It's Your Choice: 2012 Decision Guide

Group Health Insurance Plans

State of Wisconsin Employees
Retired State of Wisconsin Employees (Annuitants)
Members with Continuation Coverage (Continuants)
UW Graduate Assistants

Enrollment Period: October 3-28, 2011

etf
WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS

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STATE OF WISCONSIN
Department of Employee Trust Funds

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Fall 2011

Dear Members:

2012 will be a year of significant changes to the health plan benefits administered by the Department of Employee Trust Funds (ETF). New laws meant additional contributions toward health care premiums for most of our members in 2011, and new coinsurance requirements will apply in 2012. These changes make it critical that you have the information you need to make informed choices. Now more than ever, I urge you to carefully review and consider the information provided to you during "It's Your Choice."

Choosing a health plan is a complex and personal decision based on many considerations, such as cost, quality of care, provider preferences and convenience. Our goal is to provide important and understandable information that helps you make a decision about your health plan options during this year's open enrollment period.

This publication is structured to help readers navigate the different decision points that may be most relevant to you and your family. You can learn about changes enacted in Acts 10 and 32 in the "Important Changes" section of the book. The ``Choose Wisely'' section highlights modifications to the health plans for 2012. 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.

This 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, we will only publish a new Reference Guide during the years when there are major changes in health insurance law, coverage and plans.

Besides these publications, ETF is committed to providing service in easy online formats. See our Video Library at etf.wi.gov/webcasts.htm for short, informational videos that describe the changes coming in 2012. Also, remember that you can make changes online using the myETF benefits system available at: https://myetf.wi.gov/etf/internet/member/onm.html.

ETF's mission is to provide high quality, affordable benefits. We will continue to work with the Group Insurance Board to provide the health care delivery system you have come to rely on as affordably and efficiently as possible.

David A. Stella

Secretary, Department of Employee Trust Funds

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Cover photo: North Point Lighthouse; Lake Park, Milwaukee
All photos courtesy of the Wisconsin Department of Tourism

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

myETF Benefits System Instructions and Information

Frequently Asked Questions

Health Fair Dates and Locations

IMPORTANT CHANGES — EFFECTIVE JANUARY 1, 2012

If you have questions or concerns about any of these changes, contact your health plan using the information listed in the back of this Guide.

Types of Changes	Plan Name	Change
Decrease in premium rates	All plans	• Premium rates are lower in 2012 for most participants. Make sure you check the contribution schedule and premium rate tables to see how this affects you on Pages 25 through 27.
New changes resulting from state law are effective January 1, 2012.	Plans that offer Uniform Benefits (Insured HMOs and PPPs) For more information, see *Frequently Asked Question 3*, the *Comparison of Benefits* section starting on Page 31 and the *It's Your Choice: Reference Guide Uniform Benefits Schedule of Benefits* section.	For non-Medicare members only*: • Adding a 10% coinsurance for non-preventive medical services, annual Out-of-Pocket Maximum (OOPM) of $500 for a single subscriber or $1,000 for a family. Federally specified routine preventive services including immunizations are paid at 100%. These requirements vary by age. • Increasing the Emergency Room (ER) copay to $75 from $60. *Annuitants and their dependents with Medicare as their primary payor will see no change to their benefits.
		• Dependent coverage will end at the end of the month in which your eligible adult dependent turns age 26. The previous age limit had been 27.

Types of Changes	Plan Name	Change
New changes resulting from federal law are effective January 1, 2012.	Standard Plan	• Eliminates preexisting condition waiting period for members who are late entrants. See *Frequently Asked Question 1* in this Guide.
New enrollment opportunities	All plans	• The It's Your Choice Enrollment Period will become an Open Enrollment this year. Uninsured but eligible employees and annuitants can enroll during the period for coverage effective January 1st of the following calendar year. • Employees who are not enrolled but who want to preserve their sick leave as credits for use later, may enroll immediately prior to retirement. • Previous enrollment opportunities that applied waiting periods have been eliminated. See *Frequently Asked Question 1* for more information.
Contract changes	All plans	• Health insurance coverage for an employee will end at the end of the month in which the employee terminates employment. • The group health insurance program will now align with federal COBRA coverage (an 18-month maximum that may be increased to 29 to 36 months in mandated circumstances) except as required by state continuation law.

Types of Changes	Plan Name	Change
Prescription drug coverage for Medicare-eligible participants covered under an annuitant contract	Navitus Health Solutions: Navitus MedicareRX (PDP) Underwritten by Sterling Life Insurance Company	• Effective January 1, 2012, prescription drug coverage will be provided by a Medicare Part D Employer Group Waiver Plan. This replaces the creditable prescription drug coverage provided prior to 2012 through Navitus, and the state's participation in the Retiree Drug Subsidy program. Affected individuals will receive a new ID card. See *Frequently Asked Question* 4.
Prescription drug mail order vendor	Navitus Health Solutions: WellDyneRX	• Effective January 1, 2012, the mail order vendor will change from Prescription Solutions to WellDyneRx. Members who currently use mail order services will receive a letter with additional information regarding this change. See Page 82 for additional information.
New health plan	WEA Trust PPP Northwest	Offered in 18 counties in northwest Wisconsin and in a number of counties in Minnesota.
Significant Health Plan Provider Network changes	Health plans listed below have made significant changes by adding or terminating contracts with provider groups. Other plans have also made changes. Refer to the map on Page 29, and call the health plan for more details.	
	GHC Eau Claire	Will no longer offer providers in Barron, Chippewa, Dunn, Eau Claire, Pepin, Polk or Rusk counties.
	HealthPartners Health Plan	Added Bayfield, Burnett and Douglas counties.
	WEA Trust PPP East (Formerly WEA Trust PPP)	Expanding into Dodge, Door, Columbia, Jefferson, Marathon, Portage, Rock and Wood counties.
	State Maintenance Plan (SMP)	SMP will no longer be available in Vilas County. Subscribers using providers in this county must consider selecting another plan or will be limited to the SMP providers remaining in other areas.

Types of Changes	Plan Name	Change
Health plan changes	Standard Plan	• In-network: $200 single/$400 family deductible, 90%/10% coinsurance thereafter to an out-of-pocket maximum (OOPM) of $800 single/$1,600 family per year. • Out-of-network: Deductible remains at $500 single/$1,000 family. Coinsurance changing to 70%/30% to the existing OOPM of $2,000 single/$4,000 family. • A $75 emergency room copay applies both in- and out-of-network. Services thereafter apply to the in-network deductible and coinsurance. See *Comparison of Benefits* section on Pages 31, 34 and 35 for more information.
Health Risk Assessment (HRA) tools	All plans	HRAs are a great tool to help you understand and potentially improve your health. Every health plan will have one available for 2012 and may offer incentives for completing them. See the *Health Plan Features — At a Glance* grid on Page 40 and contact your plan for more information.
Changes to dental coverage	For more information, see the Health Plan Description pages in the *Choose Your Health Plan* section.	
	Dean Health Plan	Increasing out-of-network office visit copay to $40 from $25. Lowering annual benefit combined maximums to $1,500 per individual for in-network services and $1,000 per individual for out-of-network services. Contact Dean for more information.
	Unity - UW Health	Changing administrators to Momentum Insurance plans from Delta Dental. The provider network will change.

Choose Wisely

Types of Changes	Plan Name	Change
Other information on ETF's Internet site	All plans	The *It's Your Choice: Decision Guide* and *Reference Guide* are available at **etf.wi.gov**. Any known printing discrepancies will be clarified on this site. Other information is available about insurance programs, including the complete Report Card on health plans. Sign up for ETF E-Mail Updates for the most current information at etf.wi.gov.
Online help	All plans	Are you unsure where to start with the *It's Your Choice: Decision and Reference* guides? ETF has a number of new online videos to provide information on the changes members can expect to see to their group health insurance benefits. Find them on ETF's Internet site under the Group Health Insurance menu at **etf.wi.gov**.

How can the Employee Reimbursement Account (ERA) program help to offset my out-of-pocket medical costs?

- Increased out-of-pocket medical expenses make it more valuable than ever to participate in the ERA Program. A medical expense reimbursement account allows you to contribute tax-free money to pay for your family's health plan coinsurance, prescription drug copayments and other qualifying expenses that you pay out-of-pocket—such as dental, orthodontics and vision care. You can contribute up to $7,500 annually to a medical expense account. Review the 2012 ERA enrollment booklet at **etf.wi.gov** for information about how the ERA program can help you save money.

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 Open Enrollment period.

myETF BENEFITS SYSTEM INSTRUCTIONS AND INFORMATION

Employees* and annuitants are encouraged to submit their It's Your Choice Open Enrollment changes via the myETF Benefits Online Health Insurance Enrollment System. Enrolling in a health insurance plan is a quick and easy process through our dedicated and secure website.

If you don't have access to a computer, you may submit your enrollment change on a paper application (enclosed). Employees should submit it to their benefits/payroll/personnel office. Annuitants/continuants should send the form to ETF.

All changes must be entered online, submitted, faxed or postmarked no later than October 28, 2011.

Step 1

Home Page – Online Network for Members

Go to **myETF.wi.gov/ONM.html** (Online Network for Members). In order to login, you will need a Web Access Management System (WAMS) ID and your ETF Member ID (explained in Step 3). Click on the **myETF Benefits** link to begin the login steps.

Step 2

myIdentity Verification (WAMS ID)

Type your WAMS ID and password. Click **Login.**

If you don't have a WAMS ID, click **Register Now**. You will be taken through the quick and easy process to get one. Keep track of your WAMS ID and password, as you will need it in the future to view and change your coverage.

If you forgot your WAMS ID, click the appropriate **Go Here** link in the **Registered Users** section to recover your WAMS ID. If you need to change your WAMS ID e-mail address or password, click the appropriate **Go Here** link also in the **Registered Users** section.

*UW System employees: Do not use the myETF Benefits System to enroll in or make changes to coverage. Please go to the UW System fall enrollment website at uwservice.wisc.edu/2012 for enrollment information. Contact your UW institution's payroll and benefits office if you have questions about the enrollment process.

Step 3

myIdentity Verification (ETF Member ID)

Type your ETF Member ID (Employees: available on your Navitus Prescription Drug ID card, ETF Statement of Benefits or from your employer. Annuitants: available on your ETF Statement of Benefits or from ETF) and birth date. Your birth date must be entered per the guidelines on the screen, for example, 02/01/1960. Click **Verify** to continue.

Step 4

myIdentity Verification (Social Security Number)

Type your Social Security number without the dashes. This is a one-time event that only needs to be completed the first time you log in.

After you are logged in, the myInfo page will appear which displays your demographic information. On the top of the screen, there are other tabs that you can use to navigate. Click on the **Health** tab and the Health Insurance Enrollment Summary will appear with your current and historic health insurance information.

Step 5

myETF Benefits – It's Your Choice Change

To make your It's Your Choice Enrollment change, click the **Edit** button on the left toward the middle of the screen and complete the fields that appear. When complete, click the **Submit** button.

OR

Step 5

myETF Benefits - New Hire Enrollment

If you are a new employee enrolling for coverage for the first time, click the **Add Coverage** button at the bottom of the page to begin making your health insurance selections. When complete, click the **Submit** button.

Step 6

myETF Benefits - Log Off

Click the **Log Off** tab. You will receive an e-mail letting you know that your change is pended for review by your employer (ETF for annuitants). Later, you will receive a second e-mail informing you to check myETF Benefits to learn if your change was approved or denied.

Note: Employees with questions should contact their employers. Annuitants and continuants should contact ETF at (877) 533-5020.

FREQUENTLY ASKED QUESTIONS

IT'S YOUR CHOICE OPEN ENROLLMENT PERIOD

The "It's Your Choice" Open Enrollment period is the new annual opportunity for eligible employees and annuitants to select one of the many health plans offered by the State Group Health Insurance Program. Today, there are more than 18 different health plans to choose from.

The following list contains some of the most commonly asked questions about the enrollment period. You can also find information about key terms in the *Glossary* section at the back of this Guide.

NEW BENEFITS AND ELIGIBILITY CHANGES

1. **What is the It's Your Choice Open Enrollment period?**

   The It's Your Choice Open Enrollment period is an opportunity to change plans, change from family to single coverage and enroll if you had previously deferred coverage. It is offered only to employees, annuitants and surviving spouses and dependents who are eligible under the State of Wisconsin Group Health Insurance Program. Previously, employees and annuitants who deferred coverage were eligible to enroll by serving a preexisting condition waiting period.

2. **What are the new Dependent Eligibility changes?**

   Effective January 1, 2012, state law terminates coverage for adult children at the end of the month in which they turn age 26. This aligns with the age limit in federal law. For detailed information on which dependents are eligible, see the *It's Your Choice: Reference Guide, Frequently Asked Questions* section on Dependent Eligibility.

3. **What are routine or preventive services, and why are they treated differently than treatment of an illness or injury?**

   Routine, preventive care is care that is designed to help prevent disease, or to diagnose it in the early stages. Federal health care reform requires first dollar coverage of preventive care services when grandfathering is lost as a result of significant benefit and/or premium changes. The list of federally required preventive services is available at: healthcare.gov/law/about/provisions/services/lists.html. Your provider uses standardized codes to bill your insurer for services.

SEE THE ***IT'S YOUR CHOICE: REFERENCE GUIDE*** *FREQUENTLY ASKED QUESTION* SECTION FOR INFORMATION REGARDING DEPENDENT ELIGIBILITY, FAMILY STATUS CHANGES AND HOW TO USE YOUR BENEFITS.

These codes require providers, when performing a non-trivial treatment of an illness or injury, to separate the claim from the preventive service. In general, don't expect to have the evaluation or treatment of an illness or injury paid as preventive when it occurs during a preventive exam.

4. Which Medicare Part D prescription drug coverage is provided under the State of Wisconsin Group Health Insurance Program?

Effective January 1, 2012, Medicare related prescription drug coverage will be provided by Navitus Health Solutions (Navitus) through a self-funded, Medicare Part D Employer Group Waiver Plan (EGWP) called the Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company. This affects Medicare-eligible participants covered under an annuitant contract enrolled in the State of Wisconsin Group Health Insurance Program. As required by Uniform Benefits, a Wrap benefit is also included to provide full coverage to State of Wisconsin Group Health Insurance Program members when they reach the Medicare coverage gap, also known as the "donut hole." Sterling has been contracted with the Centers for Medicare and Medicaid Services since 2006, when Medicare Part D was first implemented, to offer Medicare Part D prescription drug plans to employer groups. Additional information will be provided to you by Navitus with your new ID card for use as of January 1, 2012.

Your group health insurance premium already includes the cost of this benefit. There is no separate premium that needs to be paid for this Medicare Part D coverage. It is important that you read and understand the information presented on the Navitus MedicareRx plan description page included in this Guide. For additional information see the *Frequently Asked Questions* about Medicare and Medicare Part D in the *It's Your Choice: Reference Guide*.

THINGS TO CONSIDER DURING IT'S YOUR CHOICE OPEN ENROLLMENT

5. May I change from single to family coverage during the It's Your Choice Open Enrollment period?

Yes, you have the opportunity to change from single to family coverage without a waiting period or exclusions for preexisting medical conditions. Coverage will be effective January 1 of the following year for all eligible dependents. Note that if you are subject to tax liability for dependents such as adult children,

and/or a domestic partner and his or her child(ren), you can elect not to cover such individuals. For information about the tax impact of covering non-tax dependents, see *Frequently Asked Question 6*.

For information on changing from family to single coverage, see the *Frequently Asked Question* section of the *It's Your Choice: Reference Guide*.

6. What are the tax implications for covering non-tax dependents?

Adult Children: The Patient Protection and Affordable Care Act (PPACA) eliminated federal tax liability for the Fair Market Value (FMV) of health coverage for your dependents through the year in which they turn 26 if eligible.

Note: The provisions of PPACA apply to federal income taxes only. As of the printing of this booklet, the FMV of coverage for adult children must be calculated for state income tax purposes for those who cannot be claimed as a dependent.

If the tax dependent status of your dependent changes, please notify your employer or for annuitants and continuants, ETF.

Domestic Partners: The FMV for insurance coverage provided for a domestic partner and his or her children must be calculated and added to your income, unless the domestic partner and his or her children qualify as your tax dependents.

The FMV of the health insurance benefits will be calculated and added to your earnings as *imputed income* (see *Frequently Asked Question 7* for definition). The monthly imputed income amounts vary by health plan and are provided for either one non-tax dependent, or two or more non-tax dependents. These dollar amounts will be adjusted annually and are available from your employer (affected annuitants may contact ETF). Employees who are unsure if a person can be claimed as a dependent should consult IRS Publication 501 or a tax advisor.

Employees may change from single to family coverage to add a newly eligible domestic partner or other dependent who does not qualify as a tax dependent under IRC Section 152 during the plan year. The additional premium attributable to the non-qualified dependent will be taxable.

7. What is imputed income?

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

See Question 6 for the exception for health coverage for adult children younger than age 26. For more information, employees should

contact their employer and annuitants should contact ETF.

8. If I do not change from single to family coverage during the It's Your Choice Open Enrollment period, will I have other opportunities to do so?

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

1. If an electronic or paper application is received by your benefits/payroll/personnel office for active employees or ETF for annuitants/continuants within 30 days of the following events, coverage becomes effective on the date of the following event:
   - Marriage.
   - The date ETF receives the completed *Affidavit of Domestic Partnership* form (ET-2371).
   - You or any of your eligible dependents involuntarily lose eligibility for 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/continuants, within 60 days of the following events, coverage becomes effective on the date of the following event:
   - Birth or 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) or date of birth with a birth certificate listing the father's name. The effective date of coverage will be the birth date, 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/continuants, 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 one or more children who are not currently covered.

9. Which other changes can only be made during the It's Your Choice Open Enrollment period if my health insurance premiums are taken pre-tax?

During the annual enrollment period, you can add or drop coverage for your adult dependent children or do a spouse/domestic partner to spouse/domestic partner transfer of your health insurance coverage.

10. Are my health insurance premiums deducted from my paycheck on a pre-tax or post-tax basis?

Your health insurance premiums are automatically deducted from your paycheck on a pre-tax basis. This is often referred to as Automatic Premium Conversion. This means that you save on federal and state income tax, and FICA taxes (Social Security and Medicare taxes). This is a permanent tax exclusion, no taxes will be owed at a later date.

IMPORTANT NOTE: When premiums are deducted on a pre-tax basis, Internal Revenue Code regulations governing premium conversion restricts changes that can be made to your health insurance benefits during the plan year. You may not make changes or cancel your participation in the health plan during the plan year unless your decision to do so is a result of a qualifying change in status event and is allowed by the health plan rules. For more information, see the *It's Your Choice: Reference Guide Frequently Asked Question 22,* When can I change from family to single coverage? *and 15,* What are my coverage options if my spouse/domestic partner is also a State or participating Wisconsin Public Employer (WPE) employee or State annuitant?

If you wish to pay your premiums on a post-tax basis, you may fill out an *Automatic Premium Conversion Waiver/Revocation of Waiver* form (ET-2340) and return it to your payroll/benefits office before the end of the year. Post-tax premium deductions will begin with the January deduction. Once you have filed a waiver, it will remain in effect for future plan years unless you file another *Automatic*

Premium Conversion Waiver/ Revocation of Waiver form (ET-2340) to revoke the waiver.

11. What if my spouse is also a state employee, annuitant or the eligible employee or insured annuitant of a Wisconsin Public Employer who participates in the State of Wisconsin Group Health Insurance Program?

If your spouse is also an eligible state employee or annuitant:

- you may each retain or select single coverage with your current plan(s); or
- one of you may retain or select family coverage under one of your current plans, which will cover your spouse and any eligible dependents.

See *Frequently Asked Question 15* in the *It's Your Choice: Reference Guide* for details. It's available electronically on ETF's Internet site at etf.wi.gov.

Note: For domestic partners, further information is available on the Internet site at **etf.wi.gov**.

HOW DO I MAKE CHANGES DURING IT'S YOUR CHOICE OPEN ENROLLMENT?

