision Exam | 90%/10% coinsurance to OOPPL for all members except 100% for children under age 5 ⁵ | 100%, one per year |
| Skilled Nursing Facility (non-custodial care) | 90%/10% coinsurance to OOPPL, 120 days per benefit period | 100%, 120 days per benefit period |
| Home Health (non-custodial) | 90%/10% coinsurance to OOPPL, 50 visits per year. Plan may approve an additional 50. | 100%, 50 visits per year. Plan may approve an additional 50. |
| Physical/Speech /Occupational Therapy | 90%/10% coinsurance to OOPPL, 50 visits per year. Plan may approve an additional 50. | 100%, 50 visits per year. Plan may approve an additional 50. |
| Durable Medical Equipment | 80%/20% coinsurance to OOPPL | 80%/20% coinsurance to annual \$500 OOPPL per individual |
| Hospital Pre-Certification | Varies by plan | Varies by plan |
| Referrals | In-network—varies by plan Out-of-network—required | In-network—varies by plan Out-of-network—required |
| Treatment for Morbid Obesity | Excluded | Excluded |
| Oral Surgery | 90%/10% coinsurance to OOPPL, 11 procedures | 100%, 11 procedures |
| Dental Care | Uniform Dental Benefit | Uniform Dental Benefit |
| Drug Copays and OOPPL ⁶ (non-specialty) | Level 1=\$5; 2=\$15; 3=\$35 ⁷ . OOPPL \$410 individual/\$820 family | Level 1=\$5; 2=\$15; 3=\$35 ⁷ . OOPPL \$410 individual/\$820 family |
| Specialty Drug Copays and OOPPL ⁶ - Preferred Pharmacy | Formulary drugs \$15 to OOPPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPPL. | Formulary drugs \$15 to OOPPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPPL. |
| Specialty Drug Copays and OOPPL ⁶ - Non-Preferred Pharmacy | Formulary drugs \$50 to OOPPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPPL. | Formulary drugs \$50 to OOPPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPPL. |

Footnotes explained on Page 29.

Choose Your Health Plan

2014 State—Comparison of Benefit Options

| BENEFIT | STANDARD PLAN | | MEDICARE PLUS and Medicare Part A, B and D ⁸ |
|---|---|---|--|
| | Preferred Provider | Non-Preferred Provider | |
| Annual Deductible ¹ | \$200 individual/ \$400 family | \$500 individual/ \$1,000 family | No deductibles |
| Annual Coinsurance ³ & OOP | 90%/10% Annual OOP (<i>includes deductible</i>): \$800 individual/\$1,600 family | 70%/30% Annual OOP (<i>includes deductible</i>): \$2,000 individual/\$4,000 family | 100% |
| Routine Preventive | 100% ⁵ | Deductible and coinsurance | 100% Covered by Medicare only |
| Hospital Days | Deductible and coinsurance as medically necessary. No day limit. | Deductible and coinsurance as medically necessary. No day limit. | 100% 120 days; semi-private room |
| Emergency Room | \$75 copay per visit, deductible and coinsurance thereafter | \$75 copay per visit, Preferred Provider deductible and coinsurance thereafter | 100% no copay |
| Ambulance | Deductible and coinsurance | Deductible and coinsurance | 100% |
| Transplants (<i>May cover these and others listed</i>) | Deductible and coinsurance <i>Bone marrow, musculoskeletal, corneal, and kidney</i> | Deductible and coinsurance <i>Bone marrow, musculoskeletal, corneal, and kidney</i> | 100% for Medicare approved heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a Medicare-certified facility |
| Mental Health/ Alcohol & Drug Abuse | Deductible and coinsurance | Deductible and coinsurance | Inpatient 100%, up to 120 days Outpatient and Transitional 100% |
| Hearing Exam | Benefit for illness or disease to deductible and coinsurance | Benefit for illness or disease to deductible and coinsurance | Benefit for illness or disease 100% |
| Hearing Aid (per ear) | For dependents younger than 18 years only, every three years—deductible and coinsurance | For dependents younger than 18 years only, every three years—deductible and coinsurance | For dependents younger than 18 years only, every three years—100% |
| Cochlear Implants | Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions | Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions | Dependents under 18, 100% device, surgery, follow-up sessions |

Footnotes explained on Page 29.

2014 State—Comparison of Benefit Options

| BENEFIT | STANDARD PLAN | | MEDICARE PLUS and Medicare Part A, B and D ⁸ |
|---|---|---|--|
| | Preferred Provider | Non-Preferred Provider | |
| Routine Vision Exam | 100% for children under age 5 ⁵ . Illness or disease only, deductible and coinsurance. | No benefit for routine. Illness or disease only, deductible and coinsurance. | No benefit for routine. Illness or disease only, 100%. |
| Skilled Nursing Facility (non-custodial care) | Deductible and coinsurance, as medically necessary, 120 days per benefit period | Deductible and coinsurance, as medically necessary, 120 days per benefit period | Medicare approved facility: 100% 120 days/benefit period. Non-Medicare approved facility, if transferred within 24 hours of hospital release, benefits payable up to 30 days/ confinement. |
| Home Health (non-custodial) | Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50. | Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50. | 100% |
| Physical/Speech/ Occupational Therapy | Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50. | Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50. | 100%, |
| Durable Medical Equipment | Deductible and coinsurance | Deductible and coinsurance | 100% |
| Hospital Pre-Certification | WPS Medical Management Program for inpatient stays | WPS Medical Management Program for inpatient stays | None required |
| Treatment for Morbid Obesity | Preferred provider deductible and coinsurance at Centers of Excellence provider | Non-preferred provider deductible and coinsurance outside Centers of Excellence provider | 100% for Medicare covered service |
| Oral Surgery | 23 procedures—deductible and coinsurance | 23 procedures— deductible and coinsurance | 100% |
| Dental Care | No benefit | No benefit | No benefit |
| Drug Copays and OOPL ⁶ (non-specialty) | Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$1,000 individual/ \$2,000 family | Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$1,000 individual/ \$2,000 family | Level 1=\$5; 2=\$15; 3=\$35 ⁶ OOPL \$410 individual/\$820 family |
| Specialty Drug Copays and OOPL ⁶ | Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPL. | Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPL. | Drugs at preferred pharmacy, see Preferred Provider column. Drugs at non-preferred pharmacy, see Non-Preferred Provider column. |

Footnotes explained on Page 29.