12. How do I change health plans during It's Your Choice Open Enrollment?

If you decide to change to a different plan, you* are encouraged to make changes online using the myETF Benefits website (see Pages 10 and 11 of this Guide), or you may submit a paper application using the following instructions:

- *Active employees may use the application in the back of this Guide, get one from ETF's Internet site at etf.wi.gov/publications/et2301.pdf or 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 Guide or get one from ETF's Internet site at etf.wi.gov/publications/et2301.pdf 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.

13. How do I use the myETF Benefits website?

Refer to Pages 10 and 11 in this Guide.

14. What happens if I enter my changes online, but did not submit them?

Your changes will not be stored unless you click on the **Submit** button. You will need to log back in and make the changes again. To view what you submitted, click the **myRequests** button on the bottom of the **myInfo** page.

*Employees of the University of Wisconsin must visit the UW System fall enrollment website at uwservice.wisc.edu/2012 for enrollment instructions.

15. What is the effective date of changes made during the It's Your Choice Open Enrollment period?

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

16. What if I change my mind about the health plan I selected during the It's Your Choice Open Enrollment period?

You may submit or make changes at any time during the It's Your Choice Open Enrollment period, either online using the myETF Benefits website or by filling out a paper application. After that time, you may rescind, that is, withdraw your application (and keep your current coverage) by following these instructions before December 31:

- active employees should inform their benefits/payroll/personnel office; or
- annuitants and continuants should notify ETF.

Other rules apply when cancelling coverage. For more information, see the Cancellation/Termination of Coverage section of the *Frequently Asked Questions* in the *It's Your Choice: Reference Guide*.

SELECTING A HEALTH PLAN

17. 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 29.
- 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 this Guide and at **etf.wi.gov**.
- Review the Plan Descriptions in the *Choose Your Health Plan* section.
- Compare the premium rates and contributions beginning on Page 25.
- Compare the health plan features grid.

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

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

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

This can be a concern for members who travel and those with covered dependents living elsewhere, such as a college student living away from home. Consider the following when selecting a health plan:

- If you are covered through an HMO, you are required to obtain routine care only 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. 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.

- If you are covered through a Preferred Provider Plan (PPP) such as WPS Metro Choice, WEA Trust PPP 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.
- **Annuitants only:** If you or your dependents are covered through the Medicare Plus plan, you have the freedom of choice to see any available provider for covered services. In addition, Humana's Medicare Advantage-Preferred Provider Organization offers coverage for participants with Medicare Parts A and B, with both in- and out-of-network benefits.

  Note: Non-Medicare members are limited to Humana's HMO network.

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

Contact the plan directly or follow the instructions provided in the *Health Plan Descriptions* section. ETF and your benefits/payroll/personnel office do not have this information.

OTHER ITEMS OF NOTE

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

Most people become eligible for Medicare at age 65, but you may or may not need to sign up. For some people, Medicare eligibility occurs earlier due to disability or End Stage Renal Disease. See the Medicare Information in the *Benefit and Services* section of the *It's Your Choice: Reference Guide* for full details.

22. What is Humana's Medicare Advantage Plan?

Humana offers a Medicare Advantage Preferred Provider Organization (MA-PPO) for members who have Medicare Parts A and B as their primary coverage.

When you use in-network providers, your benefits will be modeled on Uniform Benefits. When you use out-of-network providers, however, you will have greater out-of-pocket expenses for most services, for example, a 10% coinsurance up to a maximum of $500 per individual.

You must be enrolled in Medicare Parts A and B to be eligible for a health plan's MA-PPO. You should keep your Medicare card in a safe place, but you should not show it when you receive health care services, as the MA-PPO plan will be primary for your service. Contact Humana for further information including a list of in-network providers.

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

Each health plan has the responsibility to determine whether or not a newly enrolled disabled dependent continues to meet the contractual definition of disabled dependent. (See the *Dependent Information* contained in the *It's Your Choice: Reference Guide* for full details.)

Health Fair Dates and Locations

October

City	Date	Time
Eau Claire	**Oct. 11**	**8:00-11:30**
Department of Transportation 718 West Clairemont Avenue Chippewa Valley Conference Room		
UW-Eau Claire	**Oct. 11**	**10:00-1:00**
Davies Center 105 Garfield Potawatomi and Arrowhead Rooms		
UW-Green Bay	**Oct. 4**	**11:00-2:00**
University Union 2420 Nicolet Drive Phoenix Rooms A and B		
Green Bay	**Oct. 20**	**8:00-12:00**
Department of Transportation DTSD NE Region 944 Vanderperren Way Green Bay and Lake Michigan Conference Rooms		
UW-Parkside Kenosha	**Oct. 6**	**11:00-2:00**
Student Center 900 Wood Road University Ballroom		
King	**Oct. 6**	**10:00-2:00**
Wisconsin Veterans Home N2665 County QQ Marden Memorial Center, Multipurpose Room		
UW-La Crosse	**Oct. 13**	**10:00-3:00**
Cartwright Center 1725 State Street Valhalla Conference Room		

October

City	Date	Time
Madison	**Oct. 5**	**10:00-1:00**
Department of Corrections Central Office 3099 East Washington Avenue Training Center—Missouri and Minnesota Rooms (Park in Training Center lot)		
Madison	**Oct. 5**	**10:00-2:00**
Downtown Health Fair Department of Health Services 1 West Wilson Street Conference Room 751, Seventh Floor (Enter center door; take elevator)		
Madison	**Oct. 6**	**11:00-1:00**
Department of Revenue 2135 Rimrock Road Events Room, First Floor		
UW-Madison	**Oct. 11**	**9:00-3:00**
Memorial Union 800 Langdon Street Great Hall		
Madison	**Oct. 11**	**10:00-2:00**
Downtown Health Fair Department of Justice, Risser Justice Center 17 West Main Street Conference Room 150, Ground Floor (Enter at corner of Martin Luther King and Doty Streets)		
Madison	**Oct. 12**	**9:00-1:00**
Deptartment of Transportation Hill Farms State Office Building 4802 Sheboygan Avenue Room 421		
Madison	**Oct. 19**	**11:00-1:00**
DATCP Lobby of Prairie Oaks Building 2811 Agriculture Drive Room 172		

Health Fair Dates and Locations

October

City	Date	Time
Madison	**Oct. 26**	**8:00-12:00**
Department of Transportation 2101 Wright Street Rock, Dane and Columbia Conference Rooms		
UW-Stout Menomonie	**Oct. 12**	**10:00-2:00**
Micheels Hall 410A 10th Avenue East Room 184 (Located near 13th Avenue and 3rd Street East)		
UW-Milwaukee	**Oct. 5**	**10:00-3:30**
Student Union 2200 East Kenwood Boulevard Wisconsin Room (Third Floor)		
Milwaukee	**Oct. 13**	**10:00-1:00**
Department of Natural Resources 2300 North Martin Luther King Jr. Drive Rooms 140 and 141		
Milwaukee	**Oct. 13**	**10:00-1:00**
Milwaukee State Office Building (DOA) 819 North Sixth Street Room 40		
UW-Oshkosh	**Oct. 12**	**2:00-4:30**
Reeve Memorial Union 748 Algoma Boulevard Ballroom 227 A and B		
UW-Platteville	**Oct. 5**	**12:00-4:00**
Ullsvik Hall 1 University Plaza Velzy Commons (Located at West Main and South Hickory Streets)		

October

City	Date	Time
Plymouth	**Oct. 11**	**5:30-3:30**
Kettle Moraine Correctional Institution W9071 Forest Drive Training Center		
Rhinelander	**Oct. 13**	**9:00-12:00**
Department of Transportation 510 North Hanson Lake Road Oneida Conference Room		
UW-River Falls	**Oct. 13**	**10:00-3:00**
University Center 500 East Wild Rose Avenue Riverview Ballroom		
UW-Stevens Point	**Oct. 19**	**10:00-2:30**
Dreyfus University Center 1015 Reserve Street Alumni Room		
Superior	**Oct. 12**	**8:00-11:30**
Department of Transportation 1701 North Fourth Street Lake Superior Conference Room		
UW-Superior	**Oct. 12**	**1:00-3:00**
Yellowjacket Union 1605 Catlin Avenue Room 203		
UW-Whitewater	**Oct. 6**	**10:00-2:00**
Hamilton Center 800 West Main		
Wisconsin Rapids	**Oct. 19**	**9:00-12:00**
Department of Transportation 1681 Second Avenue South Room 124		

Choose Your Health Plan

Introduction to Health Plan Options
Health Plan 2012 Premium Rates
Health Plan Map
Comparison of Benefit Options
Health Plan Features — At a Glance
Health Plan Descriptions

INTRODUCTION TO HEALTH PLAN OPTIONS

As a participant in the State Group Health Insurance Program, all of the health plans listed in this booklet are available to you. This includes 18 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. Definitions of terms also appear in the *Glossary* at the back of this Guide. 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 98% of current state employees choose coverage through the Alternate Plans. These include 16 health maintenance organizations (HMOs) and two preferred provider plans (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. Note, benefits differ for those annuitants and their dependents who are enrolled in Medicare, versus all other members. Uniform Benefits is described in detail in the *It's Your Choice: Reference Guide*.

You should be aware that there are differences among the Alternate Health Plans, and these can change annually. When choosing a health plan, you should consider the following:

- **Premium**: As an employee, your total monthly premium contribution amount can vary, depending on the health plan's Tier ranking. A description of the tiering system appears on Page 25.
- **Provider Network**: The location, quantity, quality and availability of the doctors, clinics, hospitals and emergency/urgent care centers differ for each health plan.
- **Dental Benefits (if offered)**: The location and availability of dental benefits and providers differ for each plan.
- **Benefit Determinations**: While all alternate plans offer the Uniform Benefits package, this does not mean that all will treat all illnesses or injuries in an identical manner. Treatment will vary depending on patient needs, the physicians' preferred practices, and the health plan's managed care policies and procedures.
- **Administrative Requirements**: 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.

STATE MAINTENANCE PLAN (SMP)

The SMP is available only in counties that lack a qualified Tier 1 alternate plan HMO or PPP. It offers the same Uniform Benefits package as the alternate plans.

STANDARD PLAN

The Standard Plan is a PPP 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 31 through 35. Please note that the Standard Plan is a Tier 3 health plan for employees, meaning that your premium contribution will be higher if you select this option.

HEALTH PLANS AVAILABLE TO ANNUITANTS

Medicare Coordinated Plans

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

1. Annuitants and their dependents who become Medicare eligible will be moved into the Medicare Uniform Benefits plan. See the *Comparison of Benefit Options* starting on Page 31 for more information.
2. Members enrolled in the Standard Plan or the SMP will be moved to the Medicare Plus plan on the member's Medicare effective date. See the *Comparison of Benefit Options* starting on Page 31 for more information
3. Members enrolled in Humana will be enrolled in Humana's Medicare Advantage Preferred Provider Organization (MA-PPO) after you enroll in Medicare Parts A and B. See the *Plan Description Pages* for more information.

Medicare Plus is a fee-for-service indemnity plan administered by WPS. This plan is available to eligible annuitants enrolled in Medicare Parts A and B. Medicare Plus permits you and your eligible dependents to receive care from any qualified health care provider anywhere in the world for treatment covered by the plan. You may be responsible for filing claims and for finding the providers who can best meet your needs.

Medicare Advantage Preferred Provider Organization (MA-PPO) MA-PPO allows members to use any health care provider, however, you will have greater out-of-pocket expenses when you use out-of-network providers. The in-network MA-PPO benefit is modeled to replicate the Uniform Benefits package.

HEALTH PLAN 2012 PREMIUM RATES

ACTIVE EMPLOYEES

The Group Insurance Board and its consulting actuaries rank and assign each of the available health plans to one of three **"Tier"** categories, based on its efficiency and quality of care. Your premium contribution is determined by the Tier ranking of your health plan.

This approach encourages our members to choose the plans that are most efficient in providing quality health care. Likewise, this provides a strong incentive for our plans to hold down costs and deliver quality services.

Employee contribution rates and premium amounts for calendar year 2012 are provided to the right and on the following page.

ANNUITANTS AND CONTINUANTS

Premium amounts for calendar year 2012 appear on Page 27. These premium amounts may be withdrawn from your accumulated sick leave conversion credits, WRS annuity payment, or you may be directly billed by your health plan.

You and your dependents who are eligible for Medicare must be enrolled in Parts A and B upon retirement or when initially eligible. When you and/or your dependents are enrolled, your group health insurance coverage will be coordinated with Medicare and your monthly premium will be reduced.

2012 Employee Contribution Rates

State of Wisconsin Employees (Except as stated below*)		
Tier	**Single Rate**	**Family Rate**
Tier – 1	$81.00	$201.00
Tier – 2	$118.00	$297.00
Tier – 3	$219.00	$548.00

State Patrol Titled Classifications		
Tier	**Single Rate**	**Family Rate**
Tier – 1	$31.00	$78.00
Tier – 2	$69.00	$173.00
Tier – 3	$164.00	$412.00

UW Graduate Assistants		
Tier	**Single Rate**	**Family Rate**
Tier – 1	$40.50	$100.50
Tier – 2	$59.00	$148.50
Tier – 3	$109.50	$274.00

**For employees of the University of Wisconsin Hospital or other quasi-governmental authorities, questions about your premium contribution amounts should be directed to your benefits/payroll/personnel office.*

State of Wisconsin Employees, UW Graduate Assistants

2012 Total Premium Rates

		State of Wisconsin Employees		UW Graduate Assistants	
Plan Name	**Plan Tier**	**Single**	**Family**	**Single**	**Family**
Anthem Blue - Northeast	1	644.90	1,608.10	425.60	1,059.90
Anthem Blue - Northwest	1	740.60	1,847.30	495.60	1,234.90
Anthem Blue - Southeast	1	716.50	1,787.10	475.10	1,183.60
Arise Health Plan	1	696.50	1,737.10	495.70	1,235.10
Dean Health Plan	1	572.90	1,428.10	375.90	935.60
GHC of Eau Claire	1	777.90	1,940.60	556.60	1,387.40
GHC of South Central Wisconsin	1	561.00	1,398.30	387.30	964.10
Gundersen Lutheran Health Plan	1	749.80	1,870.30	496.60	1,237.40
Health Tradition Health Plan	1	763.60	1,904.80	512.00	1,275.90
HealthPartners	1	690.80	1,722.80	491.40	1,224.40
Humana - Eastern	1	732.30	1,826.60	508.60	1,267.40
Humana - Western	1	732.30	1,826.60	508.60	1,267.40
Medical Associates Health Plan	1	609.10	1,518.60	403.50	1,004.60
MercyCare Health Plan	1	560.70	1,397.60	345.50	859.60
Network Health Plan	1	684.90	1,708.10	426.20	1,061.40
Physicians Plus	1	586.00	1,460.80	364.80	907.90
Security Health Plan	1	752.00	1,875.80	537.30	1,339.10
Standard Plan	3	1,147.60	2,865.60	864.00	2,156.50
State Maintenance Plan	1	710.20	1,771.60	536.90	1,338.40
UnitedHealthcare of Wisconsin NE	1	688.60	1,717.30	488.50	1,217.10
UnitedHealthcare of Wisconsin SE	1	716.80	1,787.80	501.90	1,250.60
Unity - Community	1	663.30	1,654.10	470.80	1,172.90
Unity - UW Health	1	581.20	1,448.80	409.20	1,018.90
WEA Trust PPP - East	1	742.60	1,852.30	530.20	1,321.40
WEA Trust PPP - Northwest	1	777.60	1,939.80	556.50	1,387.10
WPS Metro Choice	1	739.80	1,845.30	507.90	1,265.60

Out-of-state residents assigned to work out-of-state receive the Standard Plan at a Tier 2 level.
The graduate assistant program does not offer Medicare reduced rates.

Retired State of Wisconsin Employees & Continuants

2012 Total Premium Rates

	Annuitants and Continuants				
	Non-Medicare		Medicare Rates*		
Plan Name	**Single**	**Family**	**Medicare Single**	**Medicare 1**	**Medicare 2**
Anthem Blue - Northeast	644.90	1,608.10	378.80	1,020.90	754.80
Anthem Blue - Northwest	740.60	1,847.30	426.80	1,164.60	850.80
Anthem Blue - Southeast	716.50	1,787.10	414.50	1,128.20	826.20
Arise Health Plan	696.50	1,737.10	404.80	1,098.50	806.80
Dean Health Plan	572.90	1,428.10	315.90	886.00	629.00
GHC of Eau Claire	777.90	1,940.60	398.30	1,173.40	793.80
GHC of South Central Wisconsin	561.00	1,398.30	337.00	895.20	671.20
Gundersen Lutheran Health Plan	749.80	1,870.30	302.20	1,049.20	601.60
Health Tradition Health Plan	763.60	1,904.80	437.50	1,198.30	872.20
HealthPartners	690.80	1,722.80	401.90	1,089.90	801.00
Humana - Eastern	732.30	1,826.60	301.50	1,031.00	600.20
Humana - Western	732.30	1,826.60	301.50	1,031.00	600.20
Medical Associates Health Plan	609.10	1,518.60	304.60	910.90	606.40
Medicare Plus**	NA**	NA**	283.20	NA**	563.50
MercyCare Health Plan	560.70	1,397.60	290.90	848.80	579.00
Network Health Plan	684.90	1,708.10	368.00	1,050.10	733.20
Physicians Plus	586.00	1,460.80	315.90	899.10	629.00
Security Health Plan	752.00	1,875.80	432.50	1,181.70	862.20
Standard Plan**	1,147.60	2,865.60	NA**	1,438.90	NA**
State Maintenance Plan **	710.20	1,771.60	NA**	997.10	NA**
UnitedHealthcare NE	688.60	1,717.30	400.80	1,086.60	798.80
UnitedHealthcare SE	716.80	1,787.80	414.90	1,128.90	827.00
Unity - Community	663.30	1,654.10	358.90	1,019.40	715.00
Unity - UW Health	581.20	1,448.80	321.90	900.30	641.00
WEA Trust PPP - East	742.60	1,852.30	427.80	1,167.60	852.80
WEA Trust PPP - Northwest	777.60	1,939.80	445.30	1,220.10	887.80
WPS Metro Choice	739.80	1,845.30	415.70	1,152.70	828.60

***Additional Information for Members on Medicare:** Definitions of Medicare 1 and Medicare 2 appear in the Glossary of this Guide.

**Members with Standard Plan or SMP coverage who become enrolled in Medicare Parts A and B will automatically be moved to the Medicare Plus plan. All other non-Medicare family members will remain covered under the Standard Plan or SMP.

HEALTH PLAN MAP 2012

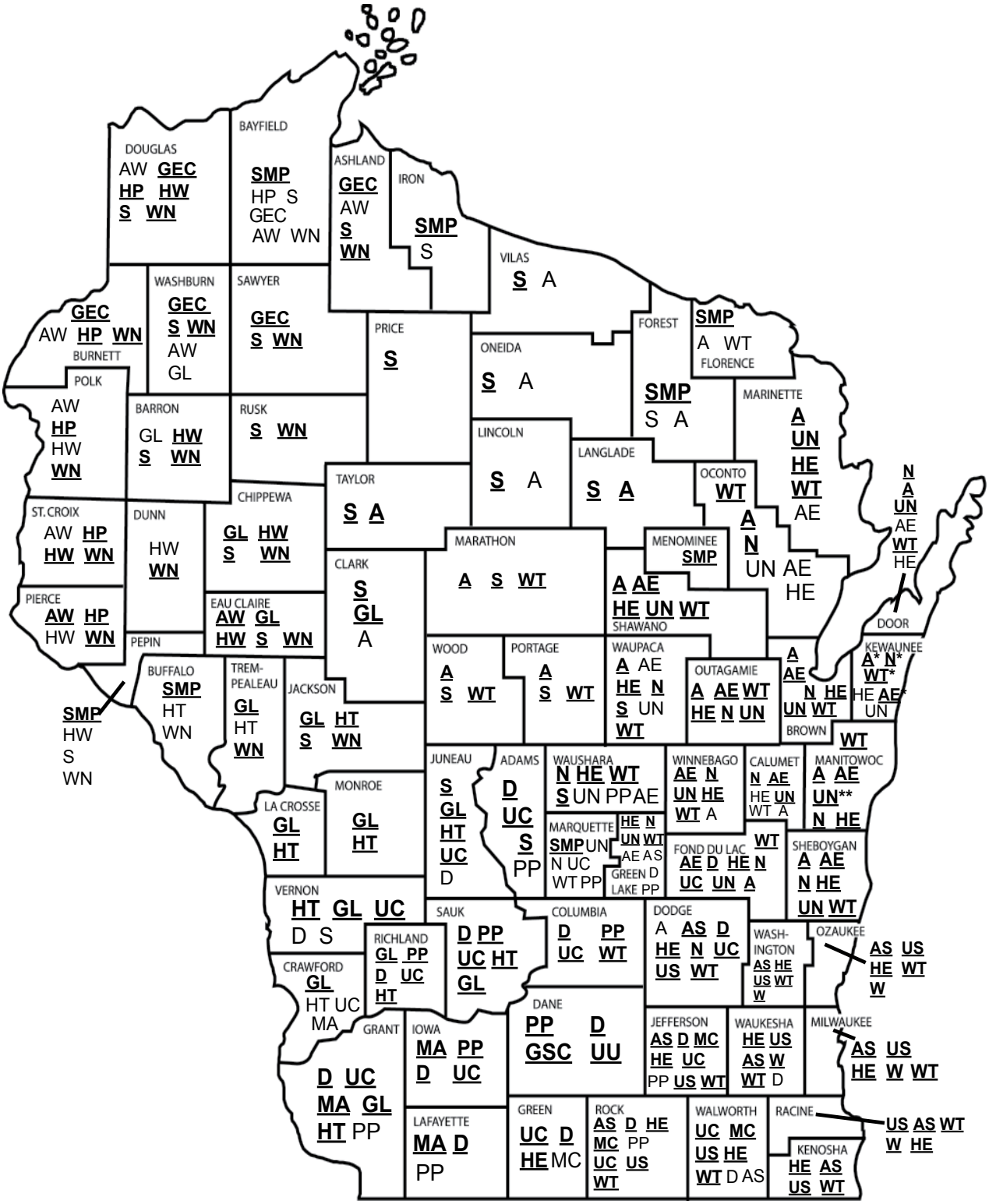
The map on the following page shows which health plans are available in each county. "Qualified" plans are highlighted in underlined, bold text. If a plan is "non-qualified," it has limited provider availability in that area.

The Standard Plan and Medicare Plus are available everywhere. As such, they don't appear on this map.

Health plan codes used on the map are explained in the chart on this page.

Plan Codes	
Anthem Blue - Northeast	AE
Anthem Blue - Northwest	AW
Anthem Blue - Southeast	AS
Arise Health Plan	A
Dean Health Plan	D
GHC of Eau Claire	GEC
GHC of South Central Wisconsin	GSC
Gundersen Lutheran Health Plan	GL
Health Tradition Health Plan	HT
HealthPartners	HP
Humana - Eastern	HE
Humana - Western	HW
Medical Associates Health Plan	MA
Medicare Plus*	N/A
MercyCare Health Plan	MC
Network Health Plan	N
Physicians Plus	PP
Security Health Plan	S
Standard Plan*	N/A
State Maintenance Plan *	SMP
UnitedHealthcare of Wisconsin NE	UN
UnitedHealthcare of Wisconsin SE	US
Unity - Community	UC
Unity - UW Health	UU
WEA Trust PPP - East	WT
WEA Trust PPP - Northwest	WN
WPS Metro Choice	W

HEALTH PLAN MAP 2012



* Qualified in a county with no hospital.
** Hospital four miles from major city.

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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. Slight differences may also exist in benefits such as dental or wellness programs, and treatment may vary depending on patient needs, the physicians' preferred practices, and the managed care policies and procedures of the health plan.

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

[1] Deductible applies to all services, except prescription drugs.

[2] PPPs have out-of-network deductibles. See PPP Plan Descriptions (WEA Trust PPPs and WPS Metro Choice) for details.

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

[4] PPPs have out-of-network coinsurance. See PPP Plan Descriptions for detail.

[5] This is separate from other out-of-pocket maximums (OOPM), such as the medical.

[6] Level 3 copays do not apply to the OOPM.

2012—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 Maximum (OOPM)	90%/10% to annual OOPM $500 individual/$1,000 family except as described[4]	As described in this grid and the one on Page 33
Routine Preventive	100%*	100%
Hospital Days	90%/10% coinsurance to OOPM 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% coinsurance thereafter to OOPM	$60 copay per visit
Ambulance	90%/10% coinsurance to OOPM	100%
Transplants *(May cover these and others listed)*	90%/10% coinsurance to OOPM. *Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung*	100% *Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung*
Mental Health/ Alcohol & Drug Abuse	90%/10% coinsurance to OOPM Inpatient, Outpatient & Transitional	100% Inpatient, Outpatient & Transitional
Hearing Exam	90%/10% coinsurance to OOPM	100%
Hearing Aid (per ear)	Every three years: Adults, 80%/20%, up to plan paid $1,000; dependents younger than 18 years, 90%/10% to OOPM.	Every three years: Adults, 80%/20%, up to plan paid $1,000; dependents younger than 18 years, 100%.

*As required by federal law: healthcare.gov/law/about/provisions/services/lists.html.
Note: coinsurance may vary by age.

Superscript footnotes 1 through 6 explained on Page 31.

2012—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
Cochlear Implants	Adults, 80%/20% for device, surgery, follow-up sessions; 90% hospital charge for surgery. Dependents under 18, 90% coinsurance up to OOPM for all services.	Adults, 80%/20% for device, surgery for implantation, follow-up sessions; 100% hospital charge. Dependents under 18, 100%.
Routine Vision Exam	90%/10% coinsurance to OOPM for all members except 100% for children under age 5*	100%, one per year
Skilled Nursing Facility (non custodial care)	90%/10% coinsurance to OOPM, 120 days per benefit period	100%, 120 days per benefit period
Home Health (non custodial)	90%/10% coinsurance to OOPM, 50 per year. Plan may approve an additional 50.	100%, 50 per year. Plan may approve an additional 50.
Physical/Speech /Occupational Therapy	90%/10% coinsurance to OOPM, 50 per year. Plan may approve an additional 50.	100%, 50 per year. Plan may approve an additional 50.
Durable Medical Equipment	80%/20% coinsurance to OOPM	80%/20% coinsurance, $500 OOPM 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.
Primary Care Provider/Clinic	Varies by plan	Varies by plan
Treatment for Morbid Obesity	Excluded	Excluded
Oral Surgery	90%/10% coinsurance to OOPM, 11 procedures	100%, 11 procedures
Dental Care	Varies by plan	Varies by plan
Drug Copays and OOPM[5]	Level 1=$5; 2=$15; 3=$35[6]. OOPM $410 individual/$820 family	Level 1=$5; 2=$15; 3=$35[6]. OOPM $410 individual/$820 family

*As required by federal law: healthcare.gov/law/about/provisions/services/lists.html.
Note: coinsurance may vary by age.

2012—State
Comparison of Benefit Options

BENEFIT	STANDARD PLAN		MEDICARE PLUS
	Preferred Provider	Non-Preferred Provider	
Annual Deductible[1]	$200 individual/$400 family	$500 individual/$1,000 family	No deductible
Annual Coinsurance[3] & OOPM	90%/10% Annual OOPM *(includes deductible)*: $800 individual/$1,600 family	70%/30% Annual OOPM *(includes deductible)*: $2,000 individual/$4,000 family	As described below
Routine Preventive*	100%	Deductible and coinsurance	Covered by Medicare only.
Hospital Days	Deductible and coinsurance as medically necessary, no day limit	Deductible and coinsurance as medically necessary, no day limit	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 *(May cover these and others listed)*	Deductible and coinsurance *Bone marrow, musculoskeletal, corneal, and kidney*	Deductible and coinsurance *Bone marrow, musculoskeletal, corneal, and kidney*	100% *Bone marrow, parathyroid, musculoskeletal, corneal, and kidney*
Mental Health/ Alcohol & Drug Abuse	Deductible and coinsurance	Deductible and coinsurance	Inpatient 100%, up to 120 days. Outpatient & 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%

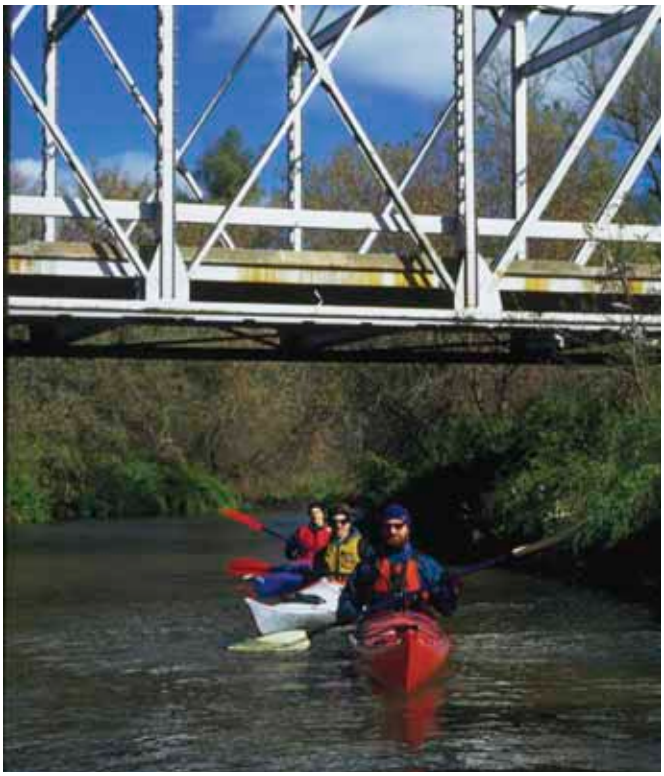
*As required by federal law: healthcare.gov/law/about/provisions/services/lists.html.
Note: coinsurance may vary by age.

Superscript footnotes 1 through 6 explained on Page 31.

2012—State
Comparison of Benefit Options

BENEFIT	STANDARD PLAN		MEDICARE PLUS
	Preferred Provider	Non-Preferred Provider	
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.
Routine Vision Exam	100% for children under age 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	120 days per benefit period
Home Health (non custodial)	Deductible and coinsurance, 50 per plan year. Plan may approve an additional 50.	Deductible and coinsurance, 50 per plan year. Plan may approve an additional 50.	100% up to 365 visits
Physical/Speech/ Occupational Therapy	Deductible and coinsurance, 50 per plan year. Plan may approve an additional 50.	Deductible and coinsurance, 50 per plan year. Plan may approve an additional 50.	100%, no limit on visits or days
Durable Medical Equipment	Deductible and coinsurance	Deductible and coinsurance	100%
Hospital Pre-Certification	WPS Medical Management Program for inpatient stays. Voluntary 2nd surgical opinion	WPS Medical Management Program for inpatient stays. Voluntary 2nd surgical opinion	None required
Referrals	Not required	Not required	Not required
Primary Care Provider/Clinic	Not required	Not required	Not 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	Not specifically excluded
Oral Surgery	23 procedures—deductible and coinsurance	23 procedures—deductible and coinsurance	23 procedures. 100%
Dental Care	No benefit	No benefit	No benefit
Drug Copays and OOPM[5]	Level 1=$5; 2=$15; 3=$35[6]. OOPM $1,000 individual/ $2,000 family	Level 1=$5; 2=$15; 3=$35[6]. OOPM $1,000 individual/ $2,000 family	Level 1=$5; 2=$15; 3=$35[6]. OOPM $410 individual/ $820 family

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 among the available health plan options. 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 *Choose Quality* section of this book.

Health Plan Services

Some of the health plans have requirements and offer additional services to assist members. The chart lists which plans offer the following services.

- Selecting a **Primary Care Physician (PCP)** or clinic location is required by some health plans.
- **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 are unable to reach your primary care physician.

Disease Management and Wellness Programs

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.

Health Risk Assessments (HRAs) 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 osteoporosis. Once you have completed the HRA questionnaire, your health plan will provide you with personalized information to help you take charge of your health. Some of the health plans also offer incentives such as gift cards, cash, etc. if you complete the HRA and/or participate in the disease management and wellness programs they offer.

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

Disease Management Programs may be offered by the health plans. These programs are for members with chronic health conditions. These programs are designed to provide education and enhance the regular treatment of your disease or condition.

Online Services

If you have Internet access, some health plans offer online information and services on their websites. Some areas of these websites may require members to enroll to gain access using a specified login identification and password. The chart lists some of the services 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	% Would Recommend Plan to Family or Friends	NCQA Accreditation	Copay/ Deductible Applies	Orthodontic Benefits	Annual Benefit Maximum per Member	Separate Dental ID Card Required
Anthem BCBS*	★★	93%	●		●		
Arise Health Plan	★★★	98%	●	●	●	●	●
Dean Health Plan	★★★	98%	●	●	●	●	●
GHC of Eau Claire	★★★	97%			●		
GHC of South Central Wisconsin	★★★★	98%	●		●		
Gundersen Lutheran Health Plan	★★★	97%	●	●		●	
Health Tradition Health Plan	★★★	95%				●	
HealthPartners	★★★	97%	●		●		●
Humana - Eastern	★	93%	●	●	●		●
Humana - Western	★	78%	●	●	●		●
Medical Associates	★★★	98%	●	●	●	●	
MercyCare	★★	92%	●	●	●	●	●
Network Health Plan	★★★	98%	●	●	●	●	●
Physicians Plus	★★★	97%	Applied		●		
Security Health Plan	★★★	95%	●		●		
State Maintenance Plan	Not available	78%		No dental coverage available.			
UnitedHealthcare NE	★★	96%	●	●	●	●	●
UnitedHealthcare SE	★★	95%	●	●	●	●	●
Unity - Community	★★★	95%	●		●	●	●
Unity - UW Health	★★★	97%	●		●	●	●
WEA Trust PPP - East & Northwest	Not available				●	●	
WPS Metro Choice	Not available	92%		●	●	●	●

*All three Anthem health plans were combined into Anthem BCBS for the purpose of calculating the composite scores.

Health Plan Features – At a Glance

• Indicates a "Yes" response. This means the health plan either offers the service or has a requirement that applies.	Health Plan Services		Online Services			
	Primary Care Physician or Clinic Required	24-hour Nurseline Offered	Searchable Provider Directory	Member Service Messaging Center	View and Review Appointments	View Electronic Health Records
Anthem BCBS*		•	•	•		•
Arise Health Plan	•		•			
Dean Health Plan	•	•	•	•	•	•
GHC of Eau Claire	•	•				
GHC of South Central Wisconsin	•		•	•	•	•
Gundersen Lutheran Health Plan		•	•	•	•	•
Health Tradition Health Plan	•	•	•	•	•	•
HealthPartners		•	•	•	•	•
Humana - Eastern	•	•	•	•		•
Humana - Western	•	•	•	•		•
Medical Associates		•	•	•		
MercyCare		•	•	•	•	•
Network Health Plan	•	•	•	•		
Physicians Plus	•	•	•	•	•	•
Security Health Plan		•	•	•		
State Maintenance Plan			•	•		
UnitedHealthcare NE		•			•	•
UnitedHealthcare SE		•			•	•
Unity - Community	•		•	•	•	•
Unity - UW Health	•		•	•	•	•
WEA Trust PPP - East & Northwest			•			
WPS Metro Choice			•	•		

Health Plan Features – At a Glance

• Indicates a "Yes" response. This means the health plan offers the service. O=Online, T=Telephone, P=Paper	Wellness Programs**				Disease Management Programs**			
	Health Risk Assessments (HRAs)	Incentive for Taking the HRA	Smoking Cessation	Weight Management	Asthma Management	Lower Back Care Management	Diabetes Care Management	Prenatal and Postnatal Programs
Anthem BCBS**	O		•	•	•		•	•
Arise Health Plan	T		•				•	•
Dean Health Plan	O		•	•	•		•	•
GHC of Eau Claire	O		•		•		•	•
GHC of South Central Wisconsin	O		•	•	•	•	•	•
Gundersen Lutheran Health Plan	O		•	•	•		•	
Health Tradition Health Plan	O		•		•	•	•	•
HealthPartners	O		•		•		•	•
Humana - Eastern	O	•	•	•	•	•	•	•
Humana - Western	O	•	•	•	•	•	•	•
Medical Associates	O		•	•	•	•	•	•
MercyCare	O		•	•	•		•	•
Network Health Plan	O	•	•	•	•		•	•
Physicians Plus	O	•	•	•			•	•
Security Health Plan	O, P		•	•	•	•	•	•
State Maintenance Plan	P				•		•	•
UnitedHealthcare NE	O	•	•	•	•		•	•
UnitedHealthcare SE	O	•	•	•	•		•	•
Unity - Community	O		•	•	•	Developing	•	•
Unity - UW Health	O		•	•	•	Developing	•	•
WEA Trust PPP - East & Northwest	O	•	•	•		•	•	•
WPS Metro Choice	O, P				•		•	•

*All three Anthem health plans were combined into Anthem BCBS for the purpose of calculating the composite scores.
**Some plans may offer incentives, discounts and/or reimbursements for participation. Check with the health plan for details.

Anthem Blue Preferred – Northeast Network

(866) 593-3085 from Oct. 1 to 31, 2011
(800) 490-6201 after Oct. 31 (Non-members, choose "1", "0#", "0#" from menu)
anthem.com

Overall Quality Rating
See *Report Card* section

What's New for 2012

When you are looking for health and wellness information, go to **MyHealth@Anthem** at **anthem.com** to check your health status, learn what you can do to improve your health, calculate your body mass index, find information on health topics and treatments, take advantage of special offers and call the Audio Health Library to hear confidential, educational recordings that cover nearly 500 health topics in both English and Spanish.

Boost your health with Anthem and Bob Harper! The "5-Day Boost" video series features Bob Harper from "The Biggest Loser." Each day for five days, a new video will provide you with a simple tip to get you on the path toward living a healthier lifestyle. Find out more at **facebook.com/healthjoinin** or **youtube.com/healthjoinin**.

Provider Directory

To access the directory, go to **anthem.com/stateofwisconsin**. You may also call Anthem's customer service area to request a paper copy.

Referrals and Prior Authorizations

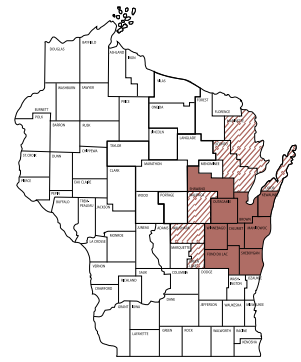
You do not need a referral from your primary care physician (PCP) to see any of the specialists who are part of the Northeast Network. You need a written referral from your PCP and authorization from Anthem to obtain services from a specialist who is not participating in the Northeast Network. Certain 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.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Mental and 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 *(Contact plan for full details.)*

Preventive Services: 100% coverage: Comprehensive, periodic exams; Diagnostic X-rays and necessary preventive cleanings every six months; Fluoride treatments for children under 12.

Restorative Services: Certain dental offices may offer a 20% discount on amalgam fillings.

Annual Benefit Maximum: None.

Orthodontics: 20% discount off participating orthodontists' fees up to $1,250 per person, where available.

Dental Network: Please call customer service for assistance in finding a provider. All family members must select a dental clinic or one will be auto-assigned.

Health Risk Assessment Information for Enrolled Members at:
anthem.com/health-insurance/health-and-wellness/hw-overview

Anthem Blue Preferred – Northwest Network

(866) 593-3085 from Oct. 1 to 31, 2011

(800) 490-6201 after Oct. 31 (Non-members, choose "1", "0#", "0#" from menu)

anthem.com

Overall Quality Rating

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Provider Directory

To access the directory, go to **anthem.com/stateofwisconsin**. You may also call Anthem's customer service area to request a paper copy.

Referrals and Prior Authorizations

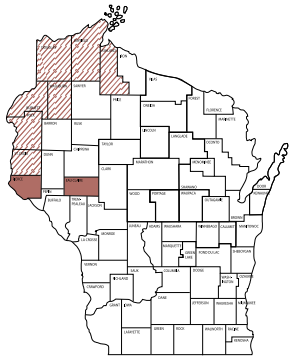
You do not need a referral from your primary care physician (PCP) to see any of the specialists who are part of the Northwest Network. You need a written referral from your PCP and authorization from Anthem to obtain services from a specialist who is not participating in the Northwest Network. Certain 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.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Mental and 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 *(Contact plan for full details.)*

Preventive Services: 100% coverage: Comprehensive, periodic exams; Diagnostic X-rays and necessary preventive cleanings every six months; Fluoride treatments for children under 12.

Restorative Services: Certain dental offices may offer a 20% discount on amalgam fillings.

Annual Benefit Maximum: None.

Orthodontics: 20% discount off participating orthodontists' fees to $1,250 per person, where available.

Dental Network: Please call customer service for assistance in finding a provider. All family members must select a dental clinic or one will be auto-assigned.

Health Risk Assessment Information for Enrolled Members at:
anthem.com/health-insurance/health-and-wellness/hw-overview

Anthem Blue Preferred – Southeast Network

(866) 593-3085 from Oct. 1 to 31, 2011

(800) 490-6201 after Oct. 31 (Non-members, choose "1", "0#", "0#" from menu)

anthem.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

When you are looking for health and wellness information, go to **MyHealth@Anthem** at **anthem.com** to check your health status, learn what you can do to improve your health, calculate your body mass index, find information on health topics and treatments, take advantage of special offers and call the Audio Health Library to hear confidential, educational recordings that cover nearly 500 health topics in both English and Spanish.

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Provider Directory

To access the directory, go to **anthem.com/stateofwisconsin**. You may also call Anthem's customer service area to request a paper copy.

Referrals and Prior Authorizations

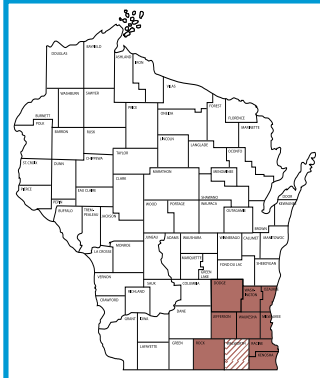
You do not need a referral from your primary care physician (PCP) to see any of the specialists who are part of the Southeast Network. You need a written referral from your PCP and authorization from Anthem to obtain services from a specialist who is not participating in the Southeast Network. Certain 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.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Mental and 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 *(Contact plan for full details.)*

Preventive Services: 100% coverage: Comprehensive, periodic exams; Diagnostic X-rays and necessary preventive cleanings every six months; Fluoride treatments for children under 12.

Restorative Services: Certain dental offices may offer a 20% discount on amalgam fillings.

Annual Benefit Maximum: None.

Orthodontics: 20% discount off participating orthodontists' fees to $1,250 per person, where available.

Dental Network: Please call customer service for assistance in finding a provider. All family members must select a dental clinic or one will be auto-assigned.

Health Risk Assessment Information for Enrolled Members at:
anthem.com/health-insurance/health-and-wellness/hw-overview

Arise Health Plan

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

Overall Quality Rating
See *Report Card* section

What's New for 2012

You may visit **WeCareForWisconsin.com** to view the most current providers in our service area. Arise Health Plan will be making operating system enhancements in 2012 to assure compliance with the new national coding requirements that insurers and providers must meet in the future.

Provider Directory

Go to **WeCareForWisconsin.com**, select **Members** and then **Find A Doctor**. Enter group number "087889." To print a provider directory, scroll to the bottom of the **Find A Doctor** page and **select the link below the search options**, or call (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 and facilities. Arise Health Plan 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?*).

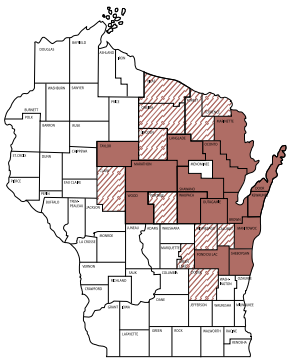
Care Outside Service Area

Emergency care is covered. If you are admitted to the hospital, you must notify Arise 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 and Behavioral Health Services

Participating providers must be used for all mental health, 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.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Dental Benefits *(Contact plan for full details.)*

Preventive Services: *Covered at 100%:* Exams, cleanings, fluoride treatments, X-rays, space maintainers. Limited to six-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, and 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 **deltadentalwi.com**. Select **Premier** or **PPO** as your dental plan. Call (800) 236-3712 with questions.

Health Risk Assessment Information for Enrolled Members:
Contact Jeff Hlavacka at (888) 333-5003

Dean Health Plan Inc.

(800) 279-1301
deancare.com

Overall Quality Rating
See *Report Card* section

What's New for 2012

Dean Health Plan members love the convenience of our new on-site customer care specialist at the Dean West Clinic. Look for additional specialists to be added to our other clinics. In 2012, Dean Clinic and St. Mary's hospital will open St. Mary's Janesville Hospital, a state-of-the-art hospital and clinic. The location will allow easy access for patients coming from surrounding communities. Want to learn more about your doctor before you make an appointment? Check out the new profile videos in Dean's online provider directory. These videos convey the personality and expertise of Dean's providers.

Provider Directory

Go to **deancare.com/wi-employees**. For a searchable directory, select **Online Provider Directory**. For a PDF directory, select **Printable Provider Directory**. You may also call the Customer Care Center to request a copy.

Referrals and Prior Authorizations

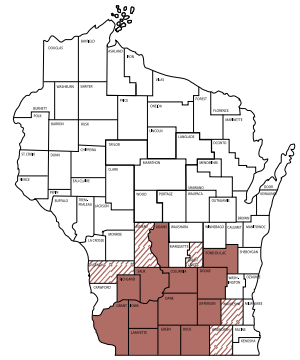
Referrals are not needed when receiving care from plan providers. Prior authorizations are required for certain services and care from all non-plan providers. If you are unsure if a service or procedure requires prior authorization, contact the Customer Care Center. You must inform your provider to contact Dean to obtain an approved prior authorization before receiving care. Dean will notify you and your provider in writing of the decision.

Care Outside Service Area

When you receive emergency or urgent care outside the Dean Health Plan network, call the number on your ID card by the next business day or as soon as possible. Non-emergeny/urgent care is not covered unless an approved prior authorization is obtained.

Mental and Behavioral Health Services

You can see any plan provider for mental and behavioral health services. Inpatient mental health must be prior authorized.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Dental Benefits *(Contact plan for full details.)*

Preventive Services: Covered at 100%, subject to office visit copay (out-of-network providers only): Exam and bite-wing X-rays (two per year), cleanings (two per year).

Restorative Services: Covered at 80%, subject to office visit copay (out-of-network providers only). Sealants (age 14 and under), restorative amalgams, restorative composites.

NEW Annual Benefit Maximum: $1,500/individual in-network or $1,000/individual out-of-network (combined benefit maximum).

NEW Office Visit Copay: $0 network provider; $40 per visit with out-of-network provider.

Deductible: $0.

Orthodontics: 50% for dependents younger than age 19, up to an individual lifetime maximum of $1,750.

Dental Network: You are free to use any dental provider. Usual and customary charges may apply when using an out-of-network provider. See above on how to find a provider.

Health Risk Assessment Information for Enrolled Members at:
deancare.com/deanconnect

Group Health Cooperative of Eau Claire

(888) 203-7770 or (715) 552-4300
group-health.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

Group Health Cooperative (GHC) of Eau Claire will no longer be offered or have providers available in the following counties: Barron, Chippewa, Dunn, Eau Claire, Pepin, Polk and Rusk.

GHC has expanded its Health Resources that are available online at **group-health.com/HealthResources.aspx**, which help members with their health care needs and decisions. Along with trusted web services and materials, GHC has added resources to help with your preventive care regimen.

Provider Directory

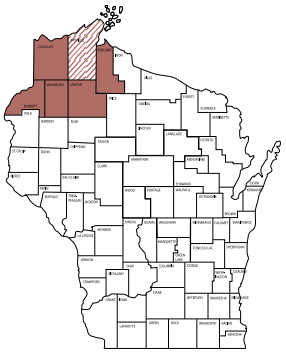
Please refer to **group-health.com/docs/GHCStateProviderDirectory.pdf.** For any questions regarding the GHC provider network, please contact a member services advocate at (888) 203-7770.

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. **For certain procedures, members will be required to participate in a patient decision aid program to review information on options, outcomes and to clarify personal values**. 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 visit GHC's website at **group-health.com/epa.aspx** or 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.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Mental and 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 *(Contact plan for full details.)*

Preventive Services: *Covered at 100%:* Routine exams and cleanings (twice a year), fluoride treatments, routine X-rays and sealants.

Restorative Services: None

Annual Benefit Maximum: None

Orthodontics: 50% for dependents through age 18, up to an individual lifetime maximum of $1,200.

Dental Network: Call member services at (888) 203-7770 or go to **group-health.com/docs/DentalProviderDirectory.pdf.**

Health Risk Assessment Information for Enrolled Members, Contact a member services advocate at (888) 203-7770

Group Health Cooperative of South Central Wisconsin

(608) 828-4853 or (800) 605-4327, ext. 4504
ghcscw.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

- New wellness reimbursements for athletic shoes and doula services.
- Check out our new complementary medicine classes and services including Personal Fitness Session, Self As Source and Thai Massage.
- Care Teams: optimizing care through your provider and supporting team.

Provider Directory

Visit **https://ghcscw.com/Advanced_Search.asp; Provider Directory; Advanced Search** to search for providers and to view their professional qualifications. Members may request a provider directory from GHC-SCW member services at (800) 605-4327, ext. 4504.

Referrals and Prior Authorizations

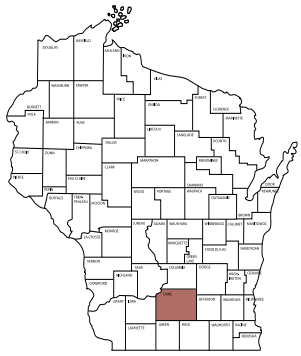
Your PCP will submit a referral request to a certified GHC-SCW case manager when you need to receive services outside of a GHC-SCW clinic or through a specialty care area. You will receive a letter from GHC-SCW, as well as notification in your GHCMyChart online account, letting you know if the referral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

Care Outside Service Area

Call GHC-SCW at (800) 605-4327, ext. 4504 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 and 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.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Dental Benefits (*See plan for full details.*)

Preventive Services: *Covered at 100%:* Exams, X-rays, cleanings, every six 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.

Health Risk Assessment Information for Enrolled Members at: ghcscw.com

Gundersen Lutheran Health Plan

(800) 897-1923 or (608) 775-8007
glhealthplan.org

Overall Quality Rating

See *Report Card* section

What's New for 2012

Gundersen Lutheran Health Plan (GLHP) is pleased to announce that in 2010 they obtained the highest accreditation status of "Excellent" by The National Committee for Quality Assurance (NCQA). To achieve this, a health plan must undergo a rigorous review by a survey team to demonstrate that they provide service and clinical quality that meets or exceeds NCQA's standards. GLHP is committed to ongoing quality measurement and improvement because you deserve quality health care.

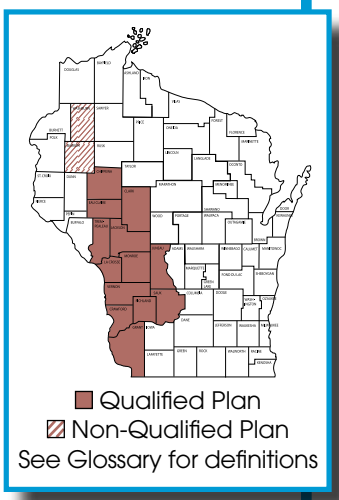
Provider Directory

To view or print a copy of the provider directory, go to **glhealthplan.org/etf**; click on **2012 Provider Directory**. To access the most current practitioners and facilities, a searchable online directory is available. Click **Online Directory**, under **Network**, select **Gundersen Lutheran Health Plan Employer Group**. Select the fields that you would like to include in your search criteria. You may also call customer service at (800) 897-1923 or (608) 775-8007 to request a provider 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 must complete a referral request form and submit it to GLHP. Selected medical procedures and services covered by GLHP require prior authorization. Your provider should submit a written prior authorization request to GLHP. 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 and 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 (*See plan for full details.*)

Preventive Services: *Covered at 100%:* Exams, prophylaxis, fluoride (to age 18), sealants (to age 18) and X-rays, two per calendar year, subject to the $500 annual benefit maximum.

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.

Health Risk Assessment Information for Enrolled Members at:
glhealthplan.org/healthresources

Health Tradition Health Plan

(877) 832-1823 or (888) 459-3020
healthtradition.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

There are no significant changes to the Health Tradition Health Plan (HTHP) offering from last year. Please continue to refer to the online provider directory to make sure the provider/facility you go to is in the HTHP network for the state of Wisconsin.

Provider Directory

Go to **healthtradition.com**. Under **Quick Links** select **Choosing a Provider**. Scroll down to **State of Wisconsin Members** and select the directory. You can also contact HTHP at (888) 459-3020 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-Rochester). 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 the HTHP website or call HTHP at (877) 832-1823.

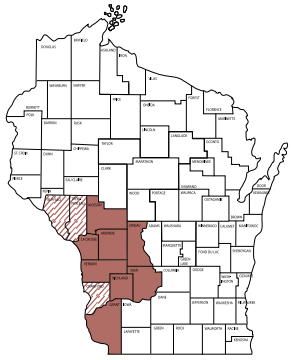
Care Outside Service Area

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

Mental and Behavioral Health Services

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

Dental Benefits *(Contact plan for full details.)*



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Preventive Services: *Covered at 100% up to annual benefit maximum:* exams, cleanings, fluoride treatments, X-rays 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 Risk Assessment Information for Enrolled Members at:
https://www.healthtradition.com/webservice

HealthPartners Health Plan

(800) 883-2177 or (952) 883-5000
healthpartners.com/stateofwis

Overall Quality Rating
See *Report Card* section

What's New for 2012

HealthPartners is happy to announce that Burnett, Douglas and Bayfield counties will be joining the HealthPartners plan service area. Virtuwell by HealthPartners is our new 24/7 online clinic available to all Minnesota and Wisconsin residents. Visit the website at **virtuwell.com** to have your symptoms reviewed by a nurse practitioner for the diagnosis and treatment of up to 30 common medical conditions, including sinus infection, pink eye and ear infections. This year HealthPartners has enhanced the cost comparison tools on its website to include a more robust list of Wisconsin providers' cost of services. As always, members can also register online to view claims, explanation of benefits and other personal health information.

Provider Directory

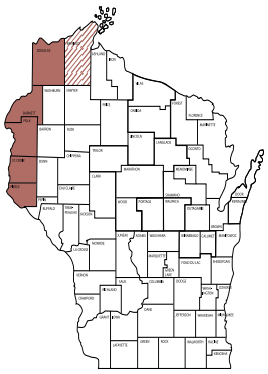
Go to **healthpartners.com/stateofwis** and click on the **search for providers** link. Click on the **PDF listing** or search our online directory for providers. (For help registering, please call the web support team at (877) 726-0203.) Call (800) 883-2177 to request a directory or for assistance in 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) 883-2177 for more information or see complete listing at **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 (800) 316-9807 within 48 hours if an admission occurs.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Mental and Behavioral Health Services

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

Dental Benefits *(Contact plan for full details.)*

Preventive Services: *Covered at 100%:* examinations, dental cleaning every six months, topical fluoride, sealants, bite-wing X-rays and full mouth panoramic X-rays (subject to limitations).

Restorative Services: None.

Annual Benefit Maximum: Unlimited for preventive services.

Orthodontics: Covered at 50% for children to age 19 up to a lifetime maximum of $1,200; 20% discount available with some providers through HealthyDiscounts.

Dental Network: Go to **healthpartners.com/stateofwis** and click on the **search for providers** link. Coverage is available for out-of-network services but charges are payable up to usual and customary levels.

Health Risk Assessment Information for Enrolled Members at: journeywell.com

Humana – Eastern

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

Overall Quality Rating
See *Report Card* section

What's New for 2012

Humana Vitality is a health and wellness program that rewards healthy lifestyle choices for members and their families. See **humana.com.** Humana's robust online tools help you choose a provider, see claim status, take a Health Risk Assessment and much, much more.

Provider Directory

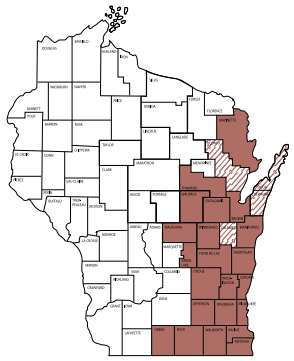
Go to **apps.humana.com/egroups/Wisconsin/home.asp**. Or go to **humana.com** to search for a provider. Select **Find a Doctor**, enter your member ID or select **Employer Group Plan** (if on Medicare, select **Medicare**). Enter your zip code. Select **HMO Premier** (if on Medicare, select **Medicare PPO**). HMO Premier (or Medicare PPO) will not appear in the list if no providers are found in the area. Call (800) 4humana to request an HMO directory. HMO Premier is a national network, but you **must** select a Wisconsin based PCP, regardless of your address. Providers outside of Wisconsin may require a referral in addition to those required by Humana. Referrals are not required in the Medicare PPO plan.

Humana is Unique for Members on Medicare

If you are retired and enrolled in Medicare Parts A and B, Humana will automatically enroll you in a Humana Medicare Advantage PPO plan. You will still have the Uniform Benefits coverage, plus more. You have flexibility to see virtually any provider in the country, but will pay 10% coinsurance, up to an annual $500 out-of-pocket maximum when seeing providers out of the network. For enrollment questions or to request an enrollment kit with area PPO directory, call Humana Group Medicare Enrollment at (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. Your PCP must contact Humana at (800) 523-0023 to make the request. Verify the status of the request by logging on to your MyHumana Web page or calling (800) 4humana.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Care Outside Service Area

Call Humana at (888) 523-0023 within 48 hours after receiving emergency or urgent care outside our network.

Mental and Behavioral Health Services

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

Dental Benefits *(Contact plan for full details.)*

Preventive Services: 100% - Exams, cleanings, fluoride, X-rays.

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

Annual Benefit Maximum: None.

Orthodontics: 50% - dependents younger than age 18. Lifetime maximum $1,200.

Dental Network: Go to **humanadental.com**. Follow the instructions above and select **Dentists** as the type of provider.

Health Risk Assessment Information for Enrolled Members at: humana.com

Humana – Western

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

Overall Quality Rating
See *Report Card* section

What's New for 2012

Humana Vitality is a health and wellness program that rewards healthy lifestyle choices for members and their families. See **humana.com.**

Online Tools: Humana's robust online tools help you choose a provider, see claim status, take a Health Risk Assessment and much, much more.

Provider Directory

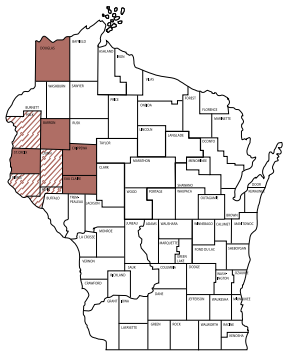
Go to **apps.humana.com/egroups/Wisconsin/home.asp**. Or go to **humana.com** to search for a provider. Select **Find a Doctor**, enter your member ID or select **Employer Group Plan** (if on Medicare, select **Medicare**). Enter your zip code. Select **HMO Premier** (if on Medicare, select **Medicare PPO**). HMO Premier (or Medicare PPO) will not appear in the list if no providers are found in the area. Call (800) 4humana to request an HMO directory. HMO Premier is a national network, but you **must** select a Wisconsin-based PCP, regardless of your address. Providers outside of Wisconsin may require a referral in addition to those required by Humana. Referrals are not required in the Medicare PPO plan.

Humana is Unique for Members on Medicare

If you are retired and enrolled in Medicare Parts A and B, Humana will automatically enroll you in a Humana Medicare Advantage PPO plan. You will still have the Uniform Benefits coverage, plus more. You have flexibility to see virtually any provider in the country, but will pay 10% coinsurance, up to an annual $500 out-of-pocket maximum when seeing providers out of the network. For enrollment questions or to request an enrollment kit with area PPO directory, call Humana Group Medicare Enrollment at (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. Your PCP must contact Humana at (800) 626-2698 to make the request. Verify the status of the request by logging on to your MyHumana Web page or calling (800) 4humana.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Care Outside Service Area

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

Mental and Behavioral Health Services

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

Dental Benefits *(Contact plan for full details.)*

Preventive Services: 100% - Exams, cleanings, fluoride, X-rays.

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

Annual Benefit Maximum: None.

Orthodontics: 50% - dependents younger than age 18. Lifetime maximum $1,200.

Dental Network: Go to **humanadental.com**. Follow the instructions above and select **Dentists** as the type of provider.

Health Risk Assessment Information for Enrolled Members at: humana.com

Medical Associates Health Plans

(800) 747-8900

mahealthcare.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

There are no significant changes to the Medical Associates Health Plans network. Check out the **mahealthcare.com** website to find plan information, provider directories and health-related topics or log on to **myELINK** for personalized claims information, explanations of benefits and plan information.

Provider Directory

Go to **mahealthcare.com/OnlineDirectories/EmpGroup.aspx** or visit the MAHP's website at **mahealthcare.com** to view an online provider directory. You may also call MAHP at (800) 747-8900 to request a directory.

Referrals and Prior Authorization

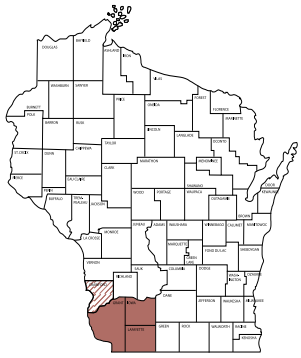
Members do not need to obtain referrals to get care within the MAHP network. However, members must obtain written authorization from the MAHP medical director prior to receiving services from a provider outside of the MAHP network. If services cannot be provided by a physician within the MAHP network, 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 emergency 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 and Behavioral Health Services

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



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Dental Benefits (*Contact plan for full details.*)

Preventive Services: *Covered at 100%:* Exams and cleanings, two per calendar year; fluoride (under age 19), two per calendar year; sealants (under age 14); bite-wing X-ray, one per calendar year; Full mouth X-ray in a three-year period.

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

Annual Maximum Benefit: $1,000 per member.

Orthodontics: 50% coverage, up to a $1,500 lifetime maximum (must start services by age 19).

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

Health Risk Assessment Information for Enrolled Members at:
Contact PathwaysHealthCoach@mahealthcare.com to establish a username and password, then go to mahealthcare.com/Health_Wellness/Personal_Wellness.cfm

Medicare Plus

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

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2012

For continued access to WPS wellness information please visit the Health Center at **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 Medicare Plus plan is designed to supplement, not duplicate, the benefits available under Medicare for State of Wisconsin Group Health Insurance Program annuitants.

See the Comparison of Benefit Options section for **benefit differences on Pages 34 and 35,** and view the Health Care Benefit Plan booklet at **etf.wi.gov/publications/et4113.pdf.**

Provider Directory

None. This plan provides you with freedom of choice among hospitals and physicians in Wisconsin, nationwide and for travel abroad.

Referrals and Prior Authorizations

Referrals are not needed.

Members or providers should request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. Please visit **wpsic.com/state** and follow the **Member Materials** link to obtain a copy of a Medical Preauthorization Request Form or call member services.

Mental and 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 120 days.

Dental Benefits

No dental coverage provided.

Health Risk Assessment Information for Enrolled Members:
Contact Jeff Hlavacka at (888) 333-5003

MercyCare Health Plans

(800) 895-2421

mercycarehealthplans.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

MercyCare Health Plan's new web portal not only allows members to access claims and communicate with customer service, but they can also establish their own personal health record to include such information as immunizations and physician visits. Sign up at **MercyCareMyPlan.com**.

Provider Directory

Go to **mercycarehealthplans.com** click on **Provider Directory** on the blue panel that runs across the middle of the page. Then select **State of Wisconsin Members** and hit continue. OR From **mercycarehealthplans.com** click on the green **For Members** box at the top of the page, choose **Provider Directory** in the green box to the right of the page, and select **State of Wisconsin Members**. Contact customer service at (800) 895-2421 to request a paper copy.

Referrals and Prior Authorizations

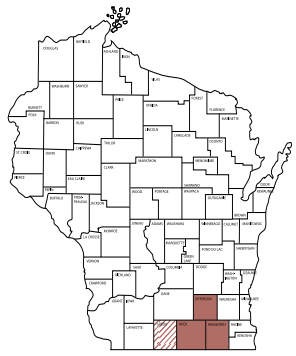
You have open access to providers and specialists in MercyCare's network. If the care is not available in MercyCare's network, your PCP must request a prior authorization from MercyCare. MercyCare will notify you in writing if authorization is approved or denied. Prior authorization is also required 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 and Behavioral Health Services

Mental health and substance abuse services must be obtained from 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.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Dental Benefits *(Contact plan for full details.)*

Preventive Services: *Covered at 100%:* exams, cleanings, fluoride treatments, X-rays, space maintainers and sealants, every six months.

Restorative Services: Covered at 80% after deductible ($25 per individual; $75 per family): fillings, emergency treatment, non-surgical and oral surgery. Covered at 50% after deductible: periodontics and endodontics.

Annual Benefit Maximum: $1,000 per individual.

Orthodontics: 50% for dependents younger than age 19, up to an individual lifetime maximum of $1,500.

Dental Network: Go to **deltadentalwi.com**. Under **Looking for a Dentist** click on **Dentist Search**. Select Premier or PPO as your dental plan. Call (800) 236-3713 with questions.

Health Risk Assessment Information for Enrolled Members at: mercycarehealthplans.com, Go to "Members," then "Health & Wellness," then "Health Risk Assessment"

Network Health Plan

(800) 826-0940
networkhealth.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

Network Health Plan (NHP) will be introducing Millennium Healthy Rewards, a great incentive for healthy living. It rewards enrolled employees and spouses for meeting health and fitness goals. By participating, you will receive a pedometer and also earn points for rewards.

Provider Directory

Go to **networkhealth.com,** click on **Find a Doc/Location** and choose **State of Wisconsin Employee** as your network, or call (800) 826-0940 to request a copy.

Referrals and Prior Authorizations

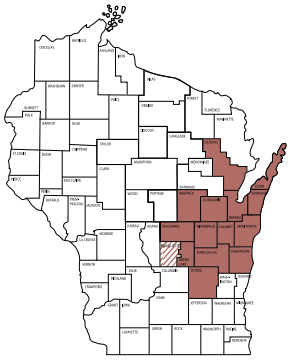
You do not need a referral to see providers participating in NHP's network. However, prior authorization is required to see a provider that is not in NHP's network. Prior authorizations are also required for certain services. Members should contact NHP's customer service for information on specific health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

Care Outside Service Area

Emergency and urgent care outside the service area is covered when medically necessary. Call us at (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 and Behavioral Health Services

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



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Dental Benefits (*Contact plan for full 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/individual.

Deductible: $25 individual/$75 family.

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

Dental Network: Go to **deltadentalwi.com** and choose **Delta Dental Premier** or **Delta Dental PPO** as your Dental Plan. You may also call Delta Dental at (800) 236-3712.

Health Risk Assessment Information for Enrolled Members at: networkhealth.com, go to "My Account Sign In," and click on "WebMD"

Physicians Plus

(608) 282-8900 or (800) 545-5015
pplusic.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

Two new clinics, Meriter DeForest-Windsor and Meriter Monona, are now available to provide greater access and convenience for Physicians Plus members. Both offer internal medicine, family practice, pediatrics and OB/GYN services—as well as other services—and are accepting new patients!

Physicians Plus MobileNurse is a cutting-edge mobile phone application that will guide users to appropriate care. Learn more about this useful application at **pplusic.com**.

Provider Directory

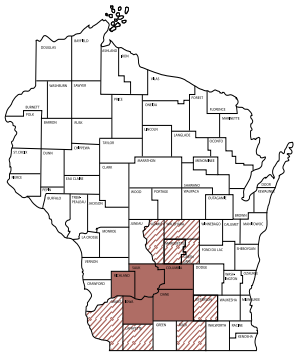
Go to **pplusic.com** and click on **Find a Provider**. To print the provider listing, select **State Directory**. To search for a provider, select **State of Wisconsin/Wisconsin Public Employee (State/WPE)** group plan member. Call member service at (608) 282-8900 for a printed copy.

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 Physicians Plus will notify you in writing of the 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 the Physicians Plus network. All other care, including follow-up care, should be obtained from network providers unless approved by Physicians Plus as described above.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Mental and Behavioral Health Services

Contact UW Behavioral Health at (608) 233-3575 or (800) 683-2300 for prior authorization Monday through Friday, 8:00 a.m. to 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 *(Contact plan for full details.)*

Preventive Services: *Covered at 100%*. Exams, two cleanings per year, fluoride treatments, X-rays.

Restorative Services: *Covered at 100%*. Fillings, extractions. Other dental services covered up to $75 member/calendar year.

Annual Benefit Maximum: Unlimited.

Orthodontics: *Covered at 50%*. Up to an individual maximum of $1,500 for dependents younger than age 19.

Dental Network: Call (800) 545-5015 for participating providers.

Health Risk Assessment Information for Enrolled Members at: pplusic.com, log on to your "GO-TO" Account

Security Health Plan

(800) 472-2363 or (715) 221-9555
securityhealth.org/state

Overall Quality Rating
See *Report Card* section

What's New for 2012

Digital health coaching programs help members create a personal action plan to improve their balance, relaxation, movement, back or overall health. Access digital coaching 24 hours a day, every day through the Life Focus health assessment at **securityhealth.org/lifefocus**.

Provider Directory

Visit **securityhealth.org/state** and click on **Provider Directory**. For a printed copy, contact customer service at (800) 472-2363.

Referrals and Prior Authorizations

Referrals: Required prior to seeing providers outside of the network.

Prior authorizations: 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 its decision.

Care Outside Service Area

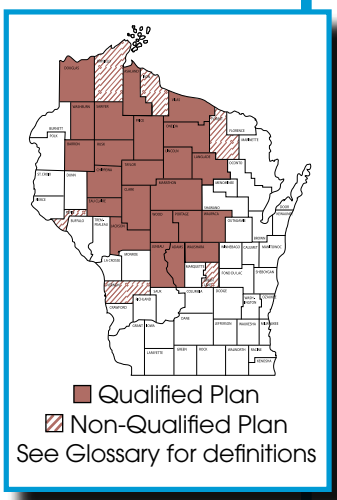
For emergency and urgent care outside of the network, you must notify Security Health Plan by the next business day or as soon as possible to ensure appropriate claim payment.

All other care obtained through providers outside of the network will not be covered unless a referral has been approved by Security Health Plan, as explained above.

Mental and 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 *(Contact plan for full details.)*



Preventive Services: *Covered at 100%:* Exams, cleanings (two per calendar year.); X-rays (with frequency limits), sealants, fluoride (one per calendar year.), and space maintainers (for non-orthodontic treatment). Visit **securityhealth.org/state** and click on **Dental Benefits Schedule** for a complete list of covered services.

Restorative Services: No restorative services coverage provided.

Annual Benefit Maximum: None.

Orthodontics: 50% for dependents younger than age 19, subject to a lifetime maximum benefit of $1,200.

Dental Network: Receive your dental care from any dentist in the United States.

Health Risk Assessment Information for Enrolled Members at: securityhealth.org/lifefocus

Standard Plan

Administered by WPS Health Insurance

(800) 634-6448 wpsic.com/state

Not Available
Overall Quality Rating

See *Report Card* section

What's New for 2012

For continued access to WPS wellness information, please visit the Health Center at **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. See the Comparison of Benefit Options section for **benefit differences on Pages 34 and 35** and view the Health Care Benefit Plan booklet for more complete details at **etf.wi.gov/publications/et2112.pdf.**

Provider Directory

Go to **wpsic.com/state/pdf/dir2012_statewide_eastern.pdf** or **wpsic.com/state/pdf/dir2012_statewide_western.pdf** to search for a provider within Wisconsin and bordering areas. You can also visit **wpsic.com/state/fad2012_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.
- Members or providers should request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. Please visit **wpsic.com/state** and follow the **Member Materials** link to obtain a copy of a Medical Preauthorization Request Form or contact member services.

Mental and 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.

Health Risk Assessment Information for Enrolled Members:
Contact Jeff Hlavacka at (888) 333-5003

SMP – State Maintenance Plan

Administered by WPS Health Insurance

(800) 634.6448 wpsic.com/state

Not Available
Overall Quality Rating

See *Report Card* section

What's New for 2012

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

For continued access to WPS wellness information, please visit the Health Center at **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

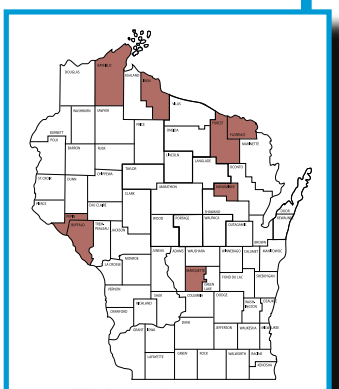
Please visit **wpsic.com/state/pdf/dir2012_state_smp.pdf** to search for a provider or contact WPS member services.

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.

Members or providers should request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. Please visit **wpsic.com/state** and follow the **Member Materials** link to obtain a copy of a Medical Preauthorization Request Form or call member services.

Care Outside Service Area



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Emergency or Urgent Care: 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, go to the nearest appropriate medical facility. Afterwards, contact member services by the next business day, or as soon as reasonably possible, and report where you received the care. Out-of-network care may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from an in-network provider.

Mental and Behavioral Health Services

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

Dental Benefits

No routine dental coverage provided.

Health Risk Assessment Information for Enrolled Members:
Contact Jeff Hlavacka at (888) 333-5003

UnitedHealthcare of Wisconsin - Northeast

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

Overall Quality Rating

See *Report Card* section

What's New for 2012

Early in 2011, UnitedHealthcare of Wisconsin Northeast added Affinity Medical Group; affiliated hospitals are Calumet Medical Center, Mercy Medical Center and St. Elizabeth Hospital.

Provider Directory

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

Referrals and Prior Authorizations

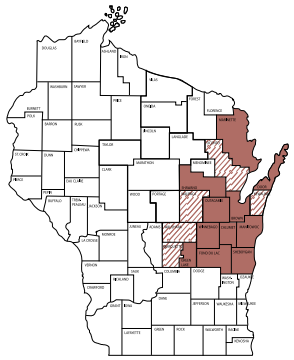
You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception." In addition, you are responsible 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, 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 (see map at right).

Mental and 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.*



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Dental Benefits (*Contact plan for full details.*)

Preventive Services: *Covered at 100%:* exams two times per calendar year, bite-wing 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 younger than age 19, up to an individual orthodontic 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.

Health Risk Assessment Information for Enrolled Members at:
myuhc.com, log on, then select "Health Risk Assessment" or call one of the numbers above

UnitedHealthcare of Wisconsin – Southeast

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

Overall Quality Rating

See *Report Card* section

What's New for 2012

Edgerton Memorial Hospital in Rock County was added to UnitedHealthcare of Wisconsin Southeast's network in April, 2011.

Provider Directory

Go to **myuhc.com/groups/state** and click on **Find Physicians & Facilities** and then click 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.

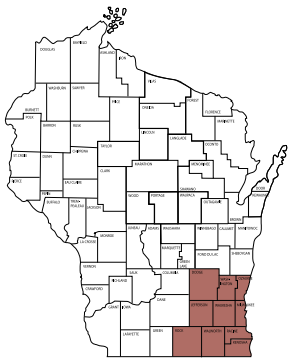
Care Outside Service Area

For emergency or urgent care, 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 in the service area (see map at right).

Mental and 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.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Dental Benefits (*Contact plan for full details.*)

Preventive Services: *Covered at 100%:* exams two times per calendar year, bite-wing 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 younger than age 19 and up to an individual orthodontic 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.

Health Risk Assessment Information for Enrolled Members at:
myuhc.com, log on, then select "Health Risk Assessment" or call one of the numbers above

Unity Health Insurance – Community

(800) 362-3310

chooseunityhealth.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

Juneau County is added to the Community Network service area. New participating providers include Mile Bluff Clinic and Mile Bluff Medical Center. Unity and UW Health now operate on a single, integrated system. As part of this integration, you will use MyChart as your member portal.

Provider Directory

Go to **chooseunityhealth.com** and click **Find A Doctor**. Here you will find links to the 2012 Community Network Directory (PDF) and the Community Network provider search function. You may also call (800) 548-6489 to request a copy of the Community Network Provider Directory.

Referrals and Prior Authorizations

Written referral requests are required to see providers not in 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. Unity will notify you in writing of our decision.

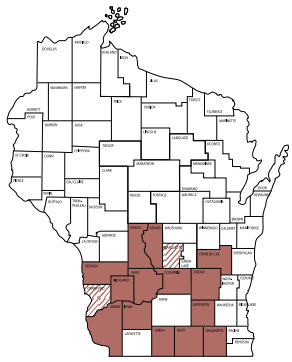
Care Outside Service Area

Call Unity at (800) 362-3310 within three 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 and 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 *(Contact plan for full details.)*



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Preventive Services: *No deductible, covered at 100%:* exams, cleanings, bite-wing X-rays, and fluoride treatments (up to age 19) are covered twice per calendar year. Full mouth X-rays covered at three year intervals.

Restorative Services: *No deductible, covered at 100%:* amalgam fillings (composite in front teeth), one topical sealant application per tooth (to age 16), non-surgical extractions and palliative treatment of dental pain (minor procedure).

Annual Benefit Maximum: $1,000 per member.

Orthodontics: 50% for dependents under 19 years, up to a lifetime maximum of $1,500.

Dental Network: Dental benefits administered by Delta Dental. To find network dentists, go to **deltadentalwi.com** and select either **Delta Dental Premier** or **Delta Dental PPO** as your Dental Plan.

Health Risk Assessment Information for Enrolled Members at: chooseunityhealth.com, sign-in for "My Chart," then click "Wellness Programs" and select "Health Risk Assessment"

Unity Health Insurance – UW Health

(800) 362-3310

chooseunityhealth.com

Overall Quality Rating

See *Report Card* section

What's New for 2012

Unity and UW Health now operate on a single, integrated system. Members of Unity with a UW Health provider have one combined record for their medical and insurance information. You can access all of this through a single portal, MyChart, instead of using multiple member/patient portals. The administrator for Unity's dental benefit is changing to Momentum Insurance Plans Inc. Your dental benefits are not changing, but the provider network is different (see dental section below).

Provider Directory

Go to **chooseunityhealth.com** and click **Find A Doctor.** Here you will find links to the 2012 UW Health Network Directory (PDF) and the UW Health Network provider search function. You may also call (800) 548-6489 to request a copy of the UW Health Network Provider Directory.

Referrals and Prior Authorizations

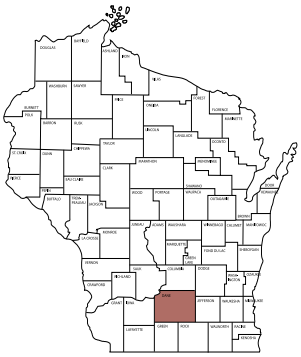
Written referral requests are *not* required to see providers in the UW Health Network. You will need a written referral request to see providers not in the UW Health Network. Prior authorizations are required for certain services. See the UW Health Network Provider Directory for more information. Your doctor must submit the request. Unity will notify you in writing of our decision.

Care Outside Service Area

Call Unity at (800) 362-3310 within three 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 and Behavioral Health Services

Before getting mental health services, you must call UW Behavioral Health at (800) 683-2300. For alcohol and other drug abuse (AODA) needs, call UW Health Gateway Recovery at (800) 785-1780. Assistance is available 24 hours a day.



Qualified Plan

Non-Qualified Plan

See Glossary for definitions

Dental Benefits *(Contact plan for full details.)*

Preventive Services: *No deductible, covered at 100%:* exams, cleanings, bite-wing X-rays, and fluoride treatments (up to age 19) are covered twice per calendar year. Full mouth X-rays covered at three year intervals.

Restorative Services: *No deductible, covered at 100%:* amalgam fillings (composite in front teeth), one topical sealant application per tooth (to age 16), non-surgical extractions and palliative treatment of dental pain (minor procedure).

Annual Benefit Maximum: $1,000 per member.

Orthodontics: 50% for dependents under 19 years, up to a lifetime maximum of $1,500.

Dental Network: Dental benefits are administered by Momentum Insurance Plans Inc. To find network dentists, go to **momentumplans.com**.

Health Risk Assessment Information for Enrolled Members at: chooseunityhealth.com, sign-in for "My Chart," then click "Wellness Programs" and select "Health Risk Assessment"

WEA Trust PPP – East

(800) 279-4000 or (608) 276-4000
weatruststatehealthplan.com

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2012

Seven more counties—Rock, Jefferson, Dodge, Columbia, Wood, Portage and Marathon—and thousands of additional providers join the WEA Trust PPP East Network, which now totals 31 counties and covers most of east-central Wisconsin. This extensive network means it's likely you can switch to WEA Trust and still keep your doctor.

Provider Directory

Go to **stateplanproviders.weatrust.com.** From there, you may search for a doctor or print from a PDF. You may also call customer service at (800) 279-4000 for assistance.

How WEA Trust PPP East is Unique

WEA Trust PPP East is a preferred provider plan—a broader alternative to HMOs that limit choices. Services received from non-network providers are covered too, but reimbursed at a lesser benefit level. (Also see Care Outside Service Area section below.)

Referrals and Prior Authorizations

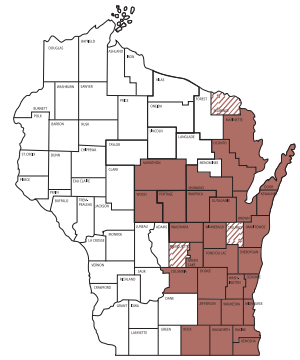
Referrals are not necessary. Some services require prior authorization—see a complete list at **stateplanproviders.weatrust.com** or call customer service at (800) 279-4000.

Care Outside Service Area

If you see a non-network provider, WEA Trust will reimburse for covered services at 70%, subject to an annual deductible of $1,000 individual/$2,000 family. For emergency and urgent care, use WEA Trust PPP East Network providers wherever possible.

Mental and Behavioral Health Services

WEA Trust covers mental and behavioral health in the same manner as other medical services. No referrals or prior authorizations are needed.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Dental Benefits *(Contact plan for full details.)*

Preventive Services: Covered at 100%: Exams, cleanings two times per year; bite-wing X-rays; fluoride treatments and sealants for dependent children.

Restorative Services: 80% coverage for fillings, extractions and periodontal services; 50% coverage for crowns and onlays, but does not include implant crowns.

Annual Benefit Maximum: $1,000 per individual. No deductible.

Orthodontics: 50% coverage for dependents up to age 19, with an individual lifetime maximum of $1,500.

Dental Network: Click **Find a Dentist** at **stateplanproviders.weatrust.com** or call customer service at (800) 279-4000. You may see any dentist but reimbursement for non-network providers is limited by WEA Trust's maximum reimbursement amount.

Health Risk Assessment Information for Enrolled Members at: trustinyourhealth.com

WEA Trust PPP – Northwest

(800) 279-4000 or (608) 276-4000
weatruststatehealthplan.com

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2012

WEA Trust PPP Northwest is a new option for state and local government employees in northwestern Wisconsin. WEA Trust's broad network features thousands of providers in Wisconsin and nearby Minnesota counties. For more than 40 years, the WEA Trust has provided a top-rated health plan and superior customer service to public school employees. In 2011, the WEA Trust PPP began serving state and public employees in eastern Wisconsin and is now available in 18 northwestern counties.

Provider Directory

Go to **stateplanproviders.weatrust.com.** From there, you may search for a doctor or print from a PDF. You may also call customer service at (800) 279-4000 for assistance.

How WEA Trust PPP Northwest is Unique

WEA Trust PPP Northwest is a preferred provider plan that allows you to see any provider and receive benefits—a broader alternative to HMOs that limit choices. Services received from non-network providers are covered too, but reimbursed at a lesser benefit level. (Also see Care Outside Service Area section.)

Referrals and Prior Authorizations

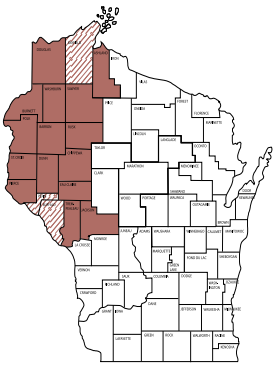
Referrals are not necessary. Some services require prior authorization—see a complete list at **stateplanproviders.weatrust.com** or call customer service at (800) 279-4000.

Care Outside Service Area

If you see a non-network provider, WEA Trust will reimburse for covered services at 70%, subject to an annual deductible of $1,000 individual/$2,000 family. For emergency and urgent care, use network providers wherever possible.

Mental and Behavioral Health Services

WEA Trust covers mental and behavioral health in the same manner as other medical services. No referrals or prior authorizations are needed.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Dental Benefits *(Contact plan for full details.)*

Preventive Services: Covered at 100%: Exams, cleanings two times per year; bite-wing X-rays; fluoride treatments and sealants for dependent children.

Restorative Services: 80% coverage for fillings, extractions and periodontal services; 50% coverage for crowns and onlays, but does not include implant crowns.

Annual Benefit Maximum: $1,000 per individual. No deductible.

Orthodontics: 50% coverage for dependents up to age 19, with an individual lifetime maximum of $1,500.

Dental network: Click **Find a Dentist** at **stateplanproviders.weatrust.com** or call customer service at (800) 279-4000. You may see any dentist but reimbursement for non-network providers is limited by WEA Trust's maximum reimbursement amount.

Health Risk Assessment Information for Enrolled Members at: trustinyourhealth.com

WPS Metro Choice

(800) 634-6448
wpsic.com/state

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2012

For continued access to WPS wellness information please visit the Health Center at **wpsic.com/healthcenter**, an online resource designed to help you make good health decisions, whether you need advice on treating a chronic condition or for tips on leading a healthy lifestyle.

Provider Directory

Go to **wpsic.com/state/pdf/dir2012_metro_choice.pdf** to search for a provider or contact WPS member services at (800) 634-6448 to request a copy.

How Metro Choice is Unique

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

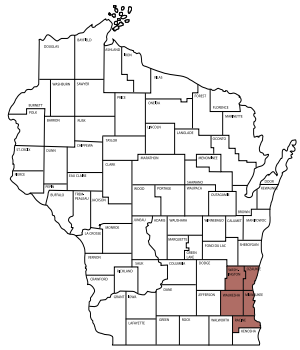
Referrals and Prior Authorizations

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 new medical or biomedical technology, methods of treatment by diet or exercise, new surgical methods or techniques, organ transplants, durable medical equipment over $500 and 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.



Qualified Plan
Non-Qualified Plan
See Glossary for definitions

Mental and Behavioral Health Services

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 *(Contact plan for full details.)*

Preventive Services: *100% after deductible:* exams, cleanings, fluoride treatments, and X-rays.

Restorative Services: *50% after deductible:* sealants and fillings.

Annual Benefit Maximum: $500 per individual.

Deductible: $25 single/$75 family per calendar year.

Orthodontics: Covered at 50% after deductible for dependents up to the age of 19 up to an Individual Lifetime Orthodontic Maximum of $1,200.

Dental Network: Delta Dental Premier. Visit **deltadentalwi.com** to find a network dentist by clicking **Dentist Search** and then selecting **Delta Dental Premier** or by calling Delta Dental at (800) 236-3712.

Health Risk Assessment Information for Enrolled Members:
Contact Jeff Hlavacka at (888) 333-5003

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Health Plan Report Card
Grievance and Complaint Information
Other Quality Information Resources

HEALTH PLAN REPORT CARD

This section provides the results of two important annual evaluations of our health plans—the member satisfaction survey—otherwise known as the Consumer Assessment of Healthcare Providers and Systems or CAHPS® — and quality performance measures — otherwise known as the Healthcare Effectiveness Data and Information Set or HEDIS® survey. We encourage you to review this information and compare how your current health plan compares with the other available health plans.

- The **Quality Composite** provides a summary of the health plans' quality scores in an overall composite. The Quality Composite Rating Chart includes all health plans that were available in 2011 and for which HEDIS® and CAHPS® data was available. Anthem Blue Northeast, Northwest and Southeast were combined into Anthem Blue for the purpose of calculating the composite scores.
- **CAHPS®** is our annual member survey. The survey reveals how members rate their health plan and the health care services they received. CAHPS® results were collected for active state, UW hospital, clinic and university employees, including graduate assistants, and state retirees. The survey only includes health plans that were available starting on January 1, 2010, no data was therefore collected for WEA Trust—a new health plan that became available January 1, 2011. 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. ETF would like to thank all of the respondents for participating in this year's survey. We look forward to your continued support and cooperation in future member satisfaction surveys. This important survey was administered by Synovate, an independent research firm on the behalf of ETF.
- The **HEDIS®** survey shows the health plan's performance from a clinical perspective. The measures in this survey evaluate whether the health plan delivered the recommended care based on medical evidence to prevent or manage illness. HEDIS® measures address health care issues that are meaningful to members. HEDIS® scores include all the health plans that were available to ETF members in 2011. HEDIS® data was collected by each health plan for its entire membership for the 2010 calendar year.

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.

PLEASE NOTE: ETF'S INTERNET SITE AT **etf.wi.gov** CONTAINS MORE DETAILED INFORMATION.

QUALITY COMPOSITE RATING CHARTS

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

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 CAHPS® questions surveying our members about whether 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 CAHPS® survey questions on whether 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 received and whether 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.

Example of information types 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?

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 BCBS	★★	★	★★★	★★	★
Arise Health Plan	★★★	★★	★★★★	★★★	★★★★
Dean Health Plan	★★★	★★	★★★	★★★	★★★
GHC of Eau Claire	★★★	★★	★	★★★	★★★
GHC of SCW	★★★★	★★★★	★★★★	★★★	★★★★
Gundersen Lutheran	★★★	★★	★	★★★	★★★
Health Tradition	★★★	★★	★★★	★★★	★★★
HealthPartners	★★★	★★★	★★★	★★★★	★★
Humana - Eastern	★	★★	★★★	★	★
Humana - Western	★	★★	★★★	★	★
Medical Associates	★★★	★	★★	★★★	★★★
MercyCare Health Plan	★★	★★	★★★	★★★	★
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. A 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 2009 to 2010.
↘ means that a health plan had a statistically significant decline in their score from 2009 to 2010.

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**
AVERAGE - All Health Plans	8.41	8.56	8.75	8.52
Anthem BCBS	★	★★↗	★★★★↗	★★
Arise Health Plan	★★★★	★★★★	★★★	★★★
Dean Health Plan	★★★★↗	★★★↗	★★★	★★★
GHC of Eau Claire	★★★★	★★★	★★★	★★★
GHC of SCW	★★★★↗	★★★★	★★	★★★
Gundersen Lutheran	★★★★	★★★★↗	★★★★	★★★★↗
Health Tradition	★★★★	★★★	★★★	★★
HealthPartners (New plan in 2010)	★★	★★	★★★	★★
Humana - Eastern	★	★★	★★★	★★
Humana - Western	★	★	★★	★
Medical Associates	★★★★	★★★	★★★★	★★★
MercyCare Health Plan	★	★	★	★★
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 2009 to 2010.
↘ means that a health plan had a statistically significant decline in their score from 2009 to 2010.

Plan Name	Customer Service	Claims Processing	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Shared Decision Making
AVERAGE - All Health Plans	3.46	3.53	3.41	3.50	3.69	3.54
Anthem BCBS	★	★	★★	★★★	★★★↗	★★
Arise Health Plan	★★★★↗	★★★★↗	★★★★	★★★★	★★	★★★
Dean Health Plan	★★★	★★★	★★↗	★★	★★★↗	★★★
GHC of Eau Claire	★★★★	★★★★	★★★	★★	★★★	★★★
GHC of SCW	★★★★	★★★★	★★	★★	★★★	★★★
Gundersen Lutheran	★★	★★★	★★★	★★★	★★★★	★★★
Health Tradition	★★★	★★★	★★	★★★	★★★	★★
HealthPartners (New plan in 2010)	★★	★★	★★	★★★★	★★	★★
Humana - Eastern	★	★	★★★	★★	★★	★★
Humana - Western	★	★	★	★★★	★	★★
Medical Associates	★★★	★★★	★★★★	★★★★	★★★★	★★★★↗
MercyCare Health Plan	★★	★★	★★	★★	★★	★★
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 Patients with Persistent Medications
Anthem BCBS	★	★	★	★	★	★★
Arise Health Plan	★★★	★★★	★★★	★★★	★★★	★
Dean Health Plan	★★	★★★	★★	★★	★★★	★★
GHC of Eau Claire	★★	★★★	★★★	★★★	★★★	★★
GHC of SCW	★★★★	★★★★	★★	★	★★★	★★★★
Gundersen Lutheran	★★★★	★★★	★★★	★★★★	★★	★★
Health Tradition	★★	★★★★	★★	★★★	★★	★★★
HealthPartners	★★★	★★★	★★★	★★★★	★★★	★★★★
Humana	★★	★	★	★	★	★★★
Medical Associates	★★	★★	★★★★	★★★	★★★	★★★
MercyCare Health Plan	★★	★★★★	★★★	★★★	★	★★
Network Health Plan	★★★	★★	★★★★	★★	★★★★	★★
Physicians Plus	★★★	★★	★★	★★	★★	★
Security Health Plan	★★★	★★	★★★	★★★	★★★★	★★★★
UnitedHealthcare	★	★★	★★	★★★	★★	★★★
Unity Health Insurance	★★★	★★	★★	★★	★★★	★★★
WEA Trust	★★★★	★	NR*	NR*	NR*	★★★

*Not all necessary data reported.

Please see page 72 for a description of the star rating system that was used for this chart.

GRIEVANCE AND COMPLAINT 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.

The most frequent types of grievances filed by members in 2010 were related to:

- Non-covered or excluded benefits;
- Plan administration; and
- Prior authorizations.

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.

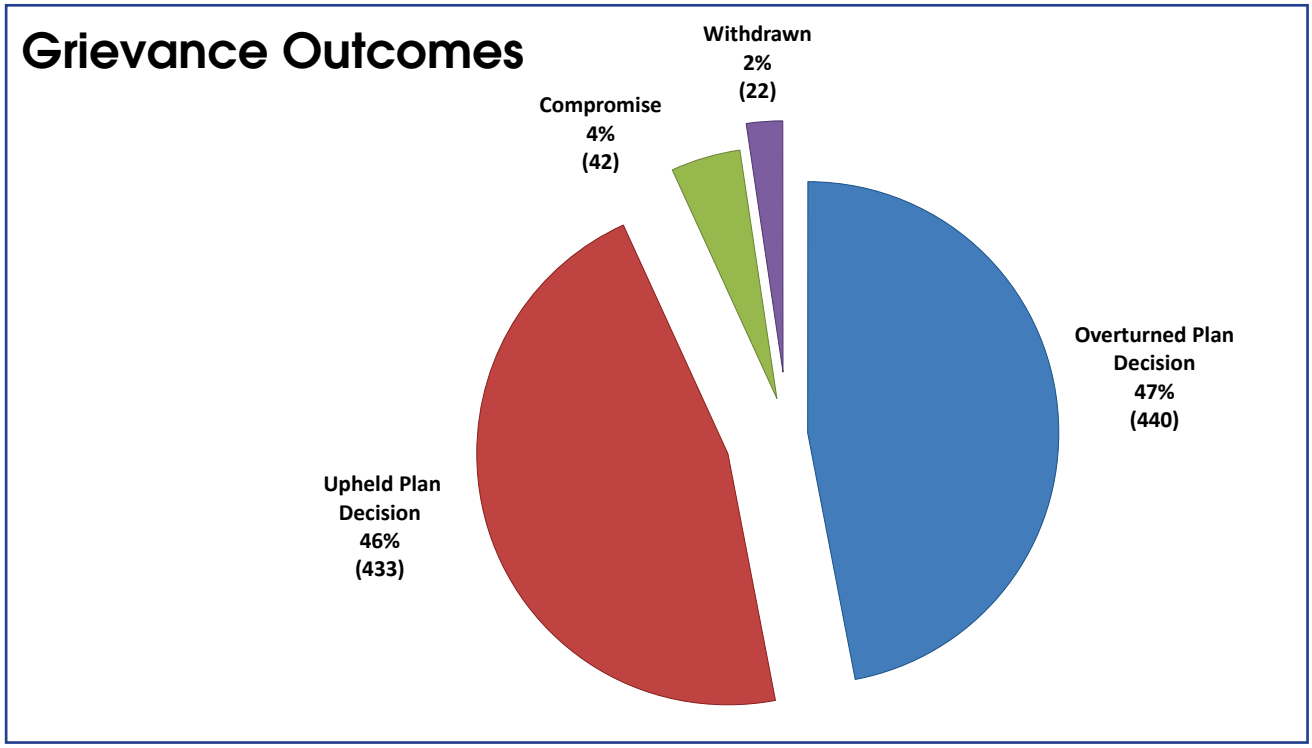
The most frequent complaints types filed by members in 2010 were related to the following:

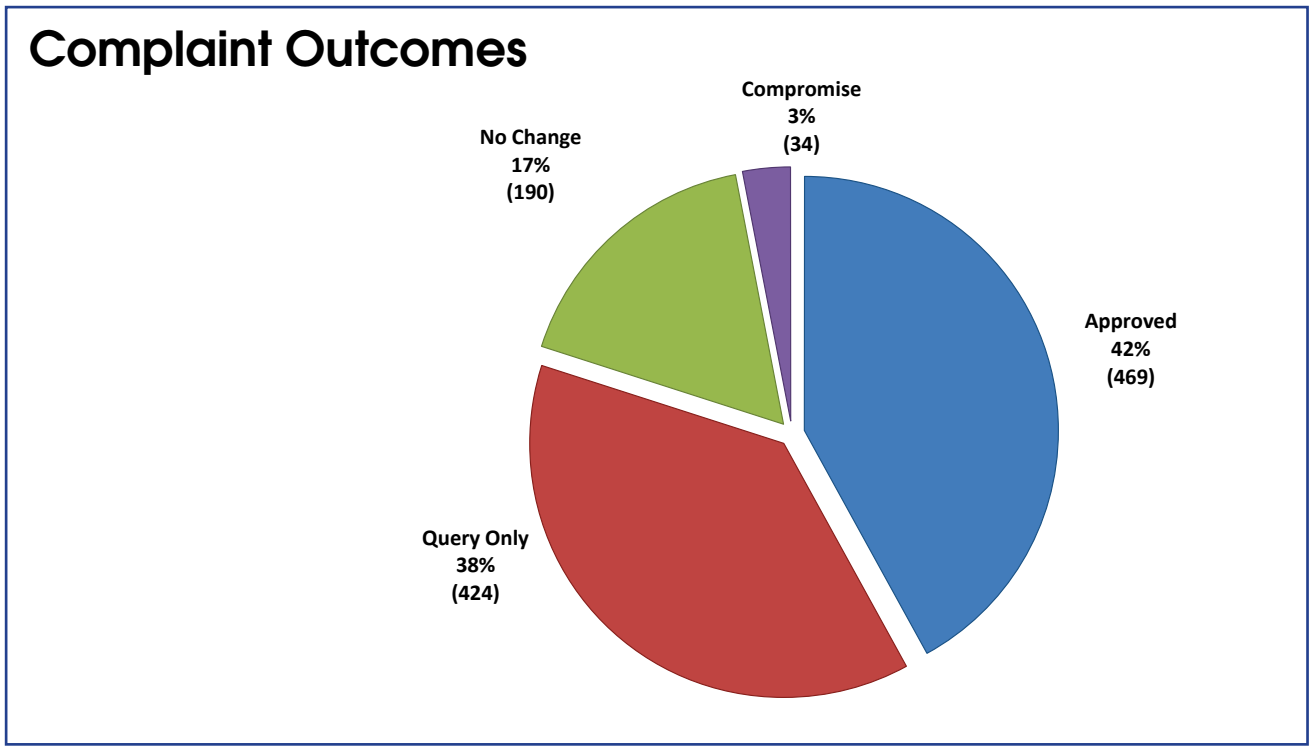
- Enrollment and eligibility;
- Billing and claim processing; and
- General program provision or design.

In 2010, 937 members filed grievances with their health plan and 1,117 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).

GRIEVANCE AND COMPLAINT CHARTS

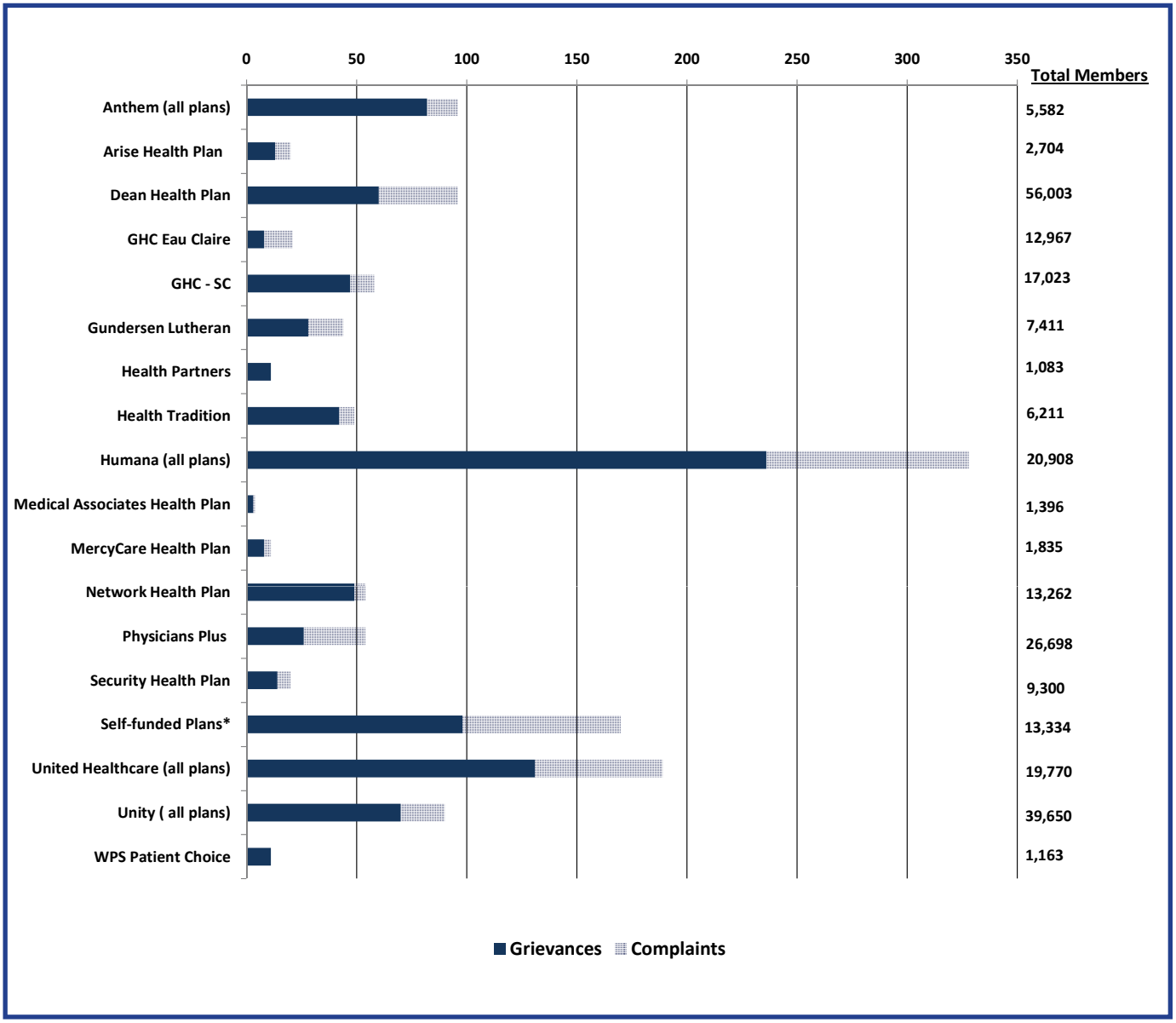




Note: *Approved* defined as: health plan's original decision was overturned.

Grievances and Complaints by Health Plan

This chart shows the total number of complaints and grievances for each health plan during the 2010 calendar year. The number on the right is the health plan's total number of members for 2010.



*Includes the Standard Plan, SMP and Medicare Plus.

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

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

Through the Leapfrog website, consumers can select hospitals and compare their patient safety ratings performance.

leapfroggroup.org

CheckPoint

CheckPoint is a program sponsored by the Wisconsin Hospital Association. It provides a snapshot of hospital performance, and information may be used 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.

wicheckpoint.org

Wisconsin Collaborative for Healthcare Quality

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, heart care, patient experience, pneumonia, cardiac surgery, surgery, women's health, chronic care, preventive care and more.

wchq.org

Hospital Compare

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 and Medicaid Services, the U.S. Department of Health and Human Services, and other members of the Hospital Quality Alliance.

hospitalcompare.hhs.gov

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Other Benefits and Information

Pharmacy Benefits

Life Insurance

Employee Reimbursement Accounts (ERAs)

Pharmacy — *NAVITUS HEALTH SOLUTIONS™*

Toll-Free Customer Care — (866) 333-2757
navitus.com

What's New for 2012

Mail Order Partner
Effective January 1, 2012, the mail order prescription drug partner is changing to WellDyneRX. Your benefits will remain the same. You will receive a letter containing additional information regarding this change in mail order partner (also see "Mail Order Program" at right).

Medicare Prescription Drug Coverage
Effective January 1, 2012, all Medicare-eligible retirees will be automatically enrolled in a new Medicare Part D program with Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company. You do not need to take any further action. Also, your benefits will remain the same.

Formulary Information

The three-level formulary requires copayments of $5 (Level 1), $15 (Level 2) and $35 (Level 3). Level 3 copayments are not applied against the prescription drug out-of-pocket maximum. Detailed and updated formulary information is available on the Navitus website through Navi-Gate for Members. Under "Quick Links," click on Members - **Your Formulary** to log in, then select the formulary named **State of WI and WI Public Employers (administered through ETF) Formulary**. You may also call Navitus customer care toll free at (866) 333-2757 with questions about the formulary.

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 prescription drug out-of-pocket maximum, unless other coverage picks up the 20% coinsurance.

90-Day-At-Retail Program

A 90-day supply of most maintenance medications can be purchased at your retail pharmacy. To take advantage of this program you must have three consecutive claims already processed for that drug in the Navitus claims system immediately before the 90-day supply is requested. In addition, your doctor must write the prescription specifically for a 90-day supply.

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 WellDyneRx's customer service at (888) 479-2000, 24 hours a day, seven days a week. More detailed information can be found on the Navitus website; the WellDyneRx website **welldynerx.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 receive the same medication and dosage while buying fewer tablets and saving on copayments. 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 this program are marked with **"GW"** in the Navitus Formulary. To try 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 and Specialty Medications)

If you are on a specialty medication, the Navitus SpecialtyRx Specialty Pharmacy Program is offered through a partnership with Diplomat 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 your self-injectible and other specialty medications from the specialty pharmacy, please call customer care at (877) 651-4943 or visit **diplomatpharmacy.com**.

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. Coordination of benefits does not guarantee that all of your out-of-pocket costs will be covered.

Pharmacy — *NAVITUS MedicareRX (PDP)*

Underwritten by Sterling Life Insurance Company

Toll-Free Customer Care — (866) 270-3877 medicarerx.navitus.com

What's New for 2012

Effective January 1, 2012, all Medicare-eligible participants covered under an annuitant contract will be automatically enrolled in a Medicare Part D prescription drug program called Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company, who is contracted with the federal government. Prior to 2012, eligible retirees and members in the State of Wisconsin Group Health Insurance Program were covered by creditable coverage through Navitus Health Solutions. Navitus will continue to be your one point of contact for all pharmacy benefit issues as you go from an active employee, to a retiree, to becoming Medicare eligible.

What does this mean to you?

You do not need to take any further action. You will maintain your current benefits. You will receive a new pharmacy ID card that you will need to present to your pharmacy when you fill a prescription. The new ID card will be different than the regular Navitus ID cards issued to active employees and retirees not eligible for Medicare.

When you become eligible for coverage under Medicare Part D, you will be enrolled in the Navitus MedicareRx (PDP) through your employer group coverage. As required by Uniform Benefits, a "Wrap" benefit is also included to provide full coverage to State of Wisconsin Group Health Insurance Program members when they reach the Medicare coverage gap, also known as the "donut hole." You will be automatically enrolled in this "Wrap" coverage. Your formulary will include a three-level copayment structure which includes: $5 (Level 1), $15 (Level 2) and $35 (Level 3). Information regarding your Medicare Part D benefit will be mailed to you by Navitus MedicareRx (PDP) upon confirmed enrollment from CMS.

Your welcome packet will include the following:

- **Your new ID card**
- **Summary of Benefits**
- **Pharmacy Directory**
- **Formulary**
- **Evidence of Coverage (details about your pharmacy coverage)**

PLEASE READ THIS NOTICE CAREFULLY AND KEEP IT WHERE YOU CAN FIND IT.

This notice has information about your prescription drug coverage with the State of Wisconsin Group Health Insurance Program for people with Medicare.

By completing your enrollment application or maintaining your enrollment with the State of Wisconsin Group Health Insurance Program, you agree to the following:

I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Navitus MedicareRx (PDP) of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Navitus MedicareRx (PDP) will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Navitus MedicareRx (PDP) serves a specific service area. If I move out of the area that Navitus MedicareRx (PDP) serves, I need to notify the plan so I can disenroll and find a

new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Navitus MedicareRx (PDP) network pharmacies. Once I am a member of Navitus MedicareRx (PDP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Navitus MedicareRx (PDP) when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Navitus MedicareRx (PDP), he/she may be paid based on my enrollment in Navitus MedicareRx (PDP). Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:
By joining this Medicare prescription drug plan, I acknowledge that Navitus MedicareRx (PDP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Navitus MedicareRx (PDP) will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on my enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on my form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on my application means that I have read and understand the contents of the application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete the enrollment and 2) documentation of this authority is available upon request by Medicare or by my employer group.

This notice is provided each year, prior to the next Medicare prescription drug coverage enrollment period or whenever State of Wisconsin Group Health Insurance Program coverage changes. For more information please contact either ETF or Navitus MedicareRx (PDP).

Navitus MedicareRx (PDP) Customer Care (Effective October 3, 2011):

CALL: (866) 270-3877—Calls to this number are free. Members can reach Navitus Customer Care 24 hours a day/seven days a week, except Thanksgiving and Christmas.

TTY: (866) 268-2501—This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. TTY hours are Monday through Friday 8:00 a.m. to 5:00 p.m. CST.

FAX: (920) 735-5355

WRITE: Navitus MedicareRx (PDP) Customer Care, P.O. Box 999, Appleton, WI 54912-0999

WEBSITE: medicarerx.navitus.com

Life Insurance — *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 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 older than age 65 and for active employees older than age 70.

- The **Supplemental Plan** provides coverage equal to your previous year's earnings, rounded up to the next thousand. Coverage may continue up to age 65, if retired, or age 70, if an active employee.

- 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. Coverage may continue until you terminate employment, cancel coverage or stop paying premium.

- The **Spouse and 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 or long-term care 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 or long-term care insurance premiums. See *Converting Your Group Life Insurance to Pay Health or Long-term Care Insurance Premiums* (ET-2325) for more information.

- **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 younger than age 70;
  - have worked six or more months in service covered by the WRS; and
  - apply within 30 days of your first eligibility.

Note: Employees who reach 70 years old before becoming eligible for the coverage may be insured under the Additional Plan only. This is subject to evidence of insurability.

For Spouse and Dependent coverage only, you may apply when you have a spouse, 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.

ERA Benefits — *Fringe Benefits Management Company*

(800) 342-8017
myFBMC.com

Employee Reimbursement Accounts (ERA) Program

The Employee Reimbursement Accounts (ERA) program is an optional benefit that allows you to set aside pre-tax income to pay for eligible IRS-approved expenses. Fringe Benefits Management Company (FBMC) administers the program.

Medical Expense Reimbursement Account

You may set aside as much as $7,500 tax-free each year for health care expenses not covered by insurance, such as coinsurance, deductibles and copays; and non-covered items, such as eyeglasses and dental expenses. Keep in mind the change in Uniform Benefits now imposes a coinsurance of 90%/10% with an annual out-of-pocket maximum of $500 single/$1,000 family on most illness or injury related services. (Preventive services are paid at 100%.) These expenses can be reimbursed through the Medical Expense Reimbursement Account.

Dependent Day Care Reimbursement Account

This account may be used for day care expenses for eligible dependent(s) that are incurred to allow you (and your spouse, if married) to work, look for work, or attend school full time. The maximum contribution amount allowed is $5,000 per plan year per family, or $2,500 per employee if married and filing taxes separately.

Plan carefully before you enroll.

In exchange for the tax advantages, the IRS has imposed strict rules. Funds remaining in your account(s) at the end of the plan year after all eligible expenses have been reimbursed will be forfeited. Also, once your coverage begins, the benefit election (including the insurance benefits for which premiums are being deducted on a pre-tax basis) cannot be cancelled or changed during the plan year, unless you experience a valid Change In Status event as described in IRS regulations. If you have your health insurance deductions taken on a pre-tax basis, see the *Cancellation/Termination of Coverage* section of the *Frequently Asked Questions* in the *It's Your Choice: Reference Guide* for more information.

Before you enroll, check out the ERA enrollment booklet, available on the ETF website, for more detailed plan information. Review your health, vision and dental benefits for the 2012 plan year to determine the available benefits, copayments and/or deductibles. Also, review the Navitus formulary to determine your drug copayments. Keep in mind the out-of-pocket maximums for drug coverage apply only to Level 1 and Level 2 drugs.

Note: The IRS does not recognize domestic partner status. You cannot, therefore, be reimbursed for a domestic partner's or partner's child's medical or dependent day care expenses unless they meet the IRS definition of dependent.

Open Enrollment Period

ERA program 2012 plan year open enrollment is October 3 to 28, 2011. Employees may enroll by telephone (IVR) system at (800) 847-8253 or online at **myFBMC.com**.

Group Health Insurance Applications

If you want to change health plans or change to family coverage for next year, submit your completed application and retain one for your records. Copies of the *Group Health Insurance Application/Change Form* (ET-2301) are also available at **etf.wi.gov**.

Your application must be submitted electronically (see Pages 10 and 11), handed in, faxed or postmarked by the last day of the It's Your Choice Open Enrollment period (October 28, 2011). Late applications will not be accepted.

Department of Employee Trust Funds

GROUP HEALTH INSURANCE APPLICATION/CHANGE FORM

State of Wisconsin Employees and Annuitants
Wisconsin Public Employees and Annuitants
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 annuitant or on continuation. Use this form to: decline, add or cancel health insurance coverage; change health plans, change coverage levels, or update personal information; and add or remove dependents. For complete enrollment and program information, read the *It's Your Choice* guides. 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 limited term employees or completion of 1,000 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. 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 opportunities available. There are no interim effective dates, except as required by federal HIPAA law. If your application is submitted after these enrollment opportunities, you will not be eligible to enroll until the annual It's Your Choice Open Enrollment period. For complete enrollment and program information, read the *It's Your Choice* guides.

INSTRUCTIONS FOR COMPLETING HEALTH INSURANCE APPLICATION/CHANGE FORM

SECTION 1 – APPLICANT INFORMATION

1. *Print* your responses *clearly* and *legibly; and provide all information requested*.
2. 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's name, SSN and birth date, even if you are applying for single coverage.
3. For initial enrollment only, indicate when you want coverage to start: 1) immediately (as soon as possible); 2) when you become eligible for the employer contribution toward the health insurance premium; or 3) It's Your Choice Open Enrollment period.
4. Coverage Desired: Indicate level of coverage desired by checking either single or family.
5. Health Plan Selected: Indicate the name of the health plan that you want to provide your health insurance.

SECTION 2 – REASON FOR APPLICATION

1. Indicate the reason for submitting this application by checking the box(es) that apply under subsections A, B, C, D, E, F, G or H. If you are completing an application to change coverage level under subsection D, or to add a dependent under subsection H due to marriage, creating a domestic partnership, birth, adoption or placement for adoption, and also wish to change health plans under subsection C, a second application must be completed to change health plans.
2. Subsection A—If declining coverage check the box and go to Section 7 to date and sign your application.
3. Subsection F—When updating personal data, this can be done on the same application when selecting a reason under subsections B, C, D, E, G or H, or on a separate application.
4. If electing a Change from Family to Single Coverage or Canceling Coverage, you must also check the pre-tax/post-tax box that applies. If you have your employee premium share taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage.

SECTION 3 – APPLICANT/DEPENDENT INFORMATION

Provide all information requested in this Section for yourself and any eligible dependents, if applicable, when selecting a reason under Adding Coverage, Subsection B; Changing Health Plan, Subsection C; and Changing Coverage Level, Subsection D.

When selecting a reason under Remove Dependents, Subsection G; or Add Dependents, Subsection H, provide all information requested in the Applicant/Dependent Information Section for all dependents who are being removed or added.

For "Rel. 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	

03=Minor Child Parent of Minor Dependent (This relationship is a Legal Ward, Stepchild, Child, or Dependent of Domestic Partner who is under age 18 and is the parent of any of your grandchildren listed as an eligible dependent on this application. Your grandchildren cannot be covered on your contract unless the parent of the grandchild is covered and is under 18.)

Indicate "Yes" or "No" if any dependent older than age 26 is disabled.

Indicate "Yes" or "No" if your domestic partner and/or dependent child is considered a "tax 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 selecting the Standard Plan, indicate "NONE."

SECTION 4 – ADDITIONAL INFORMATION

Indicate "Yes" or "No" and list the name of your grandchild's parent.

SECTION 5 – MEDICARE INFORMATION

Indicate "Yes" or "No" if you or 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 the Medicare Part A and/or Part B 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 (examples, EPIC or DentalBlue).

SECTION 7 – SIGNATURE

Read the **TERMS AND CONDITIONS** on the last page.

1. When submitting an application for any reason, you are required to read the Terms and Conditions on the last page. You must also check the box that you are applying for coverage, have read and agree to the Terms and Conditions, and sign and date the application.
2. Submit the application to your payroll representative or to ETF if you are an annuitant or continuant.
3. Your employer will complete Section 8 and provide a copy of the application to you. For annuitants/continuants, ETF will complete Section 8 and provide a copy of the application to you.
4. If submitting during the annual It's Your Choice Open 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

Home Mailing Address—Street and No.	City	State	Zip Code

County	Country (if not USA)	Primary Telephone No.	Daytime Telephone No.
		( )	( )

MARITAL OR DOMESTIC PARTNERSHIP STATUS:

☐ Single ☐ Married *(date)* _____ ☐ Divorced *(date)* _____ ☐ Widowed *(date)* _____

☐ Domestic Partnership *(date)* _____

Spouse/Domestic Partner Name _____ SSN _____ Birth Date _____

ELIGIBILITY STATUS (check one):

☐ Employee ☐ Graduate Assistant ☐ Survivor

☐ Continuant (COBRA) ☐ Annuitant

EMPLOYMENT STATUS (check one):

☐ Full Time ☐ Part Time

☐ Limited Term Employee ☐ Retiree ☐ N/A

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. Decline Coverage

☐ I do not wish to enroll at this time. *(Go to Section 7 to sign and date your application.)*

B. Add Coverage *(Check one box below and indicate the date of event. Update Section 3.):*

☐ New Hire
☐ Birth
☐ Adoption
☐ National Medical Support Notice
☐ Marriage or Domestic Partnership
☐ Spouse/Domestic Partner to Spouse/Domestic Partner Transfer
☐ Loss of Other Coverage/Employer Contributions
☐ LTE New Hire (State Only)
☐ Transfer from One Employer to Another Employer
Name of Previous Employer:_____
☐ It's Your Choice Open Enrollment Period
☐ Other:_____

Date of event: _____

C. Change Health Plan *(Indicate current health plan, check one box below and indicate the date of the event. Update Section 3.):*

Current Health Plan: _____

☐ Move from Service Area
☐ It's Your Choice Open Enrollment period
☐ Due to Birth, Adoption, Marriage/Domestic Partnership

Date of event: _____

D. Change Coverage Level

☐ Single to Family Coverage Due to *(Check one box below and indicate the date of event. Update Section 3.):*

☐ Marriage/Domestic Partnership
☐ Birth
☐ Adoption
☐ National Medical Support Notice
☐ Legal Ward, Paternity Acknowledgment
☐ It's Your Choice Open Enrollment Period
☐ Dependent Loss of Coverage
☐ Other:_____

Date of event: _____

☐ Family to Single Coverage — If your employee premium share is taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage. My employee-required premium contribution is deducted (Check one box below and update Section 3.):

☐ post-tax. Mid-year changes to your coverage level can be made at any time.
☐ pre-tax, and my employee premium contribution has increased significantly.
Date of event: _____
☐ pre-tax, and my spouse and all dependents became eligible for and enrolled in other group coverage.
Date of event: _____
☐ pre-tax, and my last dependent has become ineligible for coverage under this plan.
Date of event: _____
☐ pre-tax, and I wish to change to single coverage during the annual It's Your Choice Open Enrollment period.

Applicant Name	Social Security Number

2. REASON FOR APPLICATION (Continued)

E. Cancel Coverage

I wish to *(Check one of the two following boxes.)*:

- ☐ cancel my current coverage.
- ☐ cancel my current family coverage to complete a spouse-to-spouse transfer.

My premiums are deducted: (Check one of the two following boxes):

- ☐ post-tax. Coverage may be cancelled at any time.
- ☐ pre-tax. Coverage may be cancelled only if a qualifying event occurs or during the annual It's Your Choice Enrollment period. (Check one of the following boxes if your premiums are deducted pre-tax and provide the date of event.)
  - ☐ I am terminating employment.
  - ☐ I am going on unpaid leave of absence.
  - ☐ I am going to less than half-time employment.
  - ☐ My employee premium contribution has increased significantly.
  - ☐ I (and all my dependents, if applicable) became eligible for and enrolled in other group coverage.
  - ☐ Annual It's Your Choice Open Enrollment period

Date of event: _____

F. Update Personal Data *(Check all boxes below that apply.)*:

- ☐ Name Change:
  Indicate former name_____
- ☐ Address Change (Indicate updated address in Section 1.)
- ☐ Telephone Number Change (Indicate updated telephone number in Section 1.)
- ☐ Date of Birth Correction to (Date) _____for (Name)_____
- ☐ Social Security Number Correction to _____ for (Name)_____
- ☐ Marital Status and/or Marital Status Date Correction (Indicate updated marital status information in Section 1.)
- ☐ Medicare Information Update, complete Section 5.
- ☐ Other Insurance Update, complete Section 6.

G. Remove Dependents *(Check one box below and indicate the date of event. Update Section 3 with dependents being removed.)*:

- ☐ Divorce
- ☐ Domestic Partnership Terminated
- ☐ Death of Dependent
- ☐ Dependent Marriage
- ☐ Removing Adult Dependent During Annual It's Your Choice Open Enrollment period
- ☐ Disabled Dependent: Disability Ends
- ☐ Disabled Dependent: Support and Maintenance Less than 50%
- ☐ Legal Guardianship Ends
- ☐ Grandchild's Parent Turns 18
- ☐ Other:_____

Date of event: _____

Note: The deletion of a dependent due to loss of eligibility provides an opportunity for continuation coverage (COBRA) provided notice is given to the employer within 60 days of the event.

H. Add Dependents *(Check one box below and indicate date of event. Update Section 3 with dependents being added.)*:

- ☐ Marriage
- ☐ Domestic Partnership*
- ☐ Birth
- ☐ Adoption*
- ☐ National Medical Support Notice*
- ☐ Legal Guardianship*
- ☐ Paternity Acknowledgment*
- ☐ Adult Dependents, Annual It's Your Choice Period
- ☐ Dependent Loss of Other Group Coverage*
- ☐ Eligible Dependent Not Included on Initial Enrollment (Domestic partner or adult children cannot be Enrolled for this reason.)
- ☐ Disabled, Over Age 27*
- ☐ Other:_____

Date of event: _____

*The addition of dependents due to these reasons requires supporting documentation. Check the It's Your Choice Reference Guide for specific documentation requirements.

3. APPLICANT/DEPENDENT INFORMATION — Complete all requested information.

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

Applicant Name	Social Security Number

4. ADDITIONAL INFORMATION

a. Are any of the dependents listed under Applicant/Dependent Information 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 or annuitant (including University of Wisconsin)? ☐ Yes ☐ No

7. SIGNATURE (Read the **TERMS AND CONDITIONS** on the last page, **check the box below** and sign the application.)

☐ 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.

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. Additional documentation may be required by ETF at any time to verify eligibility.

SIGN HERE & Return to Employer ➡	Date Signed (MM/DD/CCYY)	Applicant Signature

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

Employer Number **69-036-**	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

Previous Service – Complete Information

1. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No
2. Previous service check completed? ☐ Yes ☐ No

Source of previous service check: ☐ Online Network for Employers (ONE) ☐ ETF

Date Application Received by Employer (MM/DD/CCYY)
Date WRS Eligible Employment Began or Graduate Assistant Appointment Began (MM/DD/CCYY)

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** ☐ **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. Children may be covered through the end of the month in which they turn 26 if they are not enrolled in an employer-sponsored group health insurance plan. Children may also be covered beyond age 26 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 18, 29, or 36 months, depending on the type of qualifying event, 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 months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.
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*** guides.

DUPLICATE APPLICATION 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

Home Mailing Address—Street and No.	City	State	Zip Code

County	Country (if not USA)	Primary Telephone No.	Daytime Telephone No.
		( )	( )

MARITAL OR DOMESTIC PARTNERSHIP STATUS:

☐ Single ☐ Married *(date)* _____ ☐ Divorced *(date)* _____ ☐ Widowed *(date)* _____

☐ Domestic Partnership *(date)* _____

Spouse/Domestic Partner Name _____ SSN _____ Birth Date _____

ELIGIBILITY STATUS (check one):

☐ Employee ☐ Graduate Assistant ☐ Survivor

☐ Continuant (COBRA) ☐ Annuitant

EMPLOYMENT STATUS (check one):

☐ Full Time ☐ Part Time

☐ Limited Term Employee ☐ Retiree ☐ N/A

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. Decline Coverage

☐ I do not wish to enroll at this time. *(Go to Section 7 to sign and date your application.)*

B. Add Coverage *(Check one box below and indicate the date of event. Update Section 3.):*

☐ New Hire
☐ Birth
☐ Adoption
☐ National Medical Support Notice
☐ Marriage or Domestic Partnership
☐ Spouse/Domestic Partner to Spouse/Domestic Partner Transfer
☐ Loss of Other Coverage/Employer Contributions
☐ LTE New Hire (State Only)
☐ Transfer from One Employer to Another Employer
Name of Previous Employer:_____
☐ It's Your Choice Open Enrollment Period
☐ Other:_____

Date of event: _____

C. Change Health Plan *(Indicate current health plan, check one box below and indicate the date of the event. Update Section 3.):*

Current Health Plan: _____

☐ Move from Service Area
☐ It's Your Choice Open Enrollment period
☐ Due to Birth, Adoption, Marriage/Domestic Partnership

Date of event: _____

D. Change Coverage Level

☐ Single to Family Coverage Due to *(Check one box below and indicate the date of event. Update Section 3.):*

☐ Marriage/Domestic Partnership
☐ Birth
☐ Adoption
☐ National Medical Support Notice
☐ Legal Ward, Paternity Acknowledgment
☐ It's Your Choice Open Enrollment Period
☐ Dependent Loss of Coverage
☐ Other:_____

Date of event: _____

☐ Family to Single Coverage — If your employee premium share is taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage. My employee-required premium contribution is deducted (Check one box below and update Section 3.):

☐ post-tax. Mid-year changes to your coverage level can be made at any time.
☐ pre-tax, and my employee premium contribution has increased significantly.
Date of event: _____
☐ pre-tax, and my spouse and all dependents became eligible for and enrolled in other group coverage.
Date of event: _____
☐ pre-tax, and my last dependent has become ineligible for coverage under this plan.
Date of event: _____
☐ pre-tax, and I wish to change to single coverage during the annual It's Your Choice Open Enrollment period.

DUPLICATE APPLICATION FOR YOUR RECORDS

Applicant Name	Social Security Number

2. REASON FOR APPLICATION (Continued)

E. Cancel Coverage

I wish to *(Check one of the two following boxes.)*:

- ☐ cancel my current coverage.
- ☐ cancel my current family coverage to complete a spouse-to-spouse transfer.

My premiums are deducted: (Check one of the two following boxes):

- ☐ post-tax. Coverage may be cancelled at any time.
- ☐ pre-tax. Coverage may be cancelled only if a qualifying event occurs or during the annual It's Your Choice Enrollment period. (Check one of the following boxes if your premiums are deducted pre-tax and provide the date of event.)
  - ☐ I am terminating employment.
  - ☐ I am going on unpaid leave of absence.
  - ☐ I am going to less than half-time employment.
  - ☐ My employee premium contribution has increased significantly.
  - ☐ I (and all my dependents, if applicable) became eligible for and enrolled in other group coverage.
  - ☐ Annual It's Your Choice Open Enrollment period

Date of event: _____

F. Update Personal Data *(Check all boxes below that apply.)*:

- ☐ Name Change:
  Indicate former name_____
- ☐ Address Change (Indicate updated address in Section 1.)
- ☐ Telephone Number Change (Indicate updated telephone number in Section 1.)
- ☐ Date of Birth Correction to (Date) _____for (Name)_____
- ☐ Social Security Number Correction to _____ for (Name)_____
- ☐ Marital Status and/or Marital Status Date Correction (Indicate updated marital status information in Section 1.)
- ☐ Medicare Information Update, complete Section 5.
- ☐ Other Insurance Update, complete Section 6.

G. Remove Dependents *(Check one box below and indicate the date of event. Update Section 3 with dependents being removed.)*:

- ☐ Divorce
- ☐ Domestic Partnership Terminated
- ☐ Death of Dependent
- ☐ Dependent Marriage
- ☐ Removing Adult Dependent During Annual It's Your Choice Open Enrollment period
- ☐ Disabled Dependent: Disability Ends
- ☐ Disabled Dependent: Support and Maintenance Less than 50%
- ☐ Legal Guardianship Ends
- ☐ Grandchild's Parent Turns 18
- ☐ Other:_____

Date of event: _____

Note: The deletion of a dependent due to loss of eligibility provides an opportunity for continuation coverage (COBRA) provided notice is given to the employer within 60 days of the event.

H. Add Dependents *(Check one box below and indicate date of event. Update Section 3 with dependents being added.)*:

- ☐ Marriage
- ☐ Domestic Partnership*
- ☐ Birth
- ☐ Adoption*
- ☐ National Medical Support Notice*
- ☐ Legal Guardianship*
- ☐ Paternity Acknowledgment*
- ☐ Adult Dependents, Annual It's Your Choice Period
- ☐ Dependent Loss of Other Group Coverage*
- ☐ Eligible Dependent Not Included on Initial Enrollment (Domestic partner or adult children cannot be Enrolled for this reason.)
- ☐ Disabled, Over Age 27*
- ☐ Other:_____

Date of event: _____

*The addition of dependents due to these reasons requires supporting documentation. Check the It's Your Choice Reference Guide for specific documentation requirements.

3. APPLICANT/DEPENDENT INFORMATION — Complete all requested information.

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

DUPLICATE APPLICATION FOR YOUR RECORDS

Applicant Name	Social Security Number

4. ADDITIONAL INFORMATION

a. Are any of the dependents listed under Applicant/Dependent Information 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 or annuitant (including University of Wisconsin)? ☐ Yes ☐ No

7. SIGNATURE (Read the **TERMS AND CONDITIONS** on the last page, **check the box below** and sign the application.)

☐ 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.

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. Additional documentation may be required by ETF at any time to verify eligibility.

SIGN HERE & Return to Employer ➡	Date Signed (MM/DD/CCYY)	Applicant Signature

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

Employer Number **69-036-**	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

Previous Service – Complete Information

1. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No
2. Previous service check completed? ☐ Yes ☐ No

Source of previous service check: ☐ Online Network for Employers (ONE) ☐ ETF

Date Application Received by Employer (MM/DD/CCYY)

Date WRS Eligible Employment Began or Graduate Assistant Appointment Began (MM/DD/CCYY)

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** ☐ **EMPLOYEE** ☐ **EMPLOYER**

Glossary

Glossary

Alternate Health Plans: The insurance plans in the State Group Health 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: The specific percentage of the cost of an item or service that the health plan and the member pay. For example, under Uniform Benefits, health plans pay 90% and members pay 10% of the cost for most services for an illness or injury. Also see OOPM definition.

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

Creditable Coverage: For purposes of Medicare Part D, the prescription drug coverage provided by the State Group Health Insurance Program is as good or better than the coverage a member can get by purchasing an individual commercial Part D plan. If a member needs Part D coverage in the future, there will be no penalty when creditable coverage has been maintained.

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 State Group Health Insurance Program rules.

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.

ETF: Employee Trust Funds, a state of Wisconsin agency that manages health insurance, retirement and other benefit programs for WRS participants and employers. Programs cover state and participating local employees and retirees.

Formulary: A list of covered prescription drugs. The State Group Health Insurance Program's formulary is available on Navitus Health Solutions' website at **https://www.navitus.com/Pages/default.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).

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.

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.

It's Your Choice Open Enrollment period: The annual opportunity for eligible employees and annuitants to change from one health plan to another, newly enroll or to change from single to family coverage for the upcoming year without restrictions.

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.

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 Primary Payor: Where Medicare pays insurance claims first for retirees and/or their dependents who are aged 65 and older, and certain individuals with disabilities. Other group health insurance pays claims second, after Medicare's payment.

Medicare 1 (Family 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 2 (Family 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.

Glossary

NCQA: The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to improving health care quality. For more information, go to **ncqa.org**.

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 (OOPM): The maximum amount of money a health plan member has to pay for services during a year.

Participant: The subscriber or any of his/her dependents who have been specified for enrollment and are entitled to benefits.

PBM (Pharmacy Benefit Manager): The third-party administrator 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 to Medicare-eligible participants covered under an annuitant contract.

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

Plan Service Area: The geographic area in which a health plan provides coverage through its 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). This arrangement can be attractive to participants who are generally satisfied with the health plan's providers, but who may occasionally need to use a particular specialist or need additional options while traveling. Currently, the only available Alternate Health Plans that offer a PPP are WPS Metro Choice and WEA Trust PPP. For other options, see the Standard Plan on Page 24.

Preventive Services: Routine, preventive care is care that is designed to help prevent disease or to diagnose it in the early stages. The list of federally required preventive services is available at healthcare.gov/law/about/provisions/services/lists.html. Federal requirements may vary by age.

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.

Routine Preventive Services: See Preventive Services.

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, Medicare Plus plans and Navitus Health Solutions are self-funded.

Subscriber: The employee, annuitant or continuant who is eligible to participate in the State of Wisconsin or WPE Group Health Insurance Programs 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 Program members through the HMOs and as the in-network benefit for PPPs, such as WEA Trust PPP 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 school districts.

Wrap Benefit: A supplemental prescription drug benefit for Medicare-eligible participants covered under an annuitant contract who are enrolled in the State of Wisconsin or WPE Group Health Insurance Programs. This benefit will pay for prescription drug claims up to the level of the Uniform Benefits coverage after Medicare Part D has paid its portion.

WRS: Wisconsin Retirement System.

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Health Plan Contact Information

Anthem Blue
P.O. Box 105187
Atlanta, GA 30348
Tele: (800) 490-6201
24/7 Nurseline: (866) 647-6120
Website: anthem.com

Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625
Tele: (888) 711-1444
(920) 490-6900
Fax: (920) 490-6942
Website: WeCareForWisconsin.com

Dean Health Plan
1277 Deming Way
Madison, WI 53717
Tele: (800) 279-1301
(608) 828-1301
Fax: (608) 827-4212
Dean On Call: (800) 576-8773
Website: deancare.com/wi-employees

Group Health Cooperative of Eau Claire (GHC-EC)
P.O. Box 3217
Eau Claire, WI 54702
Tele: (888) 203-7770
(715) 552-4300
Fax: (715) 552-3500
FirstCare Nurseline: (800) 586-5473
Website: group-health.com

Group Health Cooperative of South Central Wisconsin (GHC-SCW)
1265 John Q. Hammons Drive
P.O. Box 44971
Madison, WI 53744-4971
Tele: (800) 605-4327
(608) 828-4853
Fax: (608) 662-4186
GHC HealthLine: (888) 203-3504
Website: ghcscw.com

Gundersen Lutheran Health Plan
1836 South Avenue
LaCrosse, WI 54601
Tele: (800) 897-1923
(608) 775-8007
Fax: (608) 775-8042
Nurse Advisor: (800) 362-9567
ext. 54454
Website: 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
Website: healthpartners.com/stateofwis

Health Tradition Health Plan
P.O. Box 188
La Crosse, WI 54602-0188
Tele: (888) 459-3020
(608) 781-9692
Fax: (608) 781-4620
Ask Mayo Clinic: (877) 817-0936
Website: healthtradition.com

Humana
N19 W24133 Riverwood Drive #300
Waukesha, WI 53188
Tele: (800) 448-6262
HumanaFirst Nurse Advice:
(800) 622-9529
Website: humana.com, or direct at apps.humana.com/egroups/wisconsin/home.asp

Medical Associates Health Plans
1605 Associates Drive, Suite 101
P.O. Box 5002
Dubuque, IA 52004-5002
Tele: (800) 747-8900
(563) 556-8070
Fax: (563) 556-5134
Nurse Line: (800) 325-7442
Website: mahealthcare.com

MercyCare Health Plans
3430 Palmer Drive
P.O. Box 2770
Janesville, WI 53547-2770
Tele: (800) 752-3431
(608) 752-3431
Fax: (608) 752-3751
Nurse Line: (888) 756-6060
Website: mercycarehealthplans.com

Navitus Health Solutions
5 Innovation Court, Suite B
Appleton, WI 54914
Tele: (866) 333-2757
Fax: (920) 831-1930
Website: navitus.com

Navitus MedicareRx (PDP)
(Prescription drug coverage for Medicare eligible retirees)
P.O. Box 999
Appleton, WI 54912-0999
Tele: (866) 270-3877
Fax: (920) 831-1930
Website: medicarerx.navitus.com

Network Health Plan
1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Tele: (800) 826-0940
(920) 720-1300
Fax: (920) 720-1900
Nurse Direct: (800) 362-9900
Website: networkhealth.com

Physicians Plus Insurance Corp.
2650 Novation Parkway
Madison, WI 53713
Tele: (800) 545-5015
(608) 282-8900
Fax: (608) 258-1906
NursePlus: (866) 775-8776
Website: pplusinc.com

Security Health Plan
1515 Saint Joseph Avenue
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
Website: 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
Website: wpsic.com/state

UnitedHealthcare of Wisconsin Inc.
P.O. Box 13187
3100 AMS Blvd.
Green Bay, WI 54307-3187
Tele: (800) 357-0974
Fax: (866) 674-5637
Website: unitedhealthcare.com

Unity Health Insurance
840 Carolina Street
Sauk City, WI 53583-1374
Tele: (800) 362-3310
Fax: (608) 643-2564
Website: chooseunityhealth.com

WEA Trust
45 Nob Hill Road
P.O. Box 7338
Madison, WI 53707-7338
Tele: (800) 279-4000
(608) 276-4000
Fax: (608) 276-9119
Website: weatruststatehealthplan.com

WPS Metro Choice
1717 W Broadway
P.O. Box 8190
Madison, WI 53707-8190
Tele: (800) 634-6448
Fax: (608) 243-6139
Website: wpsic.com/state

